STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Anthony's Care Center	7501 Bagby Ave. Waco, TX 76712

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had a right to personal privacy and confidentiality of his or her personal and medical records for 3 of 10 residents (Resident #47, Resident #352, and Resident # 354) residents reviewed for personal privacy. CNA A, CNA B, and CNA C failed to knock before entering Resident #47, Resident #352, and Resident # 354's rooms. The deficient practice could place residents at risk of feeling like their privacy was being invaded or the facility was not their home. Findings include: Record review of Resident #47 face sheet, dated 12/17/2024, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #47 had diagnoses which included heart failure, fibromyalgia (chronic widespread pain), disease of the blood, kidney failure, high cholesterol, wound on right heel, breast cancer, falls, and a pacemaker. Record review of Resident #47's Quarterly MDS, dated [DATE], revealed Resident #47's BIMs score was 14, which meant the resident was cognitively intact. Record Review of Resident #47's care plan dated 10/07/2024 revealed that the resident had an ADL self-care deficits related to general weakness. Record review of Resident #352 face sheet, dated 12/17/2024, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #352 had diagnoses which included heart disease, kidney disease, high blood pressure, shortness of breath, depression, anxiety, high cholesterol, history of breast cancer, and pacemaker. Record review of Resident #352's Quarterly MDS, dated [DATE], revealed Resident #352's BIMs score was 15 which meant the resident was cognitively intact. Record Review of Resident #352's care plan dated 12/16/2024 did not reveal any self-care. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #354 face sheet, dated 12/17/2024, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #354 had diagnoses which included urinary tract infection, kidney disease, high blood pressure, weakness, depressive disorder, and dementia (general decline in cognitive ability). Record review of Resident #354's Quarterly MDS, dated [DATE], revealed Resident #354's BIMs score was 9 which meant the resident was moderately impaired for cognition. Record review of Resident #354's care plan, dated 12/09/2024, revealed that the resident had an ADL self-care deficits related to general weakness. Observation on 12/16/2024 at 9:05 AM revealed that CNA C opened Resident #47's door and walked into the room without knocking on the resident's door. Observation on 12/16/2024 at 12:23 PM of dining services on the hall revealed that CNA B walked into Resident #352 and Resident #354's rooms without knocking before entering. Observation on 12/17/2024 at 8:21 AM revealed CNA A and CNA C walked into Resident #47's room without knocking before entering. An Interview with Resident #47 on 12/17/2024 at 8:33 AM revealed that staff did not always knock on the resident's door. She stated that she does not really get upset but she would like for them to knock all the time before entering her room. An interview with Resident #352 on 12/17/2024 12:00 PM revealed that some staff did not knock on the resident's door. She said that if staff did not knock, she would ignore them because they did not knock. She said that she wanted staff to knock every time before they came in her room, so she knew what was going on. In an interview with Resident #354 on 12/17/2024 at 1:15 PM revealed that staff do not knock on his door. He said he does not get upset about staff not knocking. He stated that he preferred for staff to knock before entering his room. In an interview with CNA C on 12/17/2024 at 12:58 PM revealed she had been trained on resident rights. She stated the policy was for staff to knock on the resident's room and announce yourself before entering. She said that all staff were required to knock anytime they were going to enter the resident's room. She said the resident may feel that staff are intruding on their privacy. She said she thought the resident probably did not like staff not knocking. She stated that she did not know that she had to knock every time before entering the resident's room. In an interview with CNA B on 12/17/2024 at 1:12 PM revealed that she had been trained on resident rights. She stated that staff were supposed to knock on the resident's door before entering even if the staff were answering the call light. She said it was important to knock because the resident had the right to privacy. She said that the resident may get irritated if staff do not knock before entering. She said that she did not knock on the resident's door before entering because she was not thinking. She said she should have knocked. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with CNA A on 12/17/2024 at 1:16pm revealed that she had been trained on resident rights. She said that the policy for knocking on the door was that all staff were supposed to knock. She said it was important to knock on the resident's door because it is their home. She stated that if staff do not knock on the door, it could frighten the resident because they are not expecting the staff. She stated that she did not know she did not knock and that she just got busy. She said that she knows that it is important to knock on the resident's door. In an interview with the DON on 12/18/2024 at 4:39 PM revealed that she and the staff have been trained on resident rights. She said that the staff know that they are supposed to knock before entering. She said the policy was that staff were supposed to knock every time before entering. She said it was important to knock for the resident's privacy and it was their right. She said that residents may feel like staff were invading their privacy if they did not knock on their door. In an interview with the ADM on 12/18/2024 at 4:49 PM revealed her and the staff had been trained on resident rights. She stated the policy was that all staff knock on the resident's door before entering especially if they are in the bathroom. She said staff should be always knocking before entering. She said that it was important because it was the resident's home, and they have the right to let staff enter or not. She said that if staff are not knocking the resident may feel disrespected or sad. She said she did not know why staff were not knocking on the resident's door. She said she thought that staff were not paying attention. Record Review of Resident Rights Policy, undated, revealed Residents do not leave their individual personalities or basic human rights behind when they move into long term care facilities. The right to personal privacy. When providing care always provide privacy by knocking and announcing yourself.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to develop and implement a baseline care within 48 hours of admission that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 of 10 residents (Resident #21) reviewed for baseline care plans. The facility failed to create a baseline care plan was created for Resident #21 within 48 hours of admission that addressed the resident's need for nutrition via enteral feeds. This failure could place the resident at risk of further malnutrition, a lack of continuity of care and communication among nursing home staff, reduced resident satisfaction of care, and reduced safeguards against adverse events that are most likely to occur right after admission. Findings included: Record review of Resident #21's face sheet dated 12/17/24 reflected, a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of gastroparesis (a condition where the stomach stops digesting food), an artificial opening of the digestive tract (j-tube)(an artificial tube placed directly into the small intestine for food and medicine administration), unspecified protein calorie malnutrition, nausea with vomiting, and chronic obstructive pulmonary disease (an inflammatory disease of the lungs). Record review of Resident #21 's MDS dated [DATE] indicated the resident received 51% or more of her fluid and total calories through a feeding tube. Record review of Resident #21's care plan dated 08/05/2024 reflected: Focus dated 08/05/2024 - The resident has a terminal prognosis related to COPD and has elected to receive services through hospice provider. Goal dated 08/05/2024- Comfort will be maintained through the next review date. Intervention dated 08/14/2024- Adjust provisions of ADLs to compensate for the resident's changing abilities Focus dated 08/05/2024- The resident will attend activities of interest. Resident enjoys jigsaw puzzles, manicures, BINGO, and visiting with family. Goal dated 08/05/2024 Resident will continue to attend activities of interest at least 3x a week through the next review date. Interventions dated 08/05/2024- Ensure wheelchair is available to use to attend activities. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of care plan for Resident #21 on 12/17/2024 revealed no specific information or interventions about resident's physical considerations for gastroparesis , nausea, or care for her artificial J-Tube. Record review of the electronic healthcare records system for Resident #21 on 12/17/2024 revealed the baseline care plan was completed by the system on 08/08/2024. Interview on 12/17/2024 with the ADON B at 2:35 pm revealed she was not aware that the baseline care plan was done a week after Resident #21's admission. She stated it was the charge nurse's responsibility to initiate the baseline care plans upon admission if the ADON or DON were not there. She stated that there was no reason for Resident #21 to not have a baseline care plan. She stated if there was no baseline care plan available it could impact the resident's care when they were vulnerable upon admission. Interview on 12/18/2024 with the DON at 5:00 pm revealed when shown Resident #21's care plan in the Electronic Medical Record that the baseline care plan was done on 08/08/24 she replied, it should have been done in the same day. She stated they previously had issues with care plans, and they had switched to documenting on paper care plans while interviewing the resident when they were admitted . She stated it's important for residents to have care plans because the staff could be missing vital components to the resident's care. Interview on 12/18/2024 with the ADM at 5:15 pm revealed there was no base line care plan for Resident #21 , and it was the facility policy to have a baseline care plan within 24 hours of a resident admitting into the facility. She stated when a resident was admitted it was the charge nurse's responsibility to initiate the baseline care plan on the electronic healthcare record system. She was supposed to print it out and leave it for the staff to review in the morning meeting. After the care plan would be approved it should have gone to the MDS nurse's office for final input into the electronic healthcare record. She stated that even if a resident was admitted on a weekend, as Resident #21 was, her baseline care plan should have been picked up at the Monday morning all staff meeting. She stated that they changed the system for care plans in October 2024 and the DON was responsible for completing a paper baseline care plan sheet upon admission. She stated that potential outcomes for Resident #21 could have been catastrophic, such as not receiving proper care for her J-Tube. Record review of the facility's Comprehensive Care Plan policy revealed objectives that reflected, 3. To clearly delineate instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Procedure: 1. Nursing home staff will develop a baseline care plan for the resident's care within 48 hours of admission to the facility. 2. The baseline care plan will include, at a minimum the following: (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Initial goals based on admission orders b. Physician orders c. Dietary orders d. Therapy services e. Social services f. PASRR recommendation, if applicable.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure competent nursing services for 1 (Resident #21) of 10 residents reviewed for competent nursing services. 1. The facility failed to accurately administer and log a medication and then identify and report a medication administration error. This deficient practice puts the residents at risk for decline in physical condition that is unacknowledged by the facility, a risk for potential for adverse reactions due to improper medication administration and a decrease in quality of life for the residents. Review of Resident #21's Face sheet dated 12/17/24 reflected, a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of gastroparesis (a condition where the stomach stops digesting food), an artificial opening of the digestive tract (g-tube)(an artificial tube placed directly into the small intestine for food and medicine administration), unspecified protein calorie malnutrition, nausea with vomiting, and chronic obstructive pulmonary disease (an inflammatory disease of the lungs). Review of Resident #21's quarterly MDS dated [DATE] revealed resident was receiving hospice services. Review of Residents #21's care plan dated 08/05/2024 reflected, Observe resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain. Review of Resident #21's order dated 11/29/2024 reflected 10 mg of (hydrocodone/acetaminophen) every 4 hours. Review of Resident #21's order reflected 5 mg of (hydrocodone/acetaminophen) PRN was canceled 12/18/2024. Review of controlled drug sheet for Resident #21's hydrocodone/acetaminophen reflected that 5 mg PRN (hydrocodone/acetaminophen) was zeroed out on 11/29/2024. Review of pharmacy logs for resident #21 hydrocodone/acetaminophen on 12/17/2024 revealed 5 mg (hydrocodone/acetaminophen) had not been refilled since 11/29/24. Record review of the controlled drug book for Resident #21 on the floor cart reflected documented administrations of 10 mg (hydrocodone/acetaminophen) at 4 am and 5 am signed by LVN B (continued on next page)

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F 0726

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Interview with Resident #21 on 12/18/24 at 12:08 pm, she stated that she thought she had received double hydrocodone/acetaminophen this morning. She said she didn't remember getting her second dose, but she believed it happened because she felt extremely drowsy. She stated this was the first time it had happened. She stated she was not upset about the medication error because she had just slept a little longer.

Interview with LVN A on 12/18/24 at 1:00 pm, she stated she noticed the resident #21 was groggy. She had checked the logs and saw that the resident had an extra dose of (hydrocodone/acetaminophen) at 5 am and held the morning dose of the medication. She had not reported the medication error to facility staff at that time. She stated she called hospice to clarify the order but did not tell them she had an extra dose. After she spoke with hospice, she had the extra 5 mg order of (hydrocodone/acetaminophen) canceled. She stated she did not realize LVN B administered two doses of the 10 mg hydrocodone/acetaminophen until she reviewed the log with the surveyor. She stated that the logs and counts were reconciled, and she did not see LVN B added anything to the logs. She stated the resident did not ask for the medication, and she did not know why she gave it to LVN A said that she should have reported the extra dosage to the charge nurse, ADON or doctor. She believed the ADONs were responsible for reconciling the orders with the system. She stated that they should have monitored her for medication side effects and the risks to the resident for not reporting a medication error could be that the resident had a bad reaction, or she could have slept all day.

Interview with ADON A on 12/18/2024 at 12:45 pm, she stated that the 5 mg order should have been discontinued on 11/29/24 when the dosage was increased to 10 mg every 4 hours. She stated that was a medication error and both nurses should have reported the error to her. She stated that when the nurses made a medication error, they should have made sure the resident was safe, notify the doctor, and monitored the resident for any side effects. The orders were reconciled by the charge nurses or ADONs. She stated that the residents who were given too many opioid medications could have serious side effects including hospitalization or death.

Interview with the DON on 12/18/2024 at 1:00 pm, she stated that giving two doses of hydrocodone/acetaminophen was a medication error and both nurses should have reported it. She reviewed the pharmacy logs and confirmed that 5 mg dose had not been refilled since 11/29/24 and the dose had been still active in the system until today. She stated that the charge nurses and ADON should have reconciled the order. The DON stated she had received a statement from the LVN A and LVN B. She had performed a teachable moment with LVN A and had contacted the agency to place that nurse on the Do Not Return List.

Interview with LVN B on 12/18/24 at 02:27 PM, she stated that she made a mistake. She worked at the facility before but was employed by a staffing facility and had not worked in 2 weeks. She stated that the resident was very particular about her medications and about two weeks ago had told her she took 2 doses of the medication. She stated that she had given the previously scheduled doses at 8 pm and 12 am correctly. She stated the resident did not ask for the medication and she did not know why she had given it to her. She stated she had not looked at the physician's order and gave her two doses at 4 am but did not log the two doses. She stated that while she was counted the medications with LVN A, she added the 5 am dose to the sheet because she realized her mistake. She had not reported it to the charge nurse or any facility staff. She stated she should have reported the incident to the charge nurse. She had not received any training or in-services in the last 6 months from her company of any of the facilities that she had worked at. She stated if she does not report administration errors the resident could overdose or get sick.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with ADM on 12/18/24 at 4:30 pm she stated that the nurse should have read the order and followed it exactly. Both nurses should have reported the error to the ADON. Both nurses should should have checked on the resident. The DON should have taken over after the report. She stated LVN B would not be back. She expected orders to be discontinued because they had processes in place for reconciling doctors' orders. The negative outcomes were that residents would not have the best quality of care. Review of facility policy of undated medication error reflected, All medication errors must be promptly reported to the Director of Nursing Services, attending physician, and the pharmacist.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from any significant medication errors for 1(Resident #21) of 10 residents reviewed for medication errors. 1. The facility failed to accurately administer and log a medication and then identify and report a medication administration error. This deficient practice puts the residents at risk for decline in physical condition that is unacknowledged by the facility, a risk for potential for adverse reactions due to improper medication administration and a decrease in quality of life for the residents. Review of Resident #21's Face sheet dated 12/17/24 reflected, a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of gastroparesis (a condition where the stomach stops digesting food), an artificial opening of the digestive tract (g-tube)(an artificial tube placed directly into the small intestine for food and medicine administration), unspecified protein calorie malnutrition, nausea with vomiting, and chronic obstructive pulmonary disease (an inflammatory disease of the lungs). Review of Resident #21's quarterly MDS dated [DATE] revealed resident was receiving hospice services. Review of Residents #21's care plan dated 08/05/2024 reflected, Observe resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain. Review of Resident #21's order dated 11/29/2024 reflected 10 mg of (hydrocodone/acetaminophen) every 4 hours. Review of Resident #21's order reflected 5 mg of (hydrocodone/acetaminophen) PRN was canceled 12/18/2024. Review of controlled drug sheet for Resident #21's hydrocodone/acetaminophen reflected that 5 mg PRN (hydrocodone/acetaminophen) was zeroed out on 11/29/2024. Review of pharmacy logs for resident #21 hydrocodone/acetaminophen on 12/17/2024 revealed 5 mg (hydrocodone/acetaminophen) had not been refilled since 11/29/24. Record review of the controlled drug book for Resident #21 on the floor cart reflected documented administrations of 10 mg (hydrocodone/acetaminophen) at 4 am and 5 am signed by LVN B (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #21 on 12/18/24 at 12:08 pm, she stated that she thought she had received double hydrocodone/acetaminophen this morning. She said she didn't remember getting her second dose, but she believed it happened because she felt extremely drowsy. She stated this was the first time it had happened. She stated she was not upset about the medication error because she had just slept a little longer. Interview with LVN A on 12/18/24 at 1:00 pm, she stated she noticed the resident #21 was groggy. She had checked the logs and saw that the resident had an extra dose of (hydrocodone/acetaminophen) at 5 am and held the morning dose of the medication. She had not reported the medication error to facility staff at that time. She stated she called hospice to clarify the order but did not tell them she had an extra dose. After she spoke with hospice, she had the extra 5 mg order of (hydrocodone/acetaminophen) canceled. She stated she did not realize LVN B administered two doses of the 10 mg hydrocodone/acetaminophen until she reviewed the log with the surveyor. She stated that the logs and counts were reconciled, and she did not see LVN B added anything to the logs. She stated the resident did not ask for the medication, and she did not know why she gave it to LVN A said that she should have reported the extra dosage to the charge nurse, ADON or doctor. She believed the ADONs were responsible for reconciling the orders with the system. She stated that they should have monitored her for medication side effects and the risks to the resident for not reporting a medication error could be that the resident had a bad reaction, or she could have slept all day. Interview with ADON A on 12/18/2024 at 12:45 pm, she stated that the 5 mg order should have been discontinued on 11/29/24 when the dosage was increased to 10 mg every 4 hours. She stated that was a medication error and both nurses should have reported the error to her. She stated that when the nurses made a medication error, they should have made sure the resident was safe, notify the doctor, and monitored the resident for any side effects. The orders were reconciled by the charge nurses or ADONs. She stated that the residents who were given too many opioid medications could have serious side effects including hospitalization or death. Interview with the DON on 12/18/2024 at 1:00 pm, she stated that giving two doses of hydrocodone/acetaminophen was a medication error and both nurses should have reported it. She reviewed the pharmacy logs and confirmed that 5 mg dose had not been refilled since 11/29/24 and the dose had been still active in the system until today. She stated that the charge nurses and ADON should have reconciled the order. The DON stated she had received a statement from the LVN A and LVN B. She had performed a teachable moment with LVN A and had contacted the agency to place that nurse on the Do Not Return List. Interview with LVN B on 12/18/24 at 02:27 PM, she stated that she made a mistake. She worked at the facility before but was employed by a staffing facility and had not worked in 2 weeks. She stated that the resident was very particular about her medications and about two weeks ago had told her she took 2 doses of the medication. She stated that she had given the previously scheduled doses at 8 pm and 12 am correctly. She stated the resident did not ask for the medication and she did not know why she had given it to her. She stated she had not looked at the physician's order and gave her two doses at 4 am but did not log the two doses. She stated that while she was counted the medications with LVN A, she added the 5 am dose to the sheet because she realized her mistake. She had not reported it to the charge nurse or any facility staff. She stated she should have reported the incident to the charge nurse. She had not received any training or in-services in the last 6 months from her company of any of the facilities that she had worked at. She stated if she does not report administration errors the resident could overdose or get sick. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER St. Anthony's Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7501 Bagby Ave. Waco, TX 76712	

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with ADM on 12/18/24 at 4:30 pm she stated that the nurse should have read the order and followed it exactly. Both nurses should have reported the error to the ADON. Both nurses should should have checked on the resident. The DON should have taken over after the report. She stated LVN B would not be back. She expected orders to be discontinued because they had processes in place for reconciling doctors' orders. The negative outcomes were that residents would not have the best quality of care. Review of facility policy of undated medication error reflected, All medication errors must be promptly reported to the Director of Nursing Services, attending physician, and the pharmacist.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices that are complete and accurate for 1 (Resident #28) of 10 residents reviewed for medical records. The facility failed to ensure nursing staff monitored and documented oxygen saturation levels with ordered weekly vital signs for Resident #28. This deficient practice puts the residents at risk for decline in physical condition that is unacknowledged by the facility, a risk for potential for adverse reactions due to improper medication administration and a decrease in quality of life for the residents. Review of Resident #28's face sheet dated 12/17/24 revealed a [AGE] year-old woman admitted to the facility on [DATE] with a history of unspecified dementia, anxiety (intense and excessive worry and fear), unspecified atrial fibrillation (irregular heartbeat), cerebral infarction (stroke or temporary lack of blood flow to the brain), chronic embolism and thrombosis of unspecified deep veins of unspecified proximal lower extremity (blood clot that forms inside a blood vessel). Review of Resident #28's MDS dated [DATE], revealed resident had a hospitalization for pneumonia in the last six months. Review of Resident #28's care plan dated 10/05/24 revealed resident may not be able to make all her needs known due to dementia diagnosis. Review of electronic healthcare records for Resident #28 revealed an order for Vital signs q Sunday every day shift every Sun starting 9/29/2024. It showed a recent hospitalization with a diagnosis of pneumonia (inflammation usually caused by infection of the lungs), hypoxia (low oxygen levels in the blood), and sepsis (life-threatening organ dysfunction) from 08/18/2024 to 08/23/2024. Review of the most recent pulse oximetry reading for Resident #28 was recorded on 10/06/2024 at 9:27 am. This shows no pulse oximetry readings for the ordered dates of 10/13/2024, 10/20/2024, 10/27/2024, 11/03/2024, 11/10/2024, 11/17/2024, 11/24/2024, 12/01/2024,12/08/2024, and 12/15/2024. This was after a hospitalization for Pneumonia, from which she returned to the facility on [DATE]. Interview with LVN E on 12/18/24 at approximately 01:00 PM, stated that a standard full set of vital signs includes blood pressure, pulse, oxygen saturation, temperature, and respirations. Interview with ADON B on 12/18/24 at 1:40 pm, revealed that vital signs are completed by nurses when ordered as a weekly task and are assigned on the TAR. She stated that a full set of vital signs includes blood pressure, temperature, pulse, respirations, oxygen saturation, and pain. ADON added oxygen saturation as a required field on the TAR at the time of the interview. She stated she did not know why the TAR did not update when the orders were updated. She stated that she had already started in-service documents for staff on required content for vital signs. She also stated, they should have known to do that. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with ADON A on 12/18/24 at 2:53 pm, revealed that it was her responsibility to put in admission orders into the TAR. She stated there should have been six vital signs for complete vital signs: including temperature, blood pressure, pulse, oxygen saturation, and pain. When asked who put in the orders for the TAR for Resident #28, she stated it was added by the DON. When asked what the potential outcome for the patient was if not completing the weekly oxygen saturation level with vital signs, she stated that if they are in respiratory distress or if they have lung problems, we need to know that information. It could be bad if we don't have that. Interview with the DON on 12/18/24 at 4:41 pm, revealed that complete vital signs are a part of the basic nursing skills that every nurse learns. Vital signs include blood pressure, pulse, respirations, temperature, and oxygen saturation. Her expectation was that they be collected weekly, every Sunday. She stated the potential outcome for Resident #28 was that since she had pneumonia, that is more likely to happen again. Interview with the ADM on 12/18/24 in 5:08 pm, revealed that her expectation for weekly vital signs orders is that they are to be done as it was ordered and correct.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections for 4 of 11 residents (Resident #74, Resident #26, Resident #91, and Resident #64) reviewed for infection control. 1. LVN C provided catheter care and peri-care to Resident #74 without conducting hand hygiene with glove changes. 2. LVN F provided suprapubic catheter care to Resident #26 with without conducting hand hygiene with glove changes. 3. LVN D provided wound care to Resident #91 without conducting hand hygiene with glove changes. 4. CNA D provided peri-care to Resident #64 without conducting hand hygiene with glove changes. These failures could place the residents at risk of infection transmission, sepsis, and hospitalization. Findings included: Resident #74 Record review of Resident #74's face sheet reflected a [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses of osteomyelitis (infection of the bone), pressure ulcer of sacral region stage 4, diabetes mellitus type 2, hypertension, chronic kidney disease, anemia, adult failure to thrive, neuromuscular dysfunction of bladder (a condition where the muscles of the bladder do not work properly), and retention of urine. Record review of Resident #74's Annual MDS Assessment, dated 11/21/2024, reflected the resident had a BIMS Score of 13, which indicated the resident had no cognitive impairment. The resident had an indwelling catheter. Record review of Resident #74's Care Plan reflected a focus area for an indwelling catheter due to a diagnosis of neurogenic bladder. The goal reflected Resident #74 would have no injuries, infections, or complications related to indwelling catheter. The intervention reflected catheter care per facility policy and PRN. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #74's Order Summary Report dated 12/17/24 reflected an order, started on 12/28/23, for catheter care every shift. Observation on 12/16/24 at 02:47 PM of foley catheter care and peri-care for Resident #74 revealed LVN C cleansed the indwelling catheter tubing with two wipes. LVN C did not conduct hand hygiene when changing gloves. LVN C then cleansed Resident #74's bottom with wipes. LVN C did not conduct hand hygiene when changing gloves. When LVN C began conducting indwelling catheter care, she pulled the catheter tubing from the meatus and out, and Resident #74 stated, Ouch, that hurt. Bright red bleeding from Resident #74's peri area was noted after the catheter tubing was pulled. An interview on 12/16/24 at 03:18 PM with LVN C revealed she always wore a gown with gloves when taking care of residents with Foley catheters and wounds. LVN C stated Resident #74 had vaginal bleeding on occasion, and stated she did not pull on the catheter tubing. An interview on 12/16/24 at 03:23 PM with Resident #74 revealed she felt pain when her catheter was pulled on during catheter care. Resident #74 stated she didn't think she had experienced vaginal bleeding for a long time. Resident #26 Record review of Resident #26's face sheet reflected a [AGE] year-old male who admitted to the facility on [DATE], with a re-admission date of 01/31/24. He had diagnoses of obstructive and reflux uropathy (improper voiding of the kidneys) , chronic kidney disease, diabetes mellitus type 2, and benign prostatic hyperplasia (enlarged prostate gland). Record review of Resident #26's Quarterly MDS Assessment, dated 11/07/2024, reflected the resident had a BIMS Score of 14, which indicated the resident had no cognitive impairment. The resident had an indwelling catheter. Record review of Resident #26's Care Plan dated 01/31/24 reflected a focus area for an indwelling supra-pubic catheter which increased his risk for re-current urinary tract infections. The goals reflected the resident would have no injuries, infections, or complications related to an indwelling catheter and the catheter would maintain patency. The interventions reflected catheter care per facility policy and PRN. Record review of Resident #26's Order Summary Report dated 12/17/24 reflected to cleanse suprapubic catheter site with normal saline daily and monitor for signs and symptoms of infection or excoriation every shift. The Order Summary Report also reflected to conduct supra-pubic catheter care every shift. Observation on 12/16/24 at 03:22 PM revealed LVN F did not conduct hand hygiene with glove changes when providing supra-pubic catheter care for Resident #26. Interview on 12/16/24 at 03:44 PM revealed LVN F had forgotten to conduct hand hygiene with glove changes during Resident #26's supra-pubic catheter care. LVN F stated the importance of conducting good hand hygiene during resident care was to prevent the spread of infection, and the impact on the resident could be an infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #91 Record review of Resident #91's face sheet reflected an [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses of metabolic encephalopathy (brain dysfunction due to diabetes) , diabetes mellitus type 2, adult failure to thrive, peripheral vascular disease (improper circulation to the limbs), and hypertension. Record review of Resident #91's Quarterly MDS Assessment, dated 11/12/2024, reflected the resident had a BIMS Score of 6, which indicated the resident had severe cognitive impairment . The resident had an unhealed pressure injury that was present upon admission. Record review of Resident #91's Care Plan dated 01/31/24 reflected a focus area for an indwelling supra-pubic catheter which increased his risk for re-current urinary tract infections. The goals reflected the resident would have no injuries, infections, or complications related to an indwelling catheter and the catheter would maintain patency. The interventions reflected catheter care per facility policy and PRN. Record review of Resident #91's Order Summary Report dated 12/17/24 reflected to cleanse left heel with normal saline, pat dry, apply antiseptic with collagen, place alginate calcium and cover with a dry dressing every day for skin integrity. The Order Summary Report also reflected to cleanse the right lateral lower leg with normal saline, pat dry, apply triple antibiotic ointment, and then place an absorbent dressing and wrap with a kerlix dressing every Monday, Wednesday, and Friday for skin integrity. An observation on 12/17/24 at 09:51 AM of wound care for Resident #91 revealed LVN D had not sanitized her scissors when preparing a clean field with wound care supplies. LVN D removed her gloves after removing Resident #91's left wound dressing and took her scissors out of her pocket. LVN D did not conduct hand hygiene after removing her gloves and did not clean the scissors before using them to cut Resident #91's left leg dressing. An interview on 12/17/24 with LVN D revealed she should have sanitized or washed her hands after removing her gloves and stated she had sanitized her scissors before Resident #91's wound care. Resident #64 Record review of Resident #64's face sheet reflected a [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses of osteomyelitis, diabetes mellitus type 2, chronic kidney disease, hypertension, mitral and aortic valve insufficiency (bad heart valves), and anemia. Record review of Resident #64's MDS Assessment, dated 11/24/2024, reflected the resident had a BIMS Score of 13, which indicated the resident had no cognitive impairment. The MDS further reflected Resident #64 had frequent incontinence of bowel and bladder and required assistance with activities of daily living. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #64's Care Plan reflected a focus area of episodes of incontinence, and interventions were to provide incontinence checks every 2 hours and as needed. Provide incontinence care as needed. Another focus area reflected Resident #64 had an ADL self-care performance deficit, with goal of resident remaining clean, dry, and odor free. Interventions reflected to provide incontinence checks every 2 hours and as needed. Record review of Resident #64's Order Summary Report reflected to assess resident every shift for fever, sore throat, cough, new shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, or diarrhea. Observation on 12/17/24 at 01:23 PM of peri-care for Resident #64 revealed CNA D did not sanitize her hands after removing her gloves in between tasks. Interview on 12/17/24 at 01:31 PM with CNA D revealed she sanitized her hands with glove changes when a resident had a bowel movement. CNA D stated she did not have sanitizer in her pocket today. Interview on 12/18/24 at 04:20 PM with DON revealed to control infections the staff had been taught the hands were the greatest transmitter of disease. The DON stated that staff should have been sanitizing their hands when removing their gloves, and residents could have developed infections, sepsis (serious end stage infection) , and a decline in status. Her expectation was for all staff to conduct good hand hygiene to help prevent the spread of infection. The DON further stated all staff had been instructed to sanitize when they got out of their car, sanitized before entering a resident's room, after touching the sink/faucet. The DON stated she would be re-training on, Foam in, foam out, which referred to an infection control technique that emphasized the importance of using alcohol-based hand sanitizer foam before and after patient contact. The DON further stated the facility had hand sanitizer on the walls and small bottles had been available to all staff members. The DON stated training had been done on annual infection control, and the infection control nurse had done multiple in-services each month. The DON stated infection control was a collaborative effort with primarily the infection control nurse and herself. An interview on 12/18/24 at 04:49 PM with the ADM revealed all staff should have conducted hand hygiene to help prevent the spread of infections, and sanitized hands after removing gloves. The ADM stated that not sanitizing hands with glove change could have lead to infections, cross-contamination and was not a clean practice. The ADM stated her expectations were for all staff to follow the rules with no exceptions. The ADM further stated they would be re-in servicing all staff on hand hygiene when providing resident care, and on conducting hand hygiene after removing gloves. Record review of undated Policy & Procedure on Hand Cleaner, Antiseptic reflected, Purpose: To cleanse the hands between resident contacts including, but not limited to, during medication and treatment administration. To prevent the spread of infection. Equipment: Antiseptic cleanser such as alcohol gel or solution in pump container or squeeze bottle per facility procedure. Individual hand washing packets. Hands should be washed with soap and water after 10-15 applications of hand cleaner, or as directed by manufacturer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of policy Hand Hygiene dated revision 10.2022 revealed the following relevant information: 1. Wash hands with soap and water when hands are visibly soiled (e.g., blood, body fluids). 2. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non- antimicrobial) and water for the following situations: e. Before and after handling an invasive device (e.g., urinary catheters, IV access sites), h. before moving from a contaminated body site to a clean body site during resident care, and m. after removing gloves. Review of policy IPCP Standard and Transmission-Based Precautions dated revision 10.2022 revealed: It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions. Review of policy Infection Prevention and Control Program dated revision 10.2022 revealed: The infection prevention and control program are a facility wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance management program. Further it revealed the goals were to: decrease the risk of infection to residents and personnel, recognize infection control practices while providing care, identify and correct problems related to infection control, ensure compliance with state and federal regulations related to infection control and promote individual residents' rights and wellbeing while trying to prevent and control the spread of infection.