STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	2711 Pine Tree Rd Longview, TX 75604

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 0558

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Reasonably accommodate the needs and preferences of each resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46310

Based on observation, interviews and record review, the facility failed to ensure residents' right to reside and receive services in the facility with reasonable accommodations of residents needs and preferences for 1 of 16 residents reviewedresidents reviewed (Resident #11) for accommodations of needs.

The facility failed to ensure Resident #11's call light was within reach.

This deficient practice could place residents at risk of not receiving care or attention needed.

Findings include:

Record review of Resident #11's face sheet, dated 9/14/22 , revealed the resident was originally admitted to the facility on [DATE] (readmission 9/11/22) with diagnoses which included: encounter for orthopedic aftercare following surgical amputation, acquired absence of right leg below knee, type two diabetes mellitus without complications, morbid (severe) obesity due to excess calories, moderate protein-calorie malnutrition, cerebral infarction (ischemic stroke), hemiplegia (paralysis of one side of the body) and hemiparesis(weakness on one side of the body) following cerebral infarction affecting left leg non-dominant side , other asthma, contact with (suspected) exposure to other viral communicable diseases, muscle wasting and atrophy, not elsewhere classified, right shoulder, muscle wasting and atrophy, not elsewhere classified, left shoulder, muscle wasting and atrophy, not elsewhere classified, unspecified site, muscle weakness, dysphagia (discomfort in swallowing), oropharyngeal phase (airway), other lack of coordination, unspecified lack of coordination, cognitive communication deficit, need for assistance with personal care, hyperlipidemia (abnormally high concentration of fats or lipids in the blood), unspecified, other seizures, and presence of cardiac pacemaker.

Record review of Resident #11's Quarterly MDS assessment, dated 7/5/22, revealed the resident's BIMS score was 9, which indicated moderate cognitive impairment. The resident required extensive assistance (staff provide weight bearing support) with two persons physical assistance for bed mobility, and total dependence (full staff performance every time during entire 7-day period) with two persons physical assistance for transfers, dressing and toileting.

(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: 675177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/15/2022
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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #11's care plan, revised 7/19/22, revealed Resident #11 had ADL (activities of daily living) functional/rehabilitation potential with a self-care deficit, and an intervention that stated required staff assistance times one for assist bars and times two to enable self-bed mobility. Resident #11 required a lift for all transfers and toilet use requires one staff assistance. Resident # 11 had the potential for uncontrolled pain and an intervention that stated observe and report changes in unusual routine, sleep patterns, decrease in functional abilities, decrease range of motion, withdrawal, or resistance to care. Another intervention for this focus stated required monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness and falls. Resident #11 was a risk for falls with an intervention that stated be sure resident's call light was within reach and encourage the resident to use it for assistance as needed. During an observation and interview on 9/12/22 at 09:49 AM with Resident #11, she said that she required assistance from staff with all tasks. She said that she felt that staff do not come quickly when she pulls her call light. She said she has had a stroke and her speech is challenged with remembering some words. She said that she was recently in the hospital and just returned yesterday. She said that she has a pressure ulcer near her vaginal and anal area. She said staff do not reposition her as often as they should, every 2 hours. She said that her call light is on the side of her body that she cannot reach, and she thinks they move it over there purposely because she uses it when she needs them. Call light observed to be on the floor on the left side of the bed. Call light is not accessible. During an observation and interview on 9/12/22 at 11:47 AM with Resident #11, her call light was observed in the same position from the morning observation, on the floor on the left side of the bed. Call light was not accessible. During an observation on 9/12/22 at 02:34 PM with Resident #11, her call light was observed on the floor on the left side of the bed. Call light was not accessible. During an observation on 9/13/22 at 9:12 AM with Resident #11, she was seen watching TV. Call light was observed on the left side of her bed but attached to the bed rail. Resident #11 demonstrated that she still could not reach it by reaching her right hand to the left-hand side of bed. Call light was not accessible. During observation and interview on 9/13/22 at 11:38 AM with Resident #11, demonstrated that the call light was still out of her reach. Call light was not accessible. During an interview on 9/14/22 at 11:42 AM with GVN V, she said she had worked at the facility for about two weeks and is a recent graduate. She said that she works on hall four. She said that Resident #11 often pulls her call light for assistance. She said that she checks on her even without the call light notification. She said that whenever a staff member performed a task for the resident, they should ensure the call light is accessible to the resident. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 9/14/22 at 12:17 PM with CMA P, she said she was a certified medication aid but that she assisted with ADLs as she is also a CNA. She said that she provides cares for Resident #11. She said that whenever she assisted a resident, she ensured that they have continued access to their call light. She said that she has not seen a call light of any resident not be accessible as they use clips to attach to their clothing or wrap around the bed rail, whichever the resident preferred. During interview on 9/15/22 at 9:27 AM with LVN N, she said that any staff that performed s any tasks with the resident or checks on them should ensure they have access to their call lights and bed controls. She said that Resident #11 is not on her hall and has no knowledge of her care. She said a risk for a resident not having access to their call light is that they cannot receive the care they need. During interview on 9/15/22 at 10:15 AM with LVN T, she said that works halls three and four. She said that she ensured that residents have access to their call light by wrapping around their bed rail or pinning it on them whichever the resident wants. She said that she makes sure they can access it with their hands. She said the risk for not having access to call lights can be that residents cannot receive care they need timely. During interview on 9/15/22 at 10:37 AM with CNA W, she said she works on halls provides care for Resident #11 and provided assistance with ADLs to residents. She said that she always ensured that a resident has access to their call light by pinning it on their clothing or wrapping it around their bed rail, whichever the resident preferred. During interview on 9/15/22 at 11:22 AM with Regional Corporate RN E, she said was currently in the facility as the DON were not available. She said that she expected all resident's call lights to be accessible and within reach. She said that during daily Champion calls, with department heads, they discussed any concerns they have had the day before. She said that she was informed that Resident #11 has not had access to her call light and so she had a nurse correct this after the meeting. She said the risk to a resident not having access to their call light could be that they do not receive care they need timely, they could have fallen and not be able to get up, or they could have delayed care. She said that staff can either use a clip to pin the call light to the resident's clothing or wrap it around the bed rail, whichever the resident preferred. She said that all staff are responsible for ensuring this is done. During interview on 9/15/22 at 12:22 PM with the Administrator, he said the location of the call light was always between resident and staff. He said that the resident would tell the staff where he or she wanted the call light to be placed. He said some chose to have it wrapped around their bed rail and others preferred to have it pinned to their shirt for easy access. He said that he expected nursing staff to check on residents, who are not mobile or who require assistance, every two hours. He said the risk of a resident not having access to their call light is that he or she cannot get services they need, and their issue cannot be addressed. He said that he was not aware that Resident #11did not have access to her call light and that he had staff fix this issue earlier today, 9/15/22.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46299 Based on observation, interview, and record review, the facility failed to ensure alleged violations were reported immediately, but not later than 2 hours after the allegation was made if the events that result in serios bodily injury for 1 of 18 residents reviewed for reporting allegations. (Resident #40) The facility did not report to the state survey agency when Resident #40 had an unwitnessed fall with a concussion. These failures could place residents at risk for abuse and neglect that is not investigated appropriately. Findings included: Record review of a face sheet dated 09/13/22 indicated Resident #40 was [AGE] years old, admitted on [DATE] and readmitted on [DATE] with the diagnosis of Alzheimer's Disease (memory loss disease), diabetes, and high blood pressure. Record review of an Admission MDS assessment dated [DATE] indicated Resident #40 understood others and was understood by others. Resident #40's BIMs score was 5 indicating severe cognition impairment. The MDS indicated Resident #40 required limited assistance of one staff for bed mobility, walking in room, locomotion on the unit. She required extensive assistance of one staff for dressing, eating, toileting, personal hygiene, and total dependence on one staff for bathing. The MDS indicated Resident #40 was continent of bowel and bladder. The MDS did not reflect a history of falls. Record review of an undated comprehensive care plan indicated Resident #40 was at risk for falls. The goal was Resident #40 would be free from falls with the interventions of anticipating needs, the call light within reach, safety reminders, encourage activities, wear appropriate footwear, lock furniture, bed in low position, therapy to evaluate, one staff to assist with transfers, and adequate lighting. Record review of an incident report dated 08/26/22 at 9:20 p.m., LVN B documented Resident #40 was on the floor wrapped in her linen. The incident report indicated a hematoma to her face. The report indicated the mental status of Resident #40 was impulsiveness, forgetful, oriented to self, and had a lack of safety awareness. The incident report indicated she wanders and exit seeks. Record review of a hospital face sheet dated 08/27/22 indicated Resident #40 admitted to the local hospital on 8/27/22 with a diagnosis of a fall with injury. Record review of a hospital discharge summary, dated 08/28/22, indicated Resident #40 was admitted on [DATE] with the diagnoses of fall injury. The record indicated the chief complaint was trouble ambulating and altered mental status after a fall. The date of discharge was 8/28/22 with the final diagnoses of concussion injury of brain (brain injury caused by a blow to the head), and periorbital hematoma (black eye). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an event nurses note dated 08/26/22 at 9:20 p.m. revealed Resident #40 was found on the floor with bed linen wrapped around her. The note indicated Resident #40 had a bruise with swelling on her right forehead above the eye. The event note indicated Resident #40 was independent with bed mobility, one staff to assist with toileting, independent with transfers and walking. During an observation and interview on 09/12/22 at 11:14 a.m., Resident #40 was lying in her bed. Bruising remains to her right cheek. The son indicated the bruising was from a fall a few weeks back. The son indicated he leaves the rocking chair next to the bed at night to ensure she does not fall off the bed. Resident #40 was agreeing with her son but rambled her thoughts. The son indicated his mother was eventually sent to the local emergency room and found to have a concussion. During an observation on 9/12/22 at 2:40 p.m., Resident #40 was ambulating aimlessly about the facility. During an interview on 09/13/22 at 10:45 a.m., the Regional Nurse F indicated Resident #40's fall on 08/26/22 was unwitnessed. During an interview on 09/13/22 at 11:03 a.m., the Regional Nurse F indicated Resident #40's fall should have been called in to state survey office due to the fall was unwitnessed with a serious injury. The Regional Nurse Findicated because the nurse inadvertently marked the fall as witnessed the electronic record did not initiate neurological checks to denote changes in Resident #40's status. The corporate nurse indicated marking the fall as witnessed led to the abuse coordinator not reporting an incident requiring reporting to the local officials. During an interview on 9/14/22 at 12:39 p.m., the Regional Nurse F indicated she had just completed a mock survey and identified the nursing staff were not detailing the incident reports well including witness statements and other interviews. The Corporate nurse indicated she expected the DON to review the incident and accidents in the morning meeting, care plan interventions, and implement the interventions. The Corporate nurse indicated there were difficulties maintaining the morning meetings related to staff and the director of nurses turnover of 4 times in a year. Request for a nursing skills check off for LVN A and LVN B was requested during the survey but not provided. During an interview on 09/15/22 at 9:45 a.m., the ADON indicated the process for falls included a call to herself by the nurse on duty. The ADON indicated when she received calls related to a fall, she would implement notification of the abuse coordinator to ensure proper reporting including unwitnessed falls with serious injury . The ADON indicated the Administrator and the DON were responsible for reviewing the incidents and accidents for abuse and neglect. The ADON indicated she would call the Administrator with falls with serious injury. During an interview on 09/15/2022 at 12:30 p.m., Regional Nurse F indicated the accident with Resident #40 should have been reported to the state agency to ensure a thorough investigation to rule out abuse or neglect. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/15/22 at 1:00 p.m., the Administrator indicated he should have reported Resident #40's accident with a concussion. The Administrator indicated due to the charge nurse accidentally marking the fall as witnessed he did not see the documentation indicating the fall was not witnessed. Record review of an Abuse/Neglect policy dated 3/29/2018 revealed the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. 7. Neglect: is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotion distress. 12. Injury of Unknown Source any injury to a resident where: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident. E. Reporting 3. Facility employees must report all allegation of abuse, neglect exploitation, mistreatment of residents misappropriation of resident property of injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19. a. If the allegation involve abuse or a result in serious bodily injury, the report is to be made within 2 hours of the allegation. Record review of the 03/29/18 Abuse/Neglect policy revealed neglect is defined as the failure of the facility, its employees to provide services to a resident that are necessary to avoid physical harm, pain or mental anguish, or emotional distress. Investigations will be reviewed by the facility Administrator and/or Abuse Preventionist within 24 hours of complaint. Appropriate notifications to state and home office will be the responsibility of the administrator and per policy. The facility administrator or designee will report all incidents that meet the criteria of Provider Letter 19-17 dated 07/10/19.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46299 Based on observation, interview, and record review, the facility failed to develop, review, and revise a comprehensive care plan of each resident that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs for 1 of 18 residents reviewed for care plans (Residents #18). The facility failed to revise the care plan following the quarterly MDS Assessment with interventions specific to each fall for Resident #18. This failure could place residents at risk of not having their individualized needs met in a timely manner and communicated to providers and could result in a decline in physical well-being and care needs not being addressed. Findings included: Record review of the 01/26/21 Admission Face Sheet for Resident #18 revealed an [AGE] year-old female with the following diagnosis: a history of falls, abnormalities of gait/mobility, muscle wasting/atrophy, need for assistance with personal care, lack of coordination, heart failure (occurs when the heart muscle does not pump blood as well as it should) and Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). Record review of Resident #18s 07/15/22 Quarterly MDS assessment revealed a BIMS of 10, indicating moderately impaired cognition. She had no rejection of care noted and required supervision two staff assistance for transfers/toileting/dressing. She was frequently incontinent of urine but had no toileting plan in place. She was at risk for falls with one minor injury fall noted. Occupational therapy ended 07/15/22. Record review of Resident #18s 04/16/21 Comprehensive Care Plan revealed the resident had impaired cognitive function, Dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) that required task segmentation, was on anticoagulant therapy and was at risk for falls. Staff must anticipate/meet her needs, call light must be within reach and encourage resident to use it. She needs appropriate footwear, furniture in locked position with needed items within reach. Non-skid strips have been placed in the bathroom with a raised toilet seat, in front of her dresser and a call before you fall sign by her bed. Staff will review information on past falls and attempt to determine cause of falls, along with record possible root causes. Then must alter/remove any potential causes if possible. The resident required one staff assistance for dressing, transfers and toilet use including washing hands, adjusting clothing, transfer on/off toilet. Staff were to notify the charge nurse for attempts to transfer self and non-compliance calling for assistance. Resident encouraged to call for assistance and to lock wheelchair. The last update for fall interventions was completed on 04/07/22 indicating staff were to keep her call light within reach and encourage its use. The care plan lacks documentation of interventions for the following falls: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/09/22 fall due to self-toileting and then attempting to get back in bed. 01/18/22 fall due to attempted self-toileting that resulted in multiple bruise injuries, including a scalp hematoma and a laceration requiring 5 staples to her head. 01/31/22 fall due to incontinence resulting in a skin tear to her left ankle. 02/24/22 fall due to attempting self- transfer with blanket wrapped around her body. 03/01/22 fall due to attempting self-toileting. 04/11/22 fall due to attempting self-transfer. 05/24/22 fall due to resident ambulating without assistance resulting in a skin tear and bump to forehead. 06/17/22 fall due to self-toileting resulting in striking her head and an abrasion to left lower extremity. 08/19/22 fall due to fall to floor from wheelchair resulting in skin tear to left forearm. 08/21/22 fall due to self-transfer back to bed. 08/24/22 fall due to inappropriate assistance for toileting resulting in striking head, multiple bruises to left elbow and forearm, tenderness to wrist. 09/03/22 fall due to self-toileting resulting in striking head, skin tear left forearm and abrasion to right knee. Observation on 09/13/22 at 07:57 AM to 09:28 AM of Resident #18 revealed her sleeping with no signs or symptoms of distress, call light in place. At 09:12 AM it was noted that no staff had checked with the resident for toileting needs during this time. The resident had self-transferred, unsteady gait, to wheelchair to the bathroom and had removed her pants, which were soiled with bowel movement. Staff noted to walk hallways and look in resident rooms at times, but not prompting resident for toileting needs. Observation on 09/14/22 at 07:30 AM to 10:30 AM of resident revealed the resident asleep in bed. Noted sign on the wall beside her bed, call before you fall, no fall mat noted beside her bed, non-slip strips noted next to bed, dresser and in bathroom, raise toilet seat as well. At 08:07 AM CNA C in resident room and notified the resident it was shower time. The resident sat up with assistance, and with stand-by assist she transferred to wheelchair. Her transfer was very slow due to unsteady gait, but with assistance she did well. The CNA did not ask the resident about toileting at that time. From 08:30 AM to 08:54 AM the resident completed shower, prompted for toileting and completed voiding, then self-propelled back to room. At 09:59 AM this surveyor had noted no staff in room to prompt for toileting needs since shower. Staff noted to walk hallways and look in rooms, but not prompting resident for toileting needs. At 10:15 AM CNA C in room with ice/water, asked resident if she was ok, needed toileting and resident responded no. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the 09/14/22 at 12:24 PM interview, LVN D stated, for falls, staff filled out the event forms with whether the fall was witnessed/unwitnessed, by who, obtained witness statements, asked what the resident was doing, noted if they had incontinence; 99% of [Resident #18]'s falls were unwitnessed due to most, if not all of her falls, was related to her trying to get to the bathroom. She does not need someone to be with her. Staff were to prompt the resident for toileting every 2 hours or more, she takes diuretics too. Staff could have increased the frequency of prompting her for toileting, like every 15-30 minutes, if we had enough staff to do that. One aide for 15 residents that require one to two assist is time consuming, so sometimes residents have to wait: also, one nurse for 27 residents. I am unsure if or when Resident #18 had been evaluated for toileting frequency prompting needs, it has been a while. During the 09/14/22 at 12:35 PM interview with Regional Nurse E revealed she stated, I am not trying to make any excuses for any of that, but this facility has had 4 DONs in the past year, so turnover has been the biggest cause of these inconsistencies. And the when the DON works the floor, they do not always get to go to the morning meeting, so the fall interventions/investigations are not discussed and then the care plans are not updated as they should be. She stated, my expectation is that the care plans are updated by the DON/ADON after the morning meeting after the fall to ensure new interventions are available to staff to keep the resident safe. During the 09/15/22 at 10:04 AM interview with CNA G revealed she stated, CNAs can look in the Kardex/care plan to find a residents assistance needs for transfers, toilet use and stuff like that. I do not know how often the care plans/Kardex are updated. During the 09/15/22 at 10:26 AM interview with CNA H by phone revealed she stated, I look to the Kardex/care plan for resident assistance needs. The facility has had in-services in the past about prompting residents for toileting more frequently. During the 09/15/22 at 09:33 AM interview with the ADON revealed she stated, I think the Care Plan Coordinator updated the care plan with revisions, and I did not know that care plan updates/interventions have to be tasked for fall interventions. I did not know that updating the care plan interventions for fall were the DON and my responsibility. I do not have all residents' interventions memorized, so I would need to look at her care plan. There are new graduates working from agency, so that has an effect on resident care as well; the facility is training and caring for residents as best they can. During the 09/15/22 at 10:38 AM interview with CNA K by phone revealed she stated, The care plan tells staff how much assistance Resident #18 needed with ADLs. During the 09/15/22 at 09:09 AM interview with LVN A revealed he stated, The care plan indicated her required assistance for transfers and toileting. Not having the correct interventions for fall on the care plans could result in more skin tears/falls/harm from not being assisted. I am not sure who updates the care plans with new interventions, but that is how the CNAs know how to assist/care for residents. Record review of the 2003 Fall Risk Mini Manual policy revealed policy lacked documentation of care plan revision after a resident fall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Administrator failed to provide the requested policy on care plan revision on 09/15/22.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming, and personal hygiene were provided for 1 of 18 residents reviewed for ADLs. (Resident #3). The facility did not provide personal hygiene for the removal of facial hair for Resident #3. This failure could place residents at risk of not receiving services/care and a decreased quality of life. Findings included: Record review of a face sheet dated 09/14/22 indicated Resident #3 was an [AGE] year-old female who admitted on [DATE] with diagnoses of dementia, anemia, and high blood pressure. The most recent Annual MDS assessment, dated 03/21/22, indicated Resident #3 understood others and was understood by others. Resident #3's BIMS score was 4 indicating she had severe cognitive impairment. The MDS indicated Resident #3 required extensive assistance with bed mobility, dressing and toileting. She required total assistance with personal hygiene and bathing. Record review of an undated care plan indicated Resident #3 had an ADL self-care deficit. The goal of the care plan was to improve the current level of function. The intervention was to assists with personal hygiene as required: shaving, hair, and oral care. During an observation on 09/12/22 at 9:50 a.m., Resident #3 was resting in her bed. Resident #3 had numerous 1/2 inch hairs on her chin. Resident #3 said she used to have a beauty operator take them off. Resident #3 indicated she wanted them off her face. Resident #3 indicated she did not like the hairs on her face. During an observation on 09/12/22 at 3:00 p.m., Resident #3 continued to have the hairs to her chin. During an observation on 09/13/22 at 11:00 a.m., Resident #3's chin continues to have numerous long facial hairs. During an observation of Resident #3 and interview on 09/14/2022 at 12:57 p.m., CNA S indicated he provided care to Resident #3. CNA S indicated he was responsible for shaving of the residents. CNA S observed Resident #3 with the surveyor and validated she had numerous long facial hairs. CNA S indicated he was providing care to two halls and a room on another hall , and he had not had the time to address the facial hair. CNA S indicated Resident #3 would feel good emotionally if she was shaved. CNA S indicated he should offer shaving when he sees facial hairs on a woman. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Tree Lodge Nursing Center	2711 Pine Tree Rd Longview, TX 75604

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/15/22 at 12:30 p.m., Regional Nurse F indicated her expectations were if the resident does not wish to have facial hair to remove it. Regional Nurse F indicated indicated nursing was responsbile for ADLs including shaving. Regional Nurse F indicated the process of Champion rounds helps identify the need for ADL care. Regional Nurse F indicated a resident's dignity could be affected and their self-esteem. During an interview on 09/15/22 at 1:00 p.m., the Administrator indicated his expectations were women with facial hairs should have them removed. The Adminstrator indicated any staff member could identify the need but nursing was responsible for ensuring the task was completed. Record review of a Shaving, Electric/Safety Razor policy dated 2003, indicated shaving was usually done as part of daily personal hygiene although every other day is sufficient for some based on the beard growth. It is done to promote cleanliness and a positive body image. The policy goals included the resident would experience cleanliness, comfort, free from infection, and maintain intact skin integrity.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1of 18 residents reviewed for quality of care. (Residents #40) The facility failed to assess and document Resident #40's neurological checks after she was found in the floor with obvious trauma to her forehead. This failure could cause a resident to have an unrecognized head trauma leading to serious impairment and even death. Findings included: Record review of a face sheet dated 09/13/22 indicated Resident #40 was [AGE] years old, admitted on [DATE] and readmitted on [DATE] with the diagnosis of Alzheimer's Disease (memory loss disease), diabetes, and high blood pressure. Record review of an Admission MDS assessment dated [DATE] indicated Resident #40 understands and was understood. Resident #40's BIMs score was 5 indicating severe cognition impairment. The MDS indicated Resident #40 required limited assistance of one staff for bed mobility, walking in room, locomotion on the unit. She required extensive assistance of one staff for dressing, eating, toileting, personal hygiene, and total dependence on one staff for bathing. The MDS indicated Resident #40 was continent of bowel and bladder. The MDS did not reflect a history of falls. Record review of an undated comprehensive care plan indicated Resident #40 was at risk for falls. The goal was Resident #40 would be free from falls with the interventions of anticipating needs, the call light within reach, safety reminders, encourage activities, wear appropriate footwear, lock furniture, bed in low position, therapy to evaluate, one staff to assist with transfers, and adequate lighting. Record review of an event nurses note dated 08/26/22 at 9:20 p.m., Resident #40 was found on the floor with bed linen wrapped around her. The note indicated Resident #40 had a bruise with swelling on her right forehead above the eye. The event note indicated Resident #40 was independent with bed mobility, one staff to assist with toileting, and independent with transfers and walking. Record review of an incident report, dated 08/26/22 at 9:20 p.m., indicated Resident #40 was on the floor wrapped in bed linen. The report indicated the immediate action was Resident #40 was assessed for injuries and assisted back to bed. The report indicated the injuries observed at the time of the incident was a hematoma to Resident #40's face. The report indicated there were no witnesses to the incident. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of a hospital discharge summary dated 08/28/22 indicated Resident #40 was admitted on [DATE] with the diagnoses of fall injury. The record indicated the chief complaint was trouble ambulating and altered mental status after a fall. The date of discharge was 8/28/22 with the final diagnoses of concussion injury of brain (brain injury caused by a blow to the head), and periorbital hematoma (black eye). Record review of Resident #40's electronic medical record did not reflect any neurological checks after she was found on the floor with a bruised and swollen area to her forehead. During an interview on 09/13/22 at 10:45 a.m., the Regional nurse F indicated Resident #40's fall on 8/26/22 was unwitnessed. During an interview on 09/13/22 at 11:03 a.m., Regional Nurse F indicated because the nurse inadvertently marked the fall as witnessed the electronic record did not initiate neurological checks to denote changes in Resident #40's status. Regional Nurse F indicated unwitnessed falls and witnessed falls with head injuries require neurological checks. Regional Nurse F validated there were no neurological checks completed for Resident #40. During an interview on 09/13/22 at 2:47 p.m., LVN A indicated he was told in morning report by LVN B, Resident #40 had a witnessed fall on 8/26/22. LVN A indicated he had not done neurological checks on Resident #40 because he was told the fall was a witnessed fall during morning report. LVN A indicated on the morning after the fall Resident #40 was not herself. LVN A indicated when Resident #40 was assisted up she seemed more confused and increased drowsiness. LVN A said Resident #40's gait was shuffled, and her right eye was bruised down her check. LVN A indicated neurological checks should have been initiated with an unwitnessed fall to monitor for a head injury or a brain bleed. LVN A indicated he sent Resident #40 to the hospital due to her change in condition on 8/26/22. During an interview on 09/14/22 at 8:34 a.m., LVN B indicated she had been working at the facility since July. LVN B indicated Resident #40 had an unwitnessed fall on 8/26/22. LVN B said she had mistakenly marked the wrong box (witnessed fall) on the electronic record indicating the fall was witnessed when it was unwitnessed. LVN B indicated she was unsure why the computer did not automatically initiate the neurological checks. LVN B said she had completed neurological checks and had documented them in her personal records. LVN B indicated she had since thrown away the neurological checks. When asked why she did not document them somewhere in the electronic record, she indicated she did not think of it at the time. LVN B indicated monitoring the neurological status of a resident consisted of monitoring of the pupil dilation, and hand and foot grips. LVN B indicated neurological changes could indicate a stroke or a brain bleed. During an interview on 9/14/22 at 12:39 p.m., the corporate nurse indicated she had just completed a mock survey and identified the nursing staff were not detailing the incident reports well including witness statements and other interviews. The Corporate nurse indicated she expected the DON to review the incident and accidents in the morning meeting, care plan the interventions, and implement the interventions. The Corporate nurse indicated there were difficulties maintaining the morning meetings related to staffing and the director of nurses turnover of 4 times in a year. A request was made for the nurse's check off for LVN A and LVN B during the survey, but was not provided before exit. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 09/15/22 at 9:45 a.m., the ADON indicated the process for falls included a call to herself from the nurse on duty The ADON indicated when she received calls related to a fall, she would implement notification of the abuse coordinator to ensure proper reporting, and implementation of interventions including neurological checks. Record review of a skin assessment, dated 09/13/22 at 6:26 p.m., indicated LVN B documented normal skin color with normal temperature for Resident #40. LVN B documented no bruising. In the area of other skin findings, LVN B documented an open area to left lower buttock with wound care orders in place, and a diabetic ulcer to the right foot second toe with wound care orders in place. Record review of a Neurologic Checks policy dated May 2016 indicated neurologic checks were a combination of objective observations and measurements done to evaluate neurologic status. The results of the checks assist to determine nervous system damage and/or deterioration. The goal was the caregiver would identify changes indicating progressive improvement or deterioration in neurologic status. 4. Obtain vital signs: pulse, respirations, and blood pressure. 5. Assess eye response. 6. Assess verbal response. 7. Assess best motor response. 8. Use a pen light to check response of pupil to light. 9. Check hand grips. 10. Frequency of neuro checks after initial neuro check: every 15 minutes times 4; every 30 minutes times two; every one-hour times two, every two hours times two, then every shift time 48 hours. 11. All deteriorations in neurologic status will be immediately reported to the physician. The nurse will document assessment and the time of the physician notification in the clinical record. During an interview on 09/15/22 at 12:30 p.m., the Regional Nurse F indicated there was no policy and procedure for quality of care.

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46310

Based on observations, interviews, and record reviews, the facility failed to ensure treatment and services were provided, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 16 residents reviewed for pressure injuries. (Resident #11)

1. The facility failed to obtain wound treatment orders for Resident #11's the left lateral distal foot DTI (deep tissue injury from pressure), the left distal 4th toe DTI (deep tissue injury from pressure), unstageable pressure ulcer on the left ball of foot, unstageable pressure ulcer to the left proximal heel, and unstageable pressure ulcer to the left distal heel.

2. The facility did not fully assess resident #11's foot upon re-admission from the hospital for pressure injuries.

3. The facility failed to follow their policy for new injuries found on Resident #11 on readmission.

These failures could place residents at risk for worsening of existing pressure injuries, pain, and infection.

Findings include:

Record review of Resident #11's face sheet, dated 9/14//22, revealed the resident was originally admitted to the facility on [DATE] (readmission 9/11/22) with diagnoses which included: encounter for orthopedic aftercare following surgical amputation, acquired absence of right leg below knee, type two diabetes mellitus without complications, morbid (severe) obesity due to excess calories, moderate protein-calorie malnutrition, cerebral infarction (ischemic stroke), hemiplegia (paralysis of one side of the body) and hemiparesis(weakness on one side of the body) following cerebral infarction affecting left leg non-dominant side , other asthma, contact with (suspected) exposure to other viral communicable diseases, muscle wasting and atrophy, not elsewhere classified, right shoulder, muscle wasting and atrophy, not elsewhere classified, left shoulder, muscle wasting and atrophy, not elsewhere classified, unspecified site, muscle weakness, dysphagia (discomfort in swallowing), oropharyngeal phase (airway), other lack of coordination, unspecified lack of coordination, cognitive communication deficit, need for assistance with personal care, hyperlipidemia (abnormally high concentration of fats or lipids in the blood), unspecified, other seizures, and presence of cardiac pacemaker.

Record review of Resident #11's Quarterly MDS assessment, dated 7/5/22, revealed the resident's BIMS score was 9, which indicated moderate cognitive impairment. The resident required extensive assistance (staff provide weight bearing support) with two persons physical assistance for bed mobility, and total dependence (full staff performance every time during entire 7-day period) with two persons physical assistance for transfers, dressing and toileting.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #11's care plan, revised 7/19/22, revealed Resident #11 had ADL (activities of daily living) functional/rehabilitation potential with a self-care deficit, and an intervention that stated required staff assistance times one for assist bars and times two to enable self-bed mobility. Resident #11 requireds a lift for all transfers and toilet use requires one staff assistance. Resident # 11 hads the potential for uncontrolled pain and an intervention that stated observe and report changes in unusual routine, sleep patterns, decrease in functional abilities, decrease range of motion, withdrawal, or resistance to care. Another intervention for this focus stated requireds monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness and falls. Resident #11 wasis a risk for falls with an intervention that stated be sure resident's call light wasis within reach and encourage the resident to use it for assistance as needed. Record review Resident #11's hospital records from recent hospitalization dated 9/09/22, in the discharge instructions, stated apply No Sting Skin prep to dried areas of the sacrococcygeal area and perineum, allow to dry, to help protect the skin once per day/ bedside nurse to perform dressing changes to right below the knee amputation and left heel. Record review of Resident #11's weekly ulcer assessment: **Dated 9/06/22 at 3:56 PM revealed stage two pressure ulcer to the sacrum with pillows to float heels. **Dated 9/6/22 at 4:26 PM revealed a non-pressure injury to the RLE (right lower extremity) **Dated 9/13/22 at 6:58 PM revealed an unstageable pressure ulcer to the left proximal lateral heel measuring at 0.8 centimeters in length, 0.5 centimeters in width, and 0.3 centimeters in depth. About 51-75 % amount necrotic tissue (slough). Air mattress and Podus boot are pressure reducing devices added. Notification to physician on 9/13/22 at 5:00 PM **Dated 9/13/22 at 7:07 PM revealed unstageable pressure ulcer to the left distal lateral heel measuring at 1. 0 centimeters on length, 1.0 centimeters in width, and .03 centimeters in depth. About 51-75% amount necrotic tissue (slough). Air mattress and Podus boot are pressure reducing devices added. Notification to physician on 9/13/22 at 5:00PM **Dated 9/13/22 at 7:09 PM revealed deep tissue pressure injury to the left fourth toe measuring at 1.0 centimeters on length, 1.0 centimeters in width, and depth written at a 0 indicated unable to measure. Deep tissue without measurable depth. About 75-100% amount of necrotic tissue (eschar). Air mattress and Podus boot are pressure reducing devices added. Notification to physician on 9/13/22 at 5:00PM **Dated 9/13/22 at 7:12 PM revealed unstageable pressure ulcer to the ball of left foot measuring at, 2.0 centimeters on length, 2.0 centimeters in width, and 0.1 in depth. About 26-50% amount of necrotic tissue (eschar). Air mattress and Podus boot are pressure reducing devices added. Notification to physician on 9/13/22 at 5:00PM. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	**Dated 9/13/22 at 7:26 PM revealed deep tissue pressure injury to the left lateral distal foot measuring at 3.7 centimeters on length, 2.3 centimeters in width, and and depth written at a 0 indicated unable to measure. About 51-75% amount necrotic tissue (eschar). Air mattress and Podus boot are pressure reducing devices added. Notification to physician on 9/13/22 at 5:00PM During an observation and interview on 9/12/22 at 09:49 AM with Resident #11, she said that she required s assistance from staff with all tasks. She said that she staff do not come quickly when she pulleds her call light. She said she has had a stroke and her speech is challenged with remembering some words. She said that she was recently in the hospital and just returned yesterday. She said Dr. told her she has a staph infection from being wet all the time. She said that she has a pressure ulcer on her near her vaginal and anal area. She did not state she had any other open wounds or injuries. She said staff do not reposition her as often as they should, every 2 hours . She said she has a pillow under her left foot and that she has an amputation on her right side below her knee. Observation of the pillow under her foot revealed her foot was touching the footboard of the bed. She said that she was not in any pain in that area but that she does not have much feelings on the left side of her body due to her stoke. No Podus boot was observed on the foot and foot did not appear to be floated. During an observation and interview on 9/12/22 at 11:47 AM with Resident #11, she was being positioned in bed and she said she was coming in from taking a shower. Staff positioned the resident in upright position and placed a pillow under her heel. No Podus boot was observed on the foot and foot did not appear to be floated. During an observation on 9/12/22 at 02:34 PM with Resident #11, she was observed in bed asleep. She was in the same position as during lunch. She was in the sitting position with bed raised. Pillow could be observed under her right shoulder and left foot. Resident #11 foot was covered with the blanket so unable to see if a Podus boot was placed on her foot. During an observation and interview on 9/13/22 at 9:12 AM with Resident #11, she was seen watching TV. She said that she preferred to lay on her right side as she has more feelings on that side of her body. She said that her left shoulder bothers her too much to lay on that side. Resident was observed laying on her right side with a pillow under her right shoulder and left foot. She said that she was not in any pain and she had just had her morning medication pass. She said that the treatment nurse had not come in to treat her wounds yet. Her left foot was observed with a Podus boot and elevated by a pillow but not floated. The resident's left foot was touching the foot board of the bed. During an observation and interview on 9/13/22 at 11:38 AM with Resident #11, revealed she was in the upright position. She said staff had been in earlier to move her into that position for lunch. She was observed with her left foot in the Podus boot and elevated, but the foot was not floated. Her left foot was touching the foot board of the bed. During an observation on 09/14/22 at 10:30 a.m., RN R performed hand hygiene and entered into Resident #11's room with a treatment tray setup with clean dressings and supplies on top of plastic covered tray. RN R performed hand hygiene prior to treatments being performed. Resident #11 was laying on her right side with her left foot floated with a pillow. RN R performed wound treatment to all areas with good technique, using hand sanitizer and changing gloves at the proper times. The following observations of Resident #11's wounds included: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	* Left lateral distal foot appeared to be a DTI (deep tissue injury). The area had smooth, discolored skin, oval shaped, and the size of my thumb. The area was dark purple in color and non-blanchable with no drainage or open areas. * Left distal 4th toe appeared to be a DTI (deep tissue injury). The area had smooth, discolored skin, oval shaped, and the size of a dime. The area was dark purple in color and non-blanchable with no drainage or open areas. * Left ball of foot appeared to be an unstageable pressure ulcer (related to the black covered areas of the wound, making the stage undetermined). The middle of the ulcer was pink, moist, shiny, and the size of a quarter with black tissue covering the left and right edges of the wound about a centimeter out. A small amount of pink watery drainage was noted on the dressing that was removed. * Left proximal heel appeared to be an unstageable pressure ulcer with full thickness tissue loss and black eschar tissue in the middle of the ulcer. The ulcer was the size of a dime. * Left distal heel appeared to be an unstageable pressure ulcer with full thickness tissue loss and black eschar tissue covering the middle of the ulcer. The ulcer was about the size of a thumb. * Stage 2 ulcer to sacrum that had pink and healthy tissue. * Stage 2 to left buttock that had pink and healthy tissue. During an observation and interview on 9/14/22 at 11:19 AM with Resident #11, she said she did not have an air mattress nor the Podus boot on her left foot. She said that nursing and maintenance staff came in that morning to change her bed, remove the foot board, and place the Podus boot on her left foot. She said that this bed and cushion on her left foot made her feel better. She said that it took staff about 3-4 hours to come; never in two hours. She stated if they came, one will come and then go look for another staff to help since she required more than one staff assist with the Hoyer lift. She said she used to refuse repositioning but had not refused lately. She said that she asked nursing staff to reposition her now. She said she cannot feel pain but pressure on the left side of body. She said she can turn herself back to right side but not all the way. She said she preferred to lay on right side. Resident #11 said that she would yell out to get staff attention because her call light is not always within her reach. Call light was observed clipped on her gown on the right side. She said that staff did that this morning. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/14/22 at 11:42 AM with GVN V, she said she had worked at the facility for about two weeks and is a recent graduate. She said that she worke on hall four. She said that Resident #11 often pulls her call light for assistance. She said that she checked on her even without the call light notification. She said that Resident #11 had complained of pain in her left arm and on her incision from her right below knee amputation. She said that CNAs are the main staff responsible for ADLs (activities of daily living) but that charge nurses can and will assist as well. She said that whenever a staff member performed a task for the resident, they should have ensured the call light was accessible to the resident. She said that CNAs and charge nurses should also be repositioning the residents who cannot do so themselves every two hours. She said that the charge nurses are responsible for ensuring that the resident's feet are floated properly, if required. She said that floating is meant to not only elevate the feet but to ensure that they are not touching the bed or foot board. She said it should be like hanging off the pillow or wedge. She said that Resident #11 had her foot board removed from her bed, but she is not sure why as it happened when she was no longer on shift on 9/13/22. She said she was aware that Resident #11 had an open wound on her right leg from a recent amputation, sacrum, and left heel. She said that Resident #11 prefered to lay on her right side being that she has pain on her left side. She said that facility has a wound care nurse and that none of the charge nurses performed this task. She said that if a resident admitted during their shift, the charge nurse was responsible for completing head to toe skin assessments. During an interview on 9/14/22 at 12:17 PM with CMA P, she said she is a certified medication aid but that she does assist with ADLs as she is also a CNA. She said that she provided care for residents with pressure ulcers by ensuring that she does a visual skin assessment during incontinence care and transfers. She said that she was not familiar with every area a resident has a pressure ulcer until she was on duty because this was not a task that CNAs perform. She said that once they noticed an abnormality, they informed the charge nurse immediately. She said that CNAs are responsible for positioning and if a resident requires two persons assist, then she would get the charge nurse to assist. During an interview on 9/15/22 at 9:27 AM with LVN N, she said that CNAs and charge nurses are were each responsible for ADLs and assistance with repositioning of residents. She said that she feelt that it was the responsibility of the charge nurse to ensure that this was done every two hours. She said that if a resident required two persons assist, then she always assisted the CNA on her shift. She said that if a resident was known to have difficulty with positioning themselves, nursing staff should also float the resident's heels by elevating with a pillow or foam wedge and keep the feet from touching the foot board or bed. She said that Resident #11 is not on her hall and has no knowledge of her care. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/15/22 at 10:15 AM with LVN T, she said that worked with Resident #11. She said that when she admitted a resident, she was aware that she was supposed to complete the initial skin assessment from head to toe, assess for flight risks, medication ordered, and fall risks. She said that the assessments are logged into the resident's chart in the electronic charting system. She said that as a charge nurse, she would complete the skin assessment but not the ulcer assessment . She said that this was done by the treatment nurse or DON if no treatment nurse is available. She said that the Nurse Practitioner or Treatment Doctor would also complete if they are notified. She said that the Nurse Practitioner and Treatment Doctor came to the facility and performed care. This was done one a week. She said that there was no one person more responsible for ADLs, transfers, or repositioning. She said that she kept a timer on her iPad for every two hours to remind herself to check positioning of the residents that required assistance with that task. She said that when she admitted Resident #11 from her recent hospitalization on [DATE], she noted on her skin assessment that she had three wounds: one on her sacrum, one on her left foot on the bottom of the heel, and one on her amputation. She said that she did not note or notice any other skin issues on the left foot. She said the risk for not completing an accurate skin assessment was that the resident could become sepsis, get an infection, or not receive the treatment they need. LVN T could not distinguish between floating and elevating the foot. She described twice placing a pillow under the ankle area. She said that the foot does not hang over the pillow. She said that she observed Resident #11 in an air flow bed but that she could not stay in the bed. She said it was the facilities policy to not have residents in these types of beds because they could slip and become a fall risk. During an interview on 9/15/22 at 10:37 AM with CNA W, she said she worked with Resident #11 and provided assistance with ADLs to residents. She said that she did incontinence care and if she notices any abnormality on the skin, she would inform the charge or treatment nurse immediately to come assess. She said that she was not responsible for wound care but that she can assist with positioning and repositioning if a resident needed it. She said that Resident #11 and two other residents required Hoyer transfer, and two person assists, and she would get the nurse to assist her with them. She said that repositioning should be done every two hours if a resident cannot do this themselves. She said that she had not noticed any abnormalities in Resident #11's skin and that she was aware that she had pressure ulcers on her sacrum, buttock, and an open wound from her amputation. (continued on next page)

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

During an interview on 9/15/22 at 11:22 AM with Regional Corporate RN E, she said was currently in the facility, as the DON was not available. She said that she expected whichever nurse admitted a resident, new or from the hospital, to complete a full skin assessment from head to two within 24 hours. She said the tool used for that assessment was located in the electronic records system. She said that any skin issues the nurse found should be discussed with the treatment physician, treatment nurse, ADON, and DON as soon as possible. She said the risk for that not being completed timely or accurately was that a resident could not receive care needed for something not identified, treatment could be delayed, or infection. She said that it was not currently in policy but she would expect the treatment nurse to also complete an assessment the next day if the charge nurse documented something on the skin assessment. She said that an ulcer assessment would then be done by the treatment nurse, ADON, or DON. She said that that assessment should be completed within 24 hours of the admission or knowledge of skin concern. She said that another risk could be that there was no clear identification of what care the resident needed, could have deteriorated, and it could be unknown the progression of the wound. She said that the DON and ADON has been off work since last Friday, 9/9/22 and that this was the day that Resident #11 readmitted from the hospital. She said that the facility had a treatment physician who came once a week to assess residents. She said that he was there on Monday, 9/12/22, but only assessed Resident #11 for her sacrum, buttocks, and amputation. She said that the initial assessment completed by the admitting charge nurse was inaccurate in that it read right foot (resident has below knew amputation) and there was no indication of any skin concerns on the left foot. She said that the resident did not have any treatment provided for the wounds on her left as a result of this error. She said that she knows floating to mean nothing underneath and elevating means that there can be something underneath the foot.

During an interview on 9/15/22 at 12:22 PM with the Administrator, he said that he expected any nurse that admitted a resident, newly or from hospital, to complete a full initial skin assessment within 24 hours and accurately. He said that he expected it to be full head to toe assessment. He said the risk of that not being done accurately or timely would be that a resident could get an infection, not treated timely, and could result in sepsis and re-hospitalization .

Record review of facility's policy titled, Skin Integrity Management dated 10/5/16, revealed that: 1. If wound is noted, perform an assessment, and initiate a treatment plan as soon as possible. Document in resident's chart, area of change, who you notified, and treatment applied. 3. Wound care should be performed as ordered by the physician. 5. Use pillows or foam wedges to keep bony prominences from direct contact. 20. Additional heel protection may be needed even if a resident is on a pressure reducing/relieving device. Use pillows to off-pressure heels.

Record review of facility's policy titled, Skin assessment dated [DATE] revealed that It is the policy of this facility to establish a method whereby nursing can assess a resident's skin integrity to allow of appropriate intervention be initiated in a timely manner. Procedure: 1. All new admits and residents returning from a hospital stay will have a head-to-toe skin assessment completed. If the facility Treatment Nurse/designee is available, he/she should complete the assessment within four (4) yours of the resident's arrival at the facility. If the Treatment Nurse/designee isn't available, then the charge nurse should complete the assessment within four (4) hours of the resident's arrival at the facility .2. All residents should have a skin assessment on a weekly basis completed in PCC. 3. If the resident has any type of ulcer (pressure injury, arterial, venous, diabetic) an ulcer assessment should be completed at least weekly.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of facility's policy titled, Pressure Injury: Prevention, Assessment, and Treatment dated 8/12/16 revealed that 1. Nursing personnel will continually aim to maintain the skin integrity, tone, turgor, circulation to prevent breakdown, injury, and infection .

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review, the facility failed to ensure residents received appropriate treatment and services to prevent further decrease of range of motion for 1 of 18 residents reviewed for limited range of motion. (Resident #41). The facility did not ensure Resident #41 had a contracture prevention device in place for the treatment of his left-hand contracture. This failure cold place residents at risk of or decrease in mobility, decrease in range of motion, and contribute to worsening of contractures. Findings included: Record review of a face sheet dated 09/14/2022 indicated Resident #41 admitted on [DATE] with the diagnoses of stroke, left hand contracture, pain and lack of coordination. Record review of an undated care plan indicated Resident #41 had an alteration in musculoskeletal status related to a left-hand contracture. The goal was Resident #41 would exhibit adequate coping skills dealing with loss of use of limb. The intervention was to apply carrot (soft device resembling a carrot) to left hand daily, wash hand and dry completely before applying the carrot. The care plan did not address the amount of time the carrot was to be used during the day. Record review of the Admission MDS assessment, dated 05/6/22, indicated Resident #41 understood others and was understood by others. Resident #41's BIMs Score was 12 indicating moderate impairment of cognition. The MDS indicated Resident #41 required extensive assistance with bed mobility, transfers, locomotion, dressing, toilet use, and he required total assistance with bathing. The MDS section Functional Limitation in Range of Motion indicated Resident #41 had impairment on one side of the upper extremity and lower extremity. Record review of an occupational therapy evaluation and plan of treatment dated 05/2/22 indicated Resident #41 had paralysis on the left side from a stroke, had a left-hand contracture and generalized muscle weakness. The therapist implemented a new goal for Resident #41 to wear a palm protector on his left hand for up to 5 hours with minimal symptoms of redness, swelling, discomfort or pain and increasing up to six hours daily by 06/12/22. During an initial tour observation and interview on 09/12/22 at 11:01 a.m., Resident #41 was noted to have a left-hand contracture without a device in place. Resident #41 indicated, at times, the staff put the device in his hand. During an observation on 09/12/22 at 2:00 p.m., Resident #41's left hand contracture did not have a contracture preventing device. During an interview on 09/13/22 at 3:00 p.m., the Occupational Therapist Assistant indicated Resident #41 should wear the carrot to protect from further closure of the left-hand contracture. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 09/14/22 at 12:57 p.m., CNA S indicated Resident #41, in the past , had a carrot to wear in his left hand. CNA S validated Resident #41 did not have his carrot to his left hand. CNA S allowed the surveyor to see the tasks for the nursing staff on the Kardex. The Kardex for Resident #41 indicated he was to have a carrot in his left hand. CNA S said he was unsure where the carrot was at that time. During an interview on 09/15/22 at 8:37 a.m., LVN U indicated Resident #41 may use a carrot to his left-hand contracture. LVN U indicated Resident #41's hand could become odorous, and the contracture worsen without the use of the carrot. LVN U indicated the nursing staff were responsible for placement of the contracture devices. LVN U indicated she monitors for the devices during rounds. During an interview on 09/15/22 at 12:30 p.m., the Regional Nurse F indicated all nursing was responsible for putting a device in use for a contracture. The Corporate nurse indicated the ADON and DON monitor by making rounds at least every two hours. The corporate nurse indicated not having a device in the contracted hand could lead to discomfort and contribute to the contracture stiffening. During an interview on 09/15/22 at 1:00 p.m., the Administrator indicated therapy and nursing was responsible for ensuring devices were used in the contractures. He indicated the contracture could worsen if not used. Record review of an Immobilization devices, splints/slings/collars/straps policy dated 2003 Goals 2. The resident will maintain baseline neurovascular and skin status. 5. If handroll is used: position the handroll between the fingers and palm of hand and do not hyperextend the joints when inserting the handroll. 13. Cloth devices can be washed when soiled. If continuous use is required, an extra device will be kept on hand for application. 15. Document all care and the resident's response to treatment in the clinical record.

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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 33249

Based on observation, interview, and record review, the facility failed to maintain medical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, and systematically organized for 1 of 2 residents reviewed for clinical documentation. (Resident #46)

The facility failed to document Resident #46's a large bruise to her left flank and an open area to her right foot great toe and back of her right thigh after returning from a hospital visit with a return date of 09/13/22.

This failure could place residents at risk for nurses not identifying changes in the resident's wound, the wounds worsening, a wound infection, and sepsis (the body's response to an infection that could lead to tissue damage, organ failure, and even death).

Findings included:

Record review of a face sheet dated 09/15/22 indicated Resident #46 was [AGE] years old, admitted on [DATE] and readmitted on [DATE] with the diagnoses of chronic ulcer to right foot, diabetes, falls, and lack of coordination.

Record review of an Admission MDS assessment, dated 05/1/22, indicated Resident #46 understood others and was understood by others. Resident #46's BIMs score was 15 indicating no cognitive deficit. The MDS indicated Resident #46 required extensive assistance with bed mobility, transfers, bathing, and toilet use. She required limited assistance with dressing and personal hygiene. Section M of the MDS indicated Resident #46 had diabetic foot ulcers.

Record review of an undated comprehensive care plan indicated Resident #46 had a pressure ulcer or potential for pressure ulcer development with the goal of having intact skin, free of redness, blisters, or discoloration. The interventions included ensure heels were floated, incontinent care after each episode and apply moisture barrier, Resident #46 needed assistance turning and repositioning at least Q 2 hours, requires a cushion to the wheelchair and use a lifting device to reduce friction. The care plan did not address the current wounds and bruising specifically.

Record review of the consolidated physician's orders indicated, on 09/14/22, Resident #46 had a new treatment to cleanse the right posterior thigh daily with normal saline or wound cleanser, pat dry, apply collagen sheet and cover with a dry dressing daily. The physician's order indicated Resident #46 had a new order for cleansing the top of the right great toe daily with normal saline or wound cleaner spray and pat dry, apply skin prep to site and leave open to air one time a day.

Record review of a Wound Evaluation and Management Summary dated 09/06/22 indicated Resident #46 had a diabetic wound to her right foot, third toe measuring 0.2 x 0.2 x not measurable, skin tear wound to left posterior thigh and a non-pressure wound to right buttock due to moisture associated damage.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the electronic medical record indicated Resident #46 was transferred to the local emergency roiagnom on [DATE] due to a nosebleed. The record indicated Resident #46 returned on 09/13/22 in the late afternoon. Record review of a skin assessment, dated 09/13/22 at 6:26 p.m., indicated LVN B documented normal skin color with normal temperature for Resident #46. LVN B documented no bruising. In the area of other skin findings, LVN B documented an open area to left lower buttock with wound care orders in place, and a diabetic ulcer to the right foot second toe with wound care orders in place. During an observation and interview with RN R on 09/14/22 at 9:20 a.m. to 10:07 a.m., Resident #46 had an open area to her right foot great toe, a large bruise to her left flank (side of back), and an open area to the back of her right thigh. RN R indicated there were several areas not documented on the skin assessment last night including the bruising to her flank, open area to right great toe and open area to the back of the right thigh. RN R indicated she would call the physician and obtain treatments to the areas. RN R indicated the bruise did not appear new as it had color changes. Record review of an injury Nurses' note dated 09/14/22 at 10:34 p.m., Resident #46 was noted to have a bruise to her flank low back measuring 12 centimeters x 8 centimeters purple and blue in color. During an interview on 09/15/22 at 12:30 p.m., the Regional Nurse F indicated an initial assessment should be completed within 24 hours of admission and a skin assessment should be conducted by the admitting nurse within 4 hours of arriving to the facility. The corporate nurse indicated her expectation was the treatment nurse would complete the initial skin assessment or follow up on the initial skin assessment the next day. The corporate nurse indicated an ulcer assessment should be completed within 4 hours of admission for any ulcers found. The corporate nurse indicated skin assessments not completed accurately and timely leads to a risk of misunderstanding the wound status. The corporate nurse indicated the admitting nurse should have documented the bruising to Resident #46's back, right great toe and left back thigh. During an interview on 09/15/22 at 1:00 p.m., the Administrator indicated he expected any identified wounds would have wound care orders. The Administrator indicated the nurses were responsible for identification of wounds. The Administrator indicated untreated wounds could deteriorate, have symptoms of infection, and even included death. Record review of facility's policy titled, Skin Integrity Management dated 10/5/2016, revealed that: 1. If wound is noted, perform an assessment, and initiate a treatment plan as soon as possible. Document in resident's chart, area of change, who you notified, and treatment applied. 3. Wound care should be performed as ordered by the physician. 5. Use pillows or foam wedges to keep bony prominences from direct contact. 20. Additional heel protection may be needed even if a resident is on a pressure reducing/relieving device. Use pillows to off-pressure heels. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's policy titled; Skin assessment dated [DATE] revealed that It is the policy of this facility to establish a method whereby nursing can assess a resident's skin integrity to allow of appropriate intervention be initiated in a timely manner. Procedure: 1. All new admits and residents returning from a hospital stay will have a head-to-toe skin assessment completed. If the facility Treatment Nurse/designee is available, he/she should complete the assessment within four (4) yours of the resident's arrival at the facility. If the Treatment Nurse/designee isn't available, then the charge nurse should complete the assessment within four (4) hours of the resident's arrival at the facility .2. All residents should have a skin assessment on a weekly basis completed in PCC. 3. If the resident has any type of ulcer (pressure injury, arterial, venous, diabetic) an ulcer assessment should be completed at least weekly. Record review of facility's policy titled, Pressure Injury: Prevention, Assessment, and Treatment dated 8/12/2016 revealed that 1. Nursing personnel will continually aim to maintain the skin integrity, tone, turgor, circulation to prevent breakdown, injury, and infection .

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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 45810

Based observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for five (Residents #6, #28, #35, #40, and #58) of eight residents observed for infection control.

CMA P failed to perform proper hand hygiene and sanitation between Residents #6, #28, #35, #40, and #58, during medication administration.

Thisese failures could place residents at risk of cross-contamination and infections leading to illness.

Findings included:

1.Record review of Resident #6's Admission Record dated 09/14/2022 indicated that resident was an 82-year- old male who admitted to the facility on [DATE] with diagnosis of Dementia (disease associated with memory loss), Hypertension (high blood pressure), Unspecified Fall, and need for assistance with personal care.

Record review of Resident #6's MDS assessment, dated 01/14/2022, indicated that resident had a BIMS score of 9 which indicated resident had moderately impaired cognition. MDS also indicated that Resident #6 required total assistance of 1 person for bathing, limited assist of 1 person for toileting and personal hygiene, and supervision of 1 person for bed mobility, transfers, and walking.

Record review of Resident #6's undated Care Plan last reviewed on 07/14/2022 indicated that resident had impaired cognitive function related to dementia with intervention for medications to be administered as ordered.

2.Record review of Resident # 28's Admission Record dated 09/14/2022 indicated that resident was a 90-year- old female who originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of Dementia (disease associated with memory loss), Anxiety, Depressive disorder, and Hypertension (high blood pressure).

Record review of Resident #28's MDS assessment dated [DATE] indicated that resident had a BIMS score of 12 which indicates moderately impaired cognition. MDS also indicated that Resident #28 Required extensive assistance of 1-2 persons with bed mobility, transfers, dressing, and toilet use, and total assistance of 1 person for bathing.

Record review of Resident #28's undated Care Plan last reviewed on 07/06/2022 indicated that resident had impaired cognitive function related to dementia with intervention for medications to be administered as ordered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.Record review of Resident #35's Admission Record indicated that resident was an 81-year -old male who admitted to the facility on [DATE] with diagnosis of Dementia (disease associated with memory loss), Anemia (blood disorder), Depressive disorder, and Hypertension (high blood pressure), legal blindness. Record review of Resident #35's MDS assessment date 07/29/2022 indicated that resident had a BIMS score of 1 which indicated severe cognitive impairment. MDSs also indicated that Resident #35 required extensive assistance of 2 persons for bed mobility, transfers, dressing, and toilet use. Record review of Resident #35's undated Care Plan last reviewed on 08/08/2022 indicated that resident had impaired cognitive function related to dementia with intervention for medications to be administered as ordered. 4.Record review of Resident #40's Admission Record indicated that resident was an 84-year- old female who originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with the diagnosis of surgical aftercare following surgery on the circulatory system, Alzheimer's (disease associated with impaired cognition), Diabetes (disease in which body has impaired insulin production), and Hypertension (high blood pressure). Record review of Resident #40's MDS assessment dated [DATE] indicated that resident had a BIMS score of 5 which indicates severe cognitive impairment. MDS also indicated that Resident #40 required Extensive assistance of 1 person for dressing, toilet use, and personal hygiene, Limited assistance of 1 person for bed mobility, Supervision from 1 person with transfers, and total assistance of 1 person with bathing. Record review of Resident #40's undated Care Plan last reviewed on 08/22/2022 indicated that resident had impaired cognitive function related to Alzheimer's with intervention for medications to be administered as ordered. 5.Record review of Resident #58's Admission Record indicated that resident was a 73-year- old female who originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of Acute respiratory failure (inadequate oxygen exchange), Congestive heart failure (disease in which the heart does not pump as it should), and the need for assistance with personal care. Record review of Resident #58's MDS assessment dated [DATE] indicated that resident had a BIMS score of 14 which indicates resident is cognitively intact. MDS also indicated that Resident #58 required extensive assistance of 2 persons for bed mobility, dressing, and toilet use, and total assistance of 1 person with bathing and personal hygiene. Record review of Resident #58's undated Care Plan last reviewed on 08/30/2022 indicated that resident had impaired cognitive function/dementia with confusion and disorientation as well as impaired decision making. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/13/22 at 08:15 AM, CMA P was on the hallway 1 standing at the medication cart. CMA P grabbed the blood pressure cuff, knocked on Resident #40's door and went in and checked resident's blood pressure without performing handwashing or using hand sanitizer. CMA P then exited Resident #40's and prepared Resident #40's medications by popping each pill out of a blister pack into a medication cup, without washing hands or using hand sanitizer. CMA P then knocked on the door and entered Resident #40's room with medications, adjusted Resident #40 in the bed, and administered Resident #40's medications. CMA P did not use any hand sanitizer or wash hands after returning to the medication cart. During an observation on 09/13/22 at 08:25 AM, CMA P began preparing medications for Resident #28. CMA P prepared medications by popping each pill out of a blister pack into a medication cup and knocked on Resident #28's door to administer medications. CMA P entered Resident #28's room turned light on and told resident she had her medications. Resident refused medications and CMA P exited the room and went outside to the smoke area to notify the charge nurse. CMA P returned to the cart to discard medications in the sharp's container. CMA P did not wash hands or use hand sanitizer afterwards. During an observation on 09/13/22 at 08:37 AM, CMA P began to prepare medications for Resident #58. CMA P prepared medications by popping each pill out of a blister pack into a medication cup and knocked on Resident #58's door to administer medications. CMA P used the bed remote control to raise Resident #58's head of bed and administered medications. CMA P returned to the medication cart and did not use hand sanitizer or wash hands. During an observation on 09/13/22 at 08:56 AM, CMA P entered Resident #6's room to check his blood pressure. She checked blood pressure and returned to the medication cart. CMA P prepared Resident #6's medication to be administered. CMA P grabbed medications including eye drops and nose spray and entered Resident #6's room. She administered Resident #6 his medications by mouth and donned gloves to give eye drops and nose spray then removed the gloves. No hand sanitizer was used, or handwashing performed before or after medications. CMA P returned to the medication cart. During an observation on 09/13/22 at 09:06 AM CMA P entered Resident #35's room and attempted to get blood pressure but could not. CMA P asked for assistance by CNA C. CMA P applied gloves and both staff members pulled Resident #35 up in the bed. CMA P removed her gloves and checked Resident #35's blood pressure. CMA P used hand sanitizer after exiting Resident #35's room. CMA P then prepared medications for administration, crushed medications, and mixed the medications with jelly. CMA P re-entered Resident #35's room, raised head of bed, and administered medications by mouth, donned gloves and administered eye drops to left eye. CMA P removed gloves and exited Resident #35's room. CMA P did not use hand sanitizer or wash hands after exiting room. During an observation on 09/13/22 at 09:30 AM Resident #28 requested her morning medications. CMA P prepared Resident #28 medications by popping each pill out of a blister pack into a medication cup and went into Resident #28's room to give without washing hands or using hand sanitizer. During an interview on 09/13/22 at 09:37 AM with CMA P, she said she thought she did okay with the medication administration. CMA P said she should have used sanitizer in between each resident and between glove changes. CMA P said this failure could result in passing on germs from one resident to the other rooms and residents. CMA P said that she had been in-serviced on hand hygiene about one month ago in August. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/15/2022
NAME OF PROVIDER OR SUPPLIER Pine Tree Lodge Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2711 Pine Tree Rd Longview, TX 75604	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/15/22 at 10:30 AM with CMA Q, she said she had been working in the facility about two years and worked as a CMA about one year. CMA Q said when passinged medications, she washed her hands and or sanitized her hands between each resident. She said when she passed medications, she would use gloves when she had to pass medications to a resident that is in isolation. CMA Q said if staff did not wash hands in between resident's care, it could cause unknown infections to be carried from one resident to the other residents. During an interview on 09/15/22 at 11:55 AM with Regional Nurse E, she said her expectation was for staff was to use hand sanitizer between residents when they administered medications. Regional Nurse E said that medication administration proficiency check was supposed to be completed upon hire and annually. She said the handwashing proficiency check off was performed more often. Regional Nurse E said when a medication aide was passing medications to more than one resident without washing their hands or using hand sanitizer, there was a risk for cross contamination and passing infection from one resident to another. She said the DON and ADON was responsible for ensuring that the medication aides are administering medications using proper technique and proper infection control. She said even the charge nurses should have been monitoring the CMAs by making rounds every 2 hours. During an interview on 09/15/22 at 12:15 PM with The Administrator, he said CMAs should perform hand hygiene before administering medications, after they leave a resident's room, and before entering another resident's room. The Administrator said the CMAs should have been using gloves as needed as well. The Administrator said the medication aide has a proficiency check that should be completed upon hire and once a year. He said the ADON, and DON were responsible for proficiency of medication aides and nurses. The aAdministrator said that handwashing proficiency was being completed quarterly. He said they were doing handwashing with every employee once a quarter, and the process just started in September. The Administrator said that staff not using hand sanitizer or washing their hands place residents at risk for transmission of infection, the resident getting sick, being admitted to the hospital and possibly death. Record review of a Facility In-Service training Topic: Infection Control dated 06/15/2022 by DON, indicated A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control prevention. Was covered and CMA P signed the in-service. Record review of the facility's undated policy titled Fundamentals of Infection Control Precautions indicated A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control prevention. 1. Hand Hygiene Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: When coming on duty When hands are visibly soiled (hand washing with soap and water); Before and after direct resident contact . Upon and after coming in contact with a resident's skin, (e.g., when taking a pulse or blood pressure, and after lifting a resident); . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	After removing gloves or aprons; and After completing duty. Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections .