STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455412	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven Nursing and Rehabilitation Center	1855 Cheyenne Carrollton, TX 75010

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** 28637 Based on interview and record review, the facility failed to ensure that the resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences of 1 (Resident #44) of 5 residents reviewed for accommodation of needs. 1. The facility failed to ensure that Resident #44 had a mobility device that was operable and comfortable to her that promoted independence, safety, and psychosocial need. This failure could place residents at risk of increased isolation, depression and increased risk of injury. Findings Include: Record Review of Resident #44's Quarterly MDS with an ARD of 07/13/24 revealed an [AGE] year-old female who admitted to the facility on [DATE]. Resident #44's active diagnoses included: Unspecified Dementia, Unsteadiness on feet, muscle wasting and atrophy (loss of muscle leading to its shrinking and weakening) and unspecified glaucoma (progressive eye condition that can cause blindness). Resident #55 had a BIMS score of 9, indicating a moderately impaired cognition. Record Review of the facility's document titled; Work Order Number 1173 revealed the work order was created by ADON A on 5/10. The Work Order revealed that resident [#44] complain[ed] that wheels to [her] wheelchair [are] making too much noise. Interview with Resident #44 on 08/28/24 at 10:23AM revealed that her current wheelchair was not in working condition that was comfortable for her or met her needs. Resident #44 revealed that she filed a grievance with ADON A a few months ago and the Maintenance Assistance came by to fix the wheels, but the wheelchair was still not in working condition or comfortable for her. Resident #44 revealed that nobody came back from the facility to check and see if the wheelchair was working or comfortable for her after it was serviced by the facility Maintenance Assistant. Resident #44 revealed that she relies on the wheelchair to move around the facility and go out with her family. Resident #44 revealed her current wheelchair makes daily tasks harder for her. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Observation of Resident #44's wheelchair on 08/28/24 at 10:30AM revealed a [Name of Wheelchair Brand] wheelchair next to Resident #44's bed. Wheelchair was observed with a broken left arm pad with padding exposed. Wheelchair was observed to be dusty and when Resident #44 transferred from the bed into her wheelchair, the wheelchair size narrowed causing difficulty for Resident #44 to maneuver the wheels. Interview with the Maintenance Assistant on 08/28/24 at 12:37PM revealed that he did work on Resident #44's wheelchair a few months back per a work order he received for her wheelchair. The Maintenance Assistant revealed that the wheelchairs wheels were too loose at that time, and he tightened them. The Maintenance Assistant revealed that he was unaware, and it was not reported to him that Resident #44's wheelchair was broken still and needed servicing, or a new wheelchair was needed. The Maintenance Assistant revealed that he will work on getting Resident #44 a wheelchair right away. Interview with DON on 08/30/24 at 11:25AM revealed that all residents are assessed for mobility needs and preferences on admission by the admitting nursing and evaluating therapists. The DON revealed that for long-term care resident's, no specific person or department head in the facility was responsible for ensuring that the resident's equipment was working and met their needs. The DON revealed that it was the responsibility of all staff to ensure that all residents equipment was working and met their current needs. The DON revealed that he was unaware that Resident #44's wheelchair was broken and uncomfortable for her. The DON revealed that he was aware Resident #44 operated and utilized her current wheelchair on a daily basis and made no complaints to management that it was uncomfortable for her. The DON revealed that a risk to all residents if they had mobility devices that did not match their needs would be decreased involvement from those residents. Interview with Social Worker on 08/30/24 at 1:53PM revealed that she was unaware that Resident #44's wheelchair did not accommodate to her current needs. The Social Worker revealed that the responsibility of the nursing staff to ensure that all residents had mobility devices that met their needs. The Social Worker revealed that the facility was working on getting her a new wheelchair. Interview with Administrator on 08/30/24 at 4:39PM revealed that Resident #44 never addressed any issues with her current wheelchair to her or any other staff member. The Administrator revealed that every staff member is responsible for ensuring that their mobility devices, if needed, matched their current needs and was comfortable for them. Record Review of the facility policy titled, Quality of Life- Accommodation of Needs, dated August 2009 revealed that, the resident's individual needs and preferences, including the need for adaptive devices . shall be evaluated upon admission and reviewed on an ongoing basis.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interviews, and record review, the facility failed to resolve a grievance in a timely manner for 1 of 5 (Resident #44) residents reviewed for grievances. 1.The facility failed to make prompt efforts to ensure Resident #44's grievance was initiated, reported, and resolved in a timely manner. These failures could affect the Resident's ability to file a grievance without the fear of discrimination, reprisal or retribution and their right to have their grievances resolved in a timely manner. Findings Included: Record Review of Resident #44's Quarterly MDS with an ARD of 07/13/24 revealed an [AGE] year-old female who admitted to the facility on [DATE]. Resident #44's active diagnoses included: Unspecified Dementia, Unsteadiness on feet, muscle wasting and atrophy (loss of muscle leading to its shrinking and weakening) and unspecified glaucoma (progressive eye condition that can cause blindness). Resident #55 had a BIMS score of 9, indicating a moderately impaired cognition. Record Review of the facility's March 2024 Grievance Log revealed 3 logged grievances, none of which revealed a grievance filed for Resident #44. Record Review of the facility's April 2024 Grievance Log revealed 0 logged grievances. Record Review of the facility's June 2024 Grievance Log revealed 4 logged grievances, none of which revealed a grievance filed for Resident #44. Record Review of the facility's May 2024 Grievance Log revealed 1 logged grievances, none of which revealed a grievance filed for Resident #44. Record Review of the facility's July 2024 Grievance Log revealed 1 logged grievances, grievance filed was not filed by Resident #44. All grievances were dated as resolved. Record Review of the facility's August 2024 Grievance Log revealed 0 logged grievances. (continued on next page)

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #44 on 08/28/24 at 10:23AM revealed that her current wheelchair was not in working condition that was comfortable for her or met her needs . Resident #44 revealed that she filed a grievance with ADON A a few months ago and the Maintenance Assistant came by to fix the wheels, but the wheelchair was still not in working condition or comfortable for her. Resident #44 revealed that nobody came back from the facility to check and see if the wheelchair was working or comfortable for her after it was serviced by the facility Maintenance Assistant. Resident #44 revealed that she relies on the wheelchair to move around the facility and go out with her family. Resident #44 revealed her current wheelchair makes daily tasks harder for her such as coming and going from her room and attending activities. Observation of Resident #44's wheelchair on 08/28/24 at 10:30AM revealed a [Name of Wheelchair Brand] wheelchair next to Resident #44's bed. Wheelchair was observed with a broken left arm pad with padding exposed. Wheelchair was observed to be dusty and when Resident #44 transferred from the bed into her wheelchair, the wheelchair size narrowed causing difficulty for Resident #44 to maneuver the wheels. Interview with ADON A on 08/28/24 at 12:03PM revealed that Resident #44 did utilize the wheelchair on a daily basis. ADON A revealed that Resident #44 did report to him a few months back that her wheelchair was broken, and he reported the issue to the Maintenance Assistant. ADON A revealed that he was unaware that the complaint related to Resident #44's wheelchair should be constituted as a grievance and instead reported it to the maintenance department. ADON A revealed that he was unaware that Resident #44's complaint about her current wheelchair was still not resolved. ADON A revealed that the Social Worker is the facility grievance official and oversees the facility grievance procedures. ADON A revealed that if a resident had a grievance, he would fill out the facility grievance form, begin the investigation and alert the Social Worker and Administrator of the grievance. ADON A did not reveal a risk to residents for unresolved grievances. Interview with Maintenance Assistant on 08/28/24 at 12:37PM revealed that he did work on Resident #44's wheelchair a few months back per a work order he received for her wheelchair. The Maintenance Assistant revealed that the wheelchairs wheels were too loose at that time, and he tightened them. The Maintenance Assistant revealed that he was unaware, and it was not reported to him that Resident #44's wheelchair was broken still and needed servicing, or a new wheelchair was needed. The Maintenance Assistant revealed that he did not review grievances, but if a resident files a grievance related to needed maintenance, then it should have been transcribed into a work order. Interview with DON on 08/30/24 at 11:25AM revealed that the facility procedures on grievances was that the DON will receive all grievances from the resident or the staff member who received the grievance from the resident. The DON revealed that he would then either investigate the grievance or alert the appropriate department head to investigate. The DON revealed that the social worker is the facility grievance official, and she is responsible for ensuring that grievances are resolved in a timely manner. The DON revealed that residents are educated on the facility's grievance policy and procedures in resident council, on admission and through daily facility rounds conducted by all facility department heads. The DON revealed a risk to the resident for an unresolved grievance would be delay of care or concerns. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Social Worker on 08/30/24 at 1:53PM revealed that she is the facility grievance official. The Social Worker revealed that the procedure for grievances is, if a resident at the facility had a grievance they could go to the front office or the social work office to get a grievance form to fill out and turn into any staff member. The Social Worker revealed that residents can also file grievances verbally to any staff member. Once the grievance was filed it will then be reported to the Administrator and allocated to the appropriate department head. The grievance should be resolved within 72 hours. The Social Worker revealed that residents are educated on facility grievance policies and procedures during care plans. The Social Worker revealed that Resident #44 filed a grievance with ADON A or that an official grievance was filed for Resident #44 related to her wheelchair. The Social Worker revealed that she was unaware that Resident #44 had a broken wheelchair or that her current wheelchair did not meet her needs. The Social Worker did not reveal a risk to residents for unresolved grievances. Interview with Administrator on 08/30/24 at 4:39PM revealed that the facility procedures on grievances was that residents can go to any facility department head to file a grievance. The Administrator revealed that then the grievance, after it is filed, will then be transcribed to the grievance log and assigned to the appropriate department head for resolution. The Administrator revealed that the facility social worker is the grievance official and oversees the grievance procedures. The Administrator revealed that she was unaware that Resident #44's grievance related to her wheelchair was not resolved or not transcribed to the grievance log. The Administrator did not reveal a risk to residents for unresolved grievances. The facility did not provide a policy related to grievances. A policy was requested to the Administrator on 08/29/24 at 5:44PM.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on interview and record review, the facility failed to ensure the MDS (Minimum Data Set) assessment accurately reflected the resident's status for 1 (Resident #55) of 5 resident's reviewed for MDS assessment accuracy. The facility failed to ensure Resident #55's Quarterly MDS assessment with an ARD (assessment reference date) of 05/14/2024, reflected his current diagnosis of Major Depressive Disorder (clinical depression). This failure could place residents at risk of not receiving care and services to meet their needs. Findings Included: Record Review of Resident #55's Quarterly MDS with an ARD (Assessment Reference Date) of 05/14/2024 revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #55's active diagnoses included: Aphasia (brain disorder that affects the ability to speak or understand language), Hemiplegia following cerebral infarction (weakness on one side of the body following a stroke) and muscle weakness. Record Review of the MDS Section I, Active Diagnoses revealed a sub-section titled, Psychiatric/Mood Disorder. The sub-section revealed an option titled, Depression (other than bipolar), this option was not checked, indicating no active diagnoses of depression. Resident #55 had a BIMS score of 1 indicating a severe cognitive impairment. Record Review of the document titled, New Patient Referral Form, dated 02/14/2024 revealed Resident #55 was referred to [Psych provider] for psychology and psychiatry services on 02/14/2024 for: Depression/Sadness, withdrawal, tearfulness, agitation, irritability, confusion, high risk behavior and resistance to ADL/Medications. Record Review of the document titled, Psychiatric Subsequent Assessment, dated 04/24/2024, revealed Resident #55's primary treating diagnoses was, F33.9- Major Depressive Disorder, recurrent, unspecified. Reason for referral [for psychiatric services] indicated depression, withdrawal, isolation, tearfulness, agitation, irritability, confusion, and resistance to ADL/Medications. Current Psychotropic Medications revealed the following: Medication- Trazodone (medication used to treat depression) Start Date- 02/07/2024 Quantity- 1 Dosage/Frequency- 100mg Tablet/BID Treating- F33.9 (Major Depressive Disorder) No stop date indicated. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of the facility document for Resident #55 titled, Order Summary Report, dated 08/28/2024, revealed the following: Active Orders As of 08/28/24 for [Resident #55] Order Summary- Trazadone HCl Tablet 50MG (Trazodone HCl) Give 1 tablet by mouth two times a day for antidepressant Communication method- Phone Order Status- Active Interview with Resident #55 on 08/27/24 at 11:15AM revealed Resident #55 was tearful and began crying during several times of the interview. Resident #55 expressed feelings of depression, sadness and frustration with his current nursing facility placement and his inability to communicate effectively his needs with staff due to his communication deficits. Resident #55 revealed he had been seeing a psychiatrist but could not reveal if he had been diagnosed with Major Depressive Disorder. Interview with LVN I on 08/30/24 at 10:11AM revealed that she had been the nurse for Resident #55. LVN I revealed that she had witnessed crying episodes with Resident #55. LVN I revealed that she was unaware if Resident #55 was currently being treated for Major Depressive Disorder. LVN I revealed that she did have access to Resident #55's MDS and care plan but was unaware of his current and active diagnoses. LVN I revealed that Resident #55 was currently taking medications that treat depression. Interview with MDS Nurse G on 08/30/24 at 11:05AM revealed that she was unaware that Resident #55's MDS assessment did not reflect his current diagnosis of Major Depressive Disorder. MDS Nurse G revealed that she was the only person in the facility responsible for MDS assessments and their accuracy up until a few weeks ago. MDS Nurse G revealed that MDS Nurse Q recently started a few weeks ago and now is currently assisting with all assessments. MDS Nurse G revealed that she reviews all clinical documentation including psychiatry visit notes to ensure accuracy of the MDS assessment to ensure it reflects the resident's current clinical condition. MDS Nurse G revealed a risk to the resident for inaccurate MDS assessments would be the potential for missed care and care needs. Interview with MDS Nurse Q on 08/30/24 at 11:15AM revealed that revealed that she was unaware that Resident #55's MDS assessment did not reflect his current diagnosis of Major Depressive Disorder. MDS Nurse Q revealed that she had recently been hired at the facility and is responsibility for MDS assessments along with MDS Nurse G. MDS Nurse Q revealed she ensures MDS assessment accuracy by reviewing all clinical documentation along with staff and resident interviews. MDS Nurse Q revealed a risk to the resident for inaccurate MDS assessments would be the potential for missed care and care needs. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with DON on 08/30/24 at 2:50PM revealed that it was the responsibility of the MDS Nurses to ensure accuracy of all MDS assessments. The DON revealed that he was unaware that Resident #55's Quarterly MDS assessment did not reveal his active diagnosis of Major Depressive Disorder. The DON revealed that he has not seen Resident #55 tearful but was aware he was being treated for Major Depressive Disorder by the facility's psychiatrist. The DON revealed that a risk to the resident for inaccurate MDS assessments would be the missed care areas and interventions. Interview with Administrator on 08/30/24 at 5:00PM revealed that the MDS nurses are responsible for ensuring all MDS assessments are accurate and reflect the resident's diagnoses and care. The Administrator revealed that she was aware Resident #55 was currently on psychiatric services but was not aware he was currently being treated for Major Depressive Disorder. The Administrator revealed that a risk to the resident for inaccurate MDS assessments would be the potential for missed care. Record Review of the facility's policy titled, Electronic Transmission of the MDS, no date reflected, revealed that, The MDS coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS data. Record Review of the facility's document titled, Job Description-MDS, no date reflected, revealed that, [The] Job Description [is to] conduct and coordinate the development and completion of the resident assessment (MDS) in accordance with current rules, regulations, and guidelines that govern the resident assessment.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on interview and record review the facility failed to submit an accurate PL1 (PASARR Level 1) screening when residents admitted with a diagnosis of Mental Illness, Intellectual Disability or Developmental Disability for 1 (Resident #55) out of 5 residents reviewed for PASARR screenings. The facility failed to submit a new PL1 screening when Resident #55 was diagnosed with Major Depressive Disorder after admission to the facility. These failures could affect residents by not receiving a Level II PASARR Evaluation to access for needed services. Findings Included: Record Review of Resident #55's Quarterly MDS with an ARD of 05/14/2024 revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #55's active diagnoses included: Aphasia (brain disorder that affects the ability to speak or understand language), Hemiplegia following cerebral infarction (weakness on one side of the body following a stroke) and muscle weakness. Resident #55 had a BIMS score of 1 indicating a severe cognitive impairment. Record Review of the document titled, Psychiatric Subsequent Assessment, dated 04/24/2024, revealed Resident #55's primary treating diagnoses was, F33.9- Major Depressive Disorder, recurrent, unspecified. Reason for referral [for psychiatric services] indicated depression, withdrawal, isolation, tearfulness, agitation, irritability, confusion, and resistance to ADL/Medications Record Review of the document titled, PASRR Level 1 Screening dated 02/07/2024 revealed that Resident #55's PL1 screening indicated that Resident #55 did not have evidence of mental illness, intellectual disability or developmental disability. Interview with Resident #55 08/27/24 at 11:30AM revealed that he had not received PASARR services. Resident #55 revealed that nobody at the facility had discussed PASARR services with him. Resident #55 revealed that he would like to be screened for potential PASARR services if he did qualify. Interview with MDS Nurse G 08/30/24 at 11:10AM revealed that she along with MDS Nurse Q were responsible for ensuring PASARR Level 1's were accurate and received on admission. MDS Nurse G revealed that she was unaware a new PASARR Level 1 was not submitted for Resident #55 after he was diagnoses with Major Depressive Disorder. MDS Nurse G revealed that if a resident is diagnosed with a new diagnosis of mental illness, developmental disability or intellectual disability a new PASARR Level 1 should be submitted. MDS Nurse G revealed that a risk for incorrect PASARR Level 1 evaluations would be missed care. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 08/30/24 at 3:22PM revealed that MDS A and MDS Nurse Q were responsible for ensuring that the PASARR Level 1's were accurate and received on admission. The DON revealed that he was unaware that Resident #55 did not have a new PASARR Level 1 submitted after being diagnosed with Major Depressive Disorder. The DON revealed the facility procedure for PASARR's was that the facility would ensure the PASARR Level 1 is submitted to the LTC Online Portal on admission and if that PASARR Level 1 indicated yes for, mental illness, developmental disability or intellectual disability then that would trigger a PASARR Level II or evaluation to be completed. The DON revealed a risk for incorrect PASARR Level 1 evaluations would be missed care for the residents. Interview with Administrator on 08/30/24 at 5:10PM revealed that she was unaware that Resident #55 did not have a new PASARR Level 1 submitted after he was diagnosed with Major Depressive Disorder during his stay. The Administrator revealed that PASARR provided services for residents such as, therapy, case management and rehabilitation services. The Administrator revealed that it was the responsibility of MDS Nurse G and MDS Nurse Q to ensure accuracy of all PASARR assessments. The Administrator revealed a risk for incorrect PASARR Level 1 evaluations would be the opportunity for missed care needed for the residents. The facility did not provide a policy related to PASARR services or PASARR assessments. A policy was requested to the Administrator on 08/29/24 at 5:44PM.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053 Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames that met the residents clinical and psychosocial needs that were identified in the comprehensive assessment for 1 (Resident #55) out of 5 residents reviewed for care plans. The facility failed to ensure that Resident #55's comprehensive care plan included his diagnosis of Major Depressive Disorder. This failure could place residents at risk of having received inadequate interventions not individualized to their care needs and diagnoses. Findings Included: Record Review of Resident #55's Quarterly MDS with an ARD (Assessment Reference Date) of 05/14/2024 revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #55's active diagnoses included: Aphasia (brain disorder that affects the ability to speak or understand language), Hemiplegia following cerebral infarction (weakness on one side of the body following a stroke) and muscle weakness. Resident #55 had a BIMS score of 1 indicating a severe cognitive impairment. Record Review of the document titled, Psychiatric Subsequent Assessment, dated 04/24/2024, revealed Resident #55's primary treating diagnoses was, F33.9- Major Depressive Disorder, recurrent, unspecified. Reason for referral [for psychiatric services] indicated depression, withdrawal, isolation, tearfulness, agitation, irritability, confusion, and resistance to ADL/Medications. Record Review of Resident #55's comprehensive care plan, no date reflected, did not reveal Resident #55's current and active diagnosis of Major Depressive Disorder. Interview with Resident #55 on 08/27/24 at 11:15AM revealed Resident #55 was tearful and began crying during several times of the interview. Resident #55 expressed feelings of depression, sadness and frustration with his current nursing facility placement and his inability to effectively communicate his needs with staff due to his communication deficits. Resident #55 revealed he had been seeing a psychiatrist but could not reveal if he had been diagnosed with Major Depressive Disorder (he did not know all of his medical diagnoses) Interview with LVN I on 08/30/24 at 10:11AM revealed that she had been the nurse for Resident #55. LVN I revealed that she had witnessed crying episodes with Resident #55. LVN I revealed that she was unaware if Resident #55 was currently being treated for Major Depressive Disorder. LVN I revealed that she did have access to Resident #55's MDS and care plan but was unaware of his current and active diagnoses. LVN I revealed that Resident #55 was currently taking medications that treat depression. (continued on next page)

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	455412	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven Nursing and Rehabilitation Center	1855 Cheyenne Carrollton, TX 75010

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with MDS Nurse G on 08/30/24 at 11:05AM revealed that herself and MDS Nurse Q were responsible for ensuring all residents comprehensive care plans were personalized and matched their current needs. MDS Nurse G revealed that if a resident had an active diagnosis with mental illness such as, Major Depressive Disorder, then it should have been included in the resident's comprehensive plan of care along with interventions. MDS Nurse G revealed a risk of not personalizing a resident's comprehensive plan of care that matched their current clinical status would be missed care opportunities. Interview with MDS Nurse Q on 08/30/24 at 11:15AM revealed that herself and MDS Nurse G were responsible for ensuring all residents comprehensive care plan were personalized and reflect the resident's current care needs. MDS Nursed Q revealed that she had just started at the facility a few weeks ago and was unaware Resident #55's comprehensive care plan did not reflect his current diagnosis of Major Depressive Disorder. MDS Nurse Q revealed a risk of not personalizing a resident's comprehensive plan of car would be missed care. Interview with DON on 08/30/24 at 2:50PM revealed that MDS Nurse G and MDS Nurse Q were responsible for ensuring that all resident's comprehensive care plans were up to date, personalized and reflected their current needs. The DON revealed that he was unaware that Resident #55's comprehensive care plan did not reflect his current diagnosis of Major Depressive Disorder. The DON revealed a risk of not having comprehensive care plans personalized for all resident's would be the opportunity for missed care by direct care staff. Interview with Administrator on 08/30/24 at 5:00PM revealed that MDS Nurse G and MDS Nurse Q were responsible for ensuring all comprehensive care plans are individualized and person-centered. The Administrator revealed that she was unaware that Resident #55's comprehensive care plan did not include his diagnosis of Major Depressive Disorder. The Administrator revealed a risk of not personalizing a resident's comprehensive plan of care would be the opportunity for missed care. Record Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered dated December 2016 revealed that the policy statement was, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053 Based on observation, interview and record review the facility failed to ensure that the facility residents received proper treatment and care to maintain mobility and proper foot health for 1 (Resident #11) of 1 residents reviewed for foot care services. The facility failed to provide podiatry services for Residents (Resident #11). This failure could lead to increased potential negative outcomes related to foot health including development of sores, infections, amputation and death for a resident with diabetes. Findings included: Record review of Resident #11's Face Sheet, dated 08/30/24, revealed that he was a [AGE] year-old male with an initial admitted to the facility of 04/14/24. Resident #11's active diagnoses included: Type 3 Diabetes with mellitus without complications, hyperosmolality (occurs when very high blood sugar leads to severe dehydration, highly concentrated blood and mental status changes) and hypernatremia (a rise in serum sodium concentration), phosphorus metabolism (is a complex process involving endocrine (glands and organs) feedback among multiple tissues including bone, kidney, and intestine), history of falls, unspecified injury of the head, sequela (a condition which is the consequence of a previous disease or injury), vitamin b12 deficiency, anemia (lack of iron), nicotine dependence (cigarettes), muscle weakness (generalized), unsteadiness on feet, uncomplicated alcohol abuse and syncope and collapse (medical term for fainting or passing out). Record review of Resident #11's MDS dated [DATE] revealed he had a BIMS score of 10/15 indicating a moderate cognitive impairment. There was not any documentation on Resident #11's MDS regarding foot care or Podiatry Services. Record review of Resident #11's Care Plan, no date indicated, revealed the following: Focus - Resident #11, requires assistance from staff with ADLs. Requires assist from staff. Transfers; Walk in room; Walk in corridor; Locomotion off unit; Dressing; Eating; Toilet use; Personal hygiene; Bathing, date initiated - 04/15/24, revision on 04/17/24. Goal - Resident #11 will remain clean, comfortable, well groomed, and will maintain optimal mobility on a daily basis through the review date. Date Initiated: 04/15/2024 Revision on: 04/17/2024 Target Date: 10/29/2024 Focus - Resident #11 has risk for pain r/t Disease process diabetes. Date Initiated: 05/09/2024 (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Revision on: 05/09/2024 Goal - Resident #11 will not have an interruption in normal activities due to pain through the review date. Date Initiated: 05/09/2024 Target Date: 10/29/2024 Record Review of Resident #11's clinical record, progress notes, social work notes does not indicate a referral made for podiatry services. Record review of Resident #11's Weekly Skin Integrity Review on 08/27/24 at 2:04 PM revealed no information regarding Resident #11's toenails. In an interview and observation with Resident #11 on 08/28/24 at 10:54 AM revealed the resident was alert and sitting on his bed. Observation of Resident #11's toenails revealed that his toenails were long and curved into his skin. Resident #11 stated that he has been at the facility since April 2024, and he has never been seen by a podiatrist. Resident #11 stated that he had a hang nail on his foot that he had to take care of by himself and he stated that he was in some pain for some time after pulling out his own hangnail on his foot. He stated that he did not request assistance from the staff with taking care of the hangnail on his foot. He stated that he would like to have his toenails cut but has not bothered to ask staff for assistance. He stated that the Shower Aides that assist him with bathing and hygiene have not assisted him with keeping his toenails clipped. In an interview with ADON H on 08/28/24 at 11:06 AM revealed that she was not aware that Resident #11 needed an appointment for Podiatry Services due to his long toenails. She reported that Resident #11 is assisted with his baths by staff, and no one has mentioned to her that his toenails were long and needed to be clipped. She reported usually a staff member will notify the Social Worker about a resident needing Podiatry Services, and she would set up the appointments. ADON H stated that the Social Worker monitors the Podiatry Services for the residents. She stated that a resident that has diabetes should be seen by a Podiatrist regularly. She stated that if a resident with diabetes is not seen regularly by a Podiatrist, they can have injuries and wounds on their feet, which are difficult to heal, which would cause pain to the resident. In an interview with the DON on 08/30/24 at 11:35 AM, revealed that the Social Worker is responsible for making referrals for the residents to be seen for Podiatry Services. He confirmed that Resident #11 is diagnosed with diabetes and because of his diagnoses, you have to be very careful with a diabetics foot. He stated that he was unaware that Resident #11 has not been seen by a Podiatrist since his admission to the facility in April 2024. He stated that the harm that could be caused by Resident #11 not receiving any Podiatry Services could result in the resident have an injury to his feet, skin breakdown and tears which would be very hard to heal because of his diagnosis. The DON stated that he would meet with the Social Worker to have Resident #11 added to the referral list for Podiatry Services. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview with the Social Worker on 08/30/24 at 2:10 PM, revealed that she was responsible for making appointments for residents to be referred for Podiatry Services. She stated that Resident #11 has not been on her list of referrals for the Podiatrist. She stated that the Podiatrist visits the residents at the facility every month. Social Worker stated that after being informed about Resident #11, she would make an emergency request to have the Podiatrist come to the facility for Resident #11. She stated that normally after she puts in the request for an Emergency visit for the Podiatrist, the resident will be seen within a week. Social Worker stated that a resident with diabetes should be seen regularly by a Podiatrist. Social Worker stated that the risk for a resident with the diagnosis of diabetes not being seen regularly by a Podiatrist could cause pain and injuries to a resident's foot. Social Worker stated that she was not a medical professional and did not want to state what harm could be caused to a diabetic resident not being regularly seen by a Podiatrist. In an interview with the Administrator on 08/30/24 at 4:25 PM, revealed that the Social Worker is responsible for referrals for Podiatry Services for residents. The Administrator stated that she was unaware of the condition of Resident #11's toenails. She stated that Resident #11 has a diagnosis of diabetes and should be seen by a Podiatrist on a regular basis. She stated that the risk of Resident #11 not being seen by a Podiatrist are that he could have skin breakdown and injuries to his foot which could lead to ulcers and amputation. Record review of the facility's undated policy titled; Pharmacy Services reflected the following: Policy Statement: Residents will receive appropriate care and treatment in order to maintain mobility and foot health. Policy Interpretation and Implementation 1.Residents will be provided with foot care and treatment in accordance with professional standards of practice. 2.Overall foot care will include the care and treatment of medical conditions associated with foot complications (e.g., diabetes, peripheral vascular disease, etc.). 3.Residents will be assisted in making transportation appointments to and from specialists (podiatrist, endocrinologist, etc.) as needed. 4.Trained staff may provide routine foot care (e.g., toenail clipping) within professional standards of practice for residents without complicating disease processes. Residents with foot disorders or medical conditions associated with foot complications will be referred to qualified professionals. Record review of the facility's undated policy titled; Activities of Daily Living (ADL's), Supporting reflected the following: Policy Statement: Residents will provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal hygiene. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Interpretation and Implementation 1. Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical conditions) demonstrate that diminishing ADLs are unavoidable. a. Unavoidable decline may occur if he or she: (1) Has a debilitating disease with known functional decline; (2) Has suffered the onset of an acute episode that caused physical or mental disability and is receiving care to restore or maintain functional abilities; and/or Refuses care and treatment to restore or maintain functional abilities and: (a) the resident and or representative has been informed of the risk and benefits of the proposed care or treatment; and (b) he or she has been offered alternative interventions to minimize further decline; and; (c) the refusal and information are documented in the resident's clinical record. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLS independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care) . 3. Care and services to prevent and/or minimize functional decline will include appropriate pain management, as well as treatment for depression and symptoms of depression. 4. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem. 5. A resident's ability to perform ADLs will be measured using clinical tools, including the MDS. Functional decline or improvement will be evaluated in reference to the Assessment Reference Date (ARD) and the following MDS definitions: a. Independent - Resident completed activity with no help or staff oversight at any time during the last 7 days. b. Supervision - Oversight, encouragement or cueing provided 3 or more times during the last 7 days . (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. 7. The resident's response to interventions will be monitored, evaluated and revised as appropriate.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053 Based on observation, interview, and record review, the facility failed to provide supervision to prevent accidents for 2 of 10 residents (Resident # 55 and Resident #12) reviewed for Accidents and Supervision. The facility did not provide supervision for Resident #55 and Resident #12 while smoking on 08/30/24. This failure could place residents at the facility at risk of injuries related to burns. The findings included: Record review of Resident #55's Face Sheet, dated 08/30/24, revealed that he was a [AGE] year old male with an initial admitted to the facility of 02/07/24. Resident #55's active diagnoses included: dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), major depressive disorder, seizures, hemiplegia (paralysis that affects one side of the body), unspecified affecting right dominant side, aphasia (loss of ability to understand or express speech, caused by brain damage) chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), muscle weakness (generalized), unsteadiness on feet, hemiplegia and hemiparesis (hemiplegia refers to complete paralysis, while hemiparesis refers to partial weakness) following cerebral infraction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). Record review of Resident #55's MDS dated [DATE] revealed he had a BIMS score of 1/15 indicating a severe cognitive impairment. Record review of Resident #55's Care Plan, no date indicated, revealed the following: Focus - Resident #55 is a smoker and noncompliant with policies. I also smoke marijuana in the community despite numerous conversations from staff and education to stop. Date Initiated: 02/29/2024 Revision on: 08/15/2024 Goal - Resident #11 will not smoke without supervision through the review date. Date Initiated: 02/29/2024 Target Date: 10/28/2024 Interventions - (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Assess resident's coping skills and support system. Date Initiated: 08/19/2024 -Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation. Date Initiated: 08/19/2024 -Monitor behaviors; aggressiveness and combativeness. Document observed behavior and attempted interventions. Date Initiated: 08/19/2024 Revision on: 08/19/2024 -Psychiatric/Psychogeriatric consult as indicated. Date Initiated: 08/19/2024 Record review of Resident #55's Quarterly Care Plan Sheet dated 05/23/24 revealed that resident was a smoker and noncompliant. Record review of Resident #55's smoking assessment dated [DATE] and lock dated 07/01/24 indicated the resident can light his own cigarette but requires supervision while smoking. Resident #55 will need to store lighter and cigarettes. Resident #55 was deemed safe to smoke cigarettes at the facility. Record review of Resident #55's Psychiatric Note dated 08/16/2024 revealed that he was referred for depression, withdrawal, isolation, tearfulness, agitation, irritability, confusion and resistance to ADL /Medications. The Review of History revealed that Resident #55 denied drug usage and was a non-smoker. Record review of Resident #12's Face Sheet, dated 08/30/24, revealed that he was a [AGE] year old male with an initial admitted to the facility of 06/15/2016 and Re-entry admitted [DATE]. Resident #12's active diagnoses included essential (primary) hypertension (high blood pressure that is multi-factorial and doesn't have one distinct cause), Unspecified Psychosis not due to substance or known physiological condition (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), major depressive disorder, schizoaffective disorder (mental health condition that is marked by a mix of hallucinations and delusions, and mood disorder symptoms, such as depression, mania), bipolar, insomnia (loss of sleep), deep veins of the lower extremity), falls, muscle weakness, lack of coordination, displaced intertrochanteric (broken hip) fracture of right femur), abnormalities of gait and mobility, dementia, psychotic disturbance, mood disturbance and anxiety, bipolar, dysphasia (difficulty swallowing), glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye called the optic nerve), aftercare following joint hip replacement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #12's MDS dated [DATE] revealed he had a BIMS score of 15/15 indicating that his cognition is intact. Record review of Resident #12's Care Plan, no date indicated, revealed the following: Focus - Resident #12 is a smoker and noncompliant with smoking policies/procedures Date Initiated: 02/29/2024 Revision on: 03/07/2024 Goal - Resident #12 will not smoke without supervision through the review date. Date Initiated: 02/29/2024 Revision on: 05/30/2024 Target Date: 10/07/2024 Interventions - Instruct resident about the facility policy on smoking: locations, times, safety concerns. Date Initiated: 02/29/2024 -Monitor oral hygiene. Date Initiated: 02/29/2024 -Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. Date Initiated: 02/29/2024 -Observe clothing and skin for signs of cigarette burns. Date Initiated: 02/29/2024 Record review of Resident #12's smoking assessment dated [DATE] indicated the resident can light his own cigarette, Supervision provided for residents in facility, but resident able to smoke without supervision. Resident #12 will need to store lighter and cigarettes. Resident #12 indicated was deemed safe to smoke cigarettes at the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #12's smoking assessment dated [DATE] indicated the resident can light his own cigarette but requires Supervision while smoking for safety. Resident #12 will need to store lighter and cigarettes. Resident #12 indicated was deemed safe to smoke cigarettes at the facility. Record review of Resident #12's smoking assessment dated [DATE] indicated the resident can light his own cigarette but requires Supervision while smoking. Resident #12 will need to store lighter and cigarettes. Resident #12 indicated was deemed safe to smoke cigarettes at the facility. Record Review of the facility's posted Smoking Times revealed the following Smoking Times: 9 AM, 11 AM, 1 PM, 3 PM, 5 PM, 7 PM and 8 PM. These will be 15 minute breaks. Record Review of the facility's List of Smokers revealed that there were 10 residents in the facility that smoke cigarettes. The list included Resident #55 and Resident #12. In an interview with ADON H on 08/28/24 at 11:06 AM revealed that herself and staff are aware that Resident #55 and Resident #12 keep their cigarettes and lighters on their person. She stated that she has notified the DON and Administrator that both residents are not following the facility's Smoking Policy. She stated that both residents are Care Planned for being non-compliant with the facility's Smoking Policy. She reported that the Administrator and the DON have documented that Resident #12 is non-compliant, but they cannot do anything. ADON H was able to provide the red box that the residents cigarettes are located. The red box was locked and when opened revealed 3 sealed Ziploc bags with 3 resident names and inside of each Ziploc bag there were a box of cigarettes and lighters. She reported that the red box always remains locked, and the keys are always kept with a staff member. She stated that if residents keep lighters and cigarettes in their room, it has a potential to cause a fire, if a resident has fire near another resident that has oxygen, they can cause fire and harm to both residents and staff. In an interview with the DON on 08/30/24 at 11:35 AM, revealed that he was aware of Resident #55 and Resident #12 being non-compliant with the facility's Smoking Policy. He stated that both residents have a Smoking Assessments and are to be supervised by staff during scheduled smoking schedule. He stated that both residents have been observed by himself and staff smoking in the designated Smoking Area outside of the facility's smoking schedule. He confirmed that both residents have been observed with cigarettes and lighters in their possession. The DON stated that himself and staff have advised both residents that they are not to keep lighters and cigarettes in their possession, but both residents have been non-compliant, and he has documented their non-compliance in each residents Care Plan. The DON stated that himself and staff have observed cigarettes and lighters in Resident #55's room but have not observed any cigarettes or lighters in Resident #12's room. He stated that he has reeducated the residents that smoke and the staff on the risks of the residents having cigarettes and lighters in their possession. He stated that the risks of residents keeping lighters on their person and not in the designated lock box is that the resident can burn themselves or others, cause a fire and harm to themselves and other residents and staff. During an observation on 08/30/2024 at 12:14 PM, Resident #55 was in his room and sitting in a chair beside his bed, there was a box of [NAME] cigarettes on his wheelchair beside the bed. There were 3 cigarettes and 3 lighters observed in black container on the dresser underneath his television. Resident #55 has aphasia and is verbal, when asked if staff had told him that it was against the facility's policy to keep cigarettes and lighters in his room, he shook his head no. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 08/30/2024 at 1:50 PM, Resident #55 was not in his room, there were 2 cigarettes and 1 lighter observed in black container on the dresser underneath his television. During an attempted interview and observation of Resident #12 on 08/30/2024 at 1:57 PM, he was not in his room. There were not any cigarettes or lighters observed in the room. During an observation and interview on 08/30/24 at 2:12 PM, Resident #55 and Resident #12 were observed outside in the designated Smoking Area with cigarette lighters and smoking cigarettes. Resident #55 was observed from inside the facility sitting outside in the designated Smoking Area with a brown cigar on the table. Resident #55 was observed sitting at the table and began to place the brown cigar into a paper towel and rolled the paper towel several times. Resident #55 was asked to unroll the paper towel. Resident #55 stated that the brown cigar on the table was a blunt (which is a cigar that contains marijuana). Resident #12 stated that he keeps his cigarettes and lighter in his room. He stated that staff had advised him that he needs to keep his cigarettes and lighters in the locked box at the Nurses Station. Resident #12 stated that he does not want to keep his cigarettes and lighters in the locked box at the Nurses Station because he wants to smoke anytime, he wanted, and he does not want to smoke only during the facility's designated smoking times. He said he had been at the facility since December 2023. There were two lighters on his over bed table and a box of cigarettes. He said he was a smoker and he smoked after he ate, and staff were always with him when he went out to smoke. When asked if he could keep his smoking materials he did not answer. Resident #55 shook his head and stated that he felt the same way as Resident #12. In an interview with the Administrator on 08/30/24 at 4:25 PM, revealed that she was aware of Resident #55 and Resident #12 being non-compliant with the facility's Smoking Policy. The Administrator stated that herself, DON, staff and other residents have observed Resident #55 and Resident #12 smoking cigarettes in the designated Smoking Area outside of the facility's posted schedule smoking times. She stated that staff have observed Resident #55 with cigarettes and lighters on his person in the facility. She stated that staff would try to confiscate both items from Resident #55, but he would refuse to give the items to staff. She confirmed that both residents are violating the facility's Smoking Policy by keeping their cigarettes and lighters and not placing them in the lock box at the Nurses Station and by smoking outside of the facility's designated smoking times. She stated that the risk of both residents keeping their cigarettes and lighters on their person or in their room is that they can harm themselves by causing a fire, burning themselves and being injured. Record Review of the facility's, undated Smoking Policy - Residents, revealed the following: Policy Statement - This facility shall establish and maintain safe resident smoking practices. Policy Interpretation and Implementation - 1. Prior to, and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. 3. Oxygen use is prohibited in smoking areas. 4. Metal containers, with self-closing cover devices, are available in smoking areas. (continued on next page)

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	455412	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven Nursing and Rehabilitation Center	1855 Cheyenne Carrollton, TX 75010

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Ashtrays are emptied only into designated receptacles. 6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. 7. The staff shall consult with the Attending Physician and the Director of Nursing Services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Smoking Evaluation. 8. A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change and as determined by the staff. 9. Any smoking-related privileges, restrictions, and concerns shall be noted in the medical record. 10. The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision. 11. Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. 12. Residents who have independent smoking privileges are permitted to smoke without supervision. Cigarettes, e-cigarettes, pipes, tobacco, and other smoking articles are kept secured at the nurse's station. Matches are prohibited. 13. Residents are not permitted to give smoking articles to other residents. 14. Residents without independent smoking privileges may not have any smoking articles, including cigarettes, tobacco, etc., except when they are under direct supervision. 15. This facility maintains the right to confiscate smoking articles found in violation of our smoking policies.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #1) of 5 residents reviewed for pharmacy services. RN B and LVN C failed to document the administration of Ipratropium-Albuterol Inhalation Solution (inhaled treatment used to prevent difficulty breathing and coughing) to Resident #1 as ordered. LVN C failed to document the administration of Robitussin Mucus+Chest Congest Oral Liquid (used for cough and congestion) to Resident #1 as ordered. This failure placed residents at risk of not receiving their medications as ordered by a physician and worsening of their condition. Findings included: Record review of Resident #1's Admission Record dated 8/30/24 revealed he was an [AGE] year-old male admitted to the facility on [DATE] from an acute care hospital. Record review of Resident #1's 5-Day Scheduled MDS Assessment revealed his cognition was not assessed and his diagnoses included: hypertension (high blood pressure); pneumonia (an infection in the lungs), septicemia (infection that spreads into the bloodstream); atrial fibrillation (an irregular heartbeat); influenza A (respiratory illness caused by a virus); prostate cancer; and muscle weakness. Record review of Resident #1's Nursing Admission assessment dated [DATE] revealed he was oriented to person and place, he had clear speech, and needed total assistance with transfers. Record review of Resident #1's Order Recap Report dated 8/28/24 reflected the following orders were included: Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML 1 application inhale orally every 8 hours for Pneumonia. Order date 6/26/24. Robitussin Mucus+Chest Congest Oral Liquid (Guaifenesin) Give 10 ml by mouth every 6 hours for cough for 7 Days. Order date 6/27/24. Record review of Resident #1's MAR dated June 2024 reflected the following entries: Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML 1 application inhale orally every 8 hours for Pneumonia. The doses were scheduled for 12:00 AM, 8:00 AM and 4:00 PM beginning with the 8:00 AM dose on 6/26/24. The MAR reflected the following doses were left blank and not signed as administered on the following dates/times: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/26/24 4:00 PM 6/29/24 12:00 AM 6/30/24 12:00 AM Robitussin Mucus+Chest Congest Oral Liquid (Guaifenesin) Give 10 ml by mouth every 6 hours for cough for 7 Days. The doses were scheduled for 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. The MAR reflected the following doses were left blank and not signed as administered on the following dates/times: 6/29/24 12:00 AM 6/30/24 12:00 AM Record review of Resident #1's Nursing Progress Notes dated 6/25/24 through 7/1/24 revealed there were no entries indicating Resident #1 had missed any doses of his medications. The notes revealed Resident #1 was discharged from the facility on 7/1/24. A progress note dated 6/26/24 at 4:31 PM reflected: Resident continues on Nursing Services for Dx of Right Lower Lobe PNA, AFIB, Hx of Prostate Cancer on radiation, and HTN. Resident is alert and oriented x 2-3 [person, place, and time], with intermittent confusion. Resident is on droplet precautions for influenza. Resident is allergic to morphine. He swallows his pills whole, he is on mechanical soft diet. He is bed-bound and his skin is intact. Resident shows no sign of pain or distress at this time. Resident has been oriented to the facility, bed is in lowest position and call light is within reach. The entry was signed by RN B. During an interview on 8/30/24 at 10:20 AM, LVN E reviewed her computer and stated she had worked with Resident #1 on 6/30/24 during the day shift from 6 AM to 6 PM. She stated she could not recall any significant issues with the resident or being made aware he had missed any of his medications on other shifts. She was unaware he had missed his 12:00 AM breathing treatment and Robitussin. In an interview on 8/30/24 at 12:29 PM, RN B was unable to recall Resident #1 missing any doses of his medications and would review his medical record. She stated, if a resident refused a medication, she would generally return and try again a little later. If they still refused, she would have educated the resident, entered the refusal in the MAR, documented the refusal in the nurses' notes, and let the physician know. In an interview on 8/30/24 at 12:38 PM, RN B stated she had looked at Resident #1's record. While reviewing his MAR, she stated she recalled he was receiving breathing treatments but could not recall him missing his dose on 6/26/24 or why he missed it. She stated medications usually showed up on their computer screens in red when due and she could not understand how she had missed it. RN B stated the risk for missing respiratory treatments was it could decrease the oxygen saturation in his blood. She stated she checked his oxygen saturation level every shift. Record review of the facility staffing schedules dated 6/29/24 to 6/30/24 reflected LVN C was scheduled on Resident #1's hall to work 6 PM to 6 AM on both dates. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Attempts to reach LVN C via telephone on 8/30/24 at 8:51 AM and 1:41 PM were unsuccessful. During an interview with ADON A on 8/29/24 at 11:35 AM, he stated the ADONs and DON monitored new medication orders and admission orders for transcription issues and stop dates. ADON A stated medication administration was the responsibility of the charge nurses and medication aides. He stated the administrative staff performed spot-checks for administration issues and was unaware of any problems with Resident #1's medications. He stated he knew Resident #1 had not been at the facility very long, was taking antibiotics and had some laboratory concerns that were addressed by his physician. He could not recall whether he had reviewed Resident #1's MAR after he discharged . During an interview on 8/30/24 at 11:07 AM, the DON was shown Resident #1's MAR and stated he was unaware Resident #1 had missed any medication doses. He stated he did not know why there was no documentation associated with the missed doses. He stated, if a resident refused a medication or it was held for any reason, there was a code to be used on the MAR and there should have been documentation explaining the missed medication in the progress notes. The DON stated the risk of missing medication doses was the resident's condition could deteriorate. In an interview on 8/30/24 at 12:24 PM, ADON A was shown Resident #1's MAR indicating the missed medication doses. He stated he was previously unaware Resident #1 had missed any medications. ADON A stated, if a resident missed any medication doses, the nurse should have coded the missed dose on the MAR, entered a progress note indicating the reason the dose was missed and notified the physician. He stated the risk of missing medication doses was worsening of their condition. During a telephone interview on 8/30/24 at 1:53 PM, Attending Physician D, Resident #1's primary physician, stated she remembered Resident #1 and was previously unaware he had missed his doses of Ipratropium-Albuterol and Robitussin. She stated the doses missed would not have changed his prognosis or outcome of his condition and he had extra doses ordered as needed if his breathing had worsened. Attending Physician D stated she was not concerned the missed doses worsened his condition in any way. She stated he had been quite ill with pneumonia; they had recently extended his antibiotic treatment and were addressing other issues related to his condition as well. During an interview on 8/30/24 at 4:42 PM, the Administrator was shown Resident #1's MAR and missing medication doses. She stated the DON and ADON were responsible for monitoring the medication administration performed in the facility which included monitoring MARs. The Administrator stated, if a resident missed any medication dose, the staff should have documented why the medication dose was missed and the physician should have been notified. She stated the risk for missing medications included an increase in the symptoms the medication was prescribed to prevent. Record review of the facility's undated policy titled; Pharmacy Services reflected the following: Policy Statement: The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Interpretation and Implementation: 1. Pharmaceutical services consist of: a. The process of receiving and interpreting prescriber's orders; acquiring, receiving, storing, controlling, reconciling .distributing, administering, monitoring responses to, using and/or disposing of all medications, biologicals, chemicals; .c. The process of identifying, evaluating and addressing medication=related issues including the prevention and reporting of medication errors .3. Pharmacy services are available to residents 24 hours a day, seven days a week. 4. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner .

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview, and record review the facility failed to assist in obtaining routine and emergency dental care for 1 out of 5 residents (Resident #55) reviewed for dental services. The facility failed to complete and submit a dental referral for Resident #55 This failure could place Resident's at risk for oral complications, dental pain and diminished quality of life. Findings Included: Record Review of Resident #55's Quarterly MDS with an ARD (Assessment Reference Date) of 05/14/2024 revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #55's active diagnoses included: Aphasia (brain disorder that affects the ability to speak or understand language), Hemiplegia following cerebral infarction (weakness on one side of the body following a stroke) and muscle weakness. Resident #55 had a BIMS score of 1 indicating a severe cognitive impairment. Review of the assessment revealed that Resident #55 had no dental issues identified and he required setup or clean-up assistance for oral hygiene. Record Review of the document titled, Care Plan Sheet, dated 05/23/24 revealed Resident #55's quarterly care plan meeting was held on 05/23/24. Document revealed Resident #55 was not present and Resident #55's family member was called, but did not indicate if they were present. Document did not reveal if dental services were reviewed or offered or if a dental referral was initiated or completed. Record Review of Resident #55's comprehensive care plan, no date reflected, did not reveal Resident #55's oral/dental status or any interventions related to Resident #55's current dental/oral health needs. Interview with Resident #55 on 08/27/24 at 11:15AM revealed that he was aware that the facility offered dental services. Resident #55 revealed that he was able to brush his own teeth, the best he could. Resident #55 revealed that he would like to see the dentist, but he did not know who to ask at the facility about dental services. Observation of Resident #55's teeth on 08/27/24 at 11:21AM revealed his teeth were cracked, missing teeth noted, and a strong odor arose from Resident #55's mouth. Interview with RP #2 on 08/27/24 at 12:42PM revealed that she was aware that the facility provided routine dental services. RP #2 revealed that she requested a dental referral be completed for Resident #55, but could not remember the exact date. RP #2 revealed that Resident #55 did complain of dental pain to her, RP#2 stated that Resident #55's dental pain was not reported to the facility nursing staff as she was under the impression the dental referral had been completed. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN F on 08/27/24 at 3:55PM revealed that she had been the nurse assigned to Resident #55 during the 6AM-6PM shift and that had been her normal assignment. LVN F revealed that Resident #55 did not complain of dental or oral pain to her. LVN F revealed Resident #55 could independently manage his oral hygiene needs. LVN F revealed if a resident reported to her of any oral or dental pain or if a resident or family member requested dental services she would alert the attending physician for that resident and the facility social worker. Interview with Social Worker on 08/30/24 at 1:59PM revealed that she was responsible for ancillary service coordination at the facility which did include, dental services. The Social Worker revealed that she was not aware Resident #55 was complaining of dental or oral pain or that RP #2 requested dental services. The Social Worker revealed that if a dental referral was made to her or if she was alerted that a resident did need services of any kind, that referral would be completed typically within the week. The Social Worker did not reveal a risk to residents if they did not receive dental services when requested or needed. Interview with DON on 08/30/24 at 2:40PM revealed that the facility Social Worker was responsible for ensuring all Resident's are assessed for ancillary services, including dental services. The DON revealed that he was not aware Resident #55 was complaining of oral or mouth pain or that RP #2 requested dental services for Resident #55. The DON revealed that it was his expectation for all Resident's to be assessed for ancillary services, including dental services, quarterly, annually and on admission. The DON revealed if the oral or dental pain was emergent, then the Resident's attending physician would be contacted. The DON revealed a risk to Resident's who do not receive routine dental services when requested or needed would be an increased risk to oral complications and infection. Interview with Administrator on 08/30/24 at 4:05PM revealed that dental services along with other ancillary services are reviewed on admission, quarterly and annually with all resident's and their representatives. The Administrator revealed that the facility does have routine dental and emergency dental services available for the facility residents. The Administrator revealed that the Social Worker is responsible for screening Resident's for needed services. The Administrator revealed she was not aware Resident #55 was complaining of mouth and oral pain and that RP #2 requested dental services for Resident #55. The Administrator revealed she would get with the Social Worker to initiate a dental referral immediately for Resident #55. The Administrator revealed a risk to residents who do not receive routine dental services when requested or needed would be an increased risk to oral and health complications. Record Review of facility's policy titled, Dental Services, dated December 2016 revealed that, Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care .social services representatives