STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455475	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Settlement Nursing Center	7820 Skyline Park Dr White Settlement, TX 76108

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to provide housekeeping and maintenance services necessary to maintain a safe, sanitary, orderly, and comfortable interior for 2 of 18 residents (Residents #15 and #59) of residents and one of two halls (Station 1) reviewed for safe clean homelike environment. 1. The facility failed to properly clean and maintain a sanitary and comfortable environment free of foul odors on Station 1. 2. The facility failed to ensure Resident #15 and #59 had a clean privacy curtain. 3. The facility failed to maintain resident's wheelchairs in a sanitary and safe operating condition according to 4 residents who attended the confidential group interview. These failures could affect residents and place them at risk for not having a safe and sanitary homelike environment. Findings included: 1. An observation on 04/02/24 through 04/04/24 from 9:00 AM-5:00 PM on the Front Hall Station 1 revealed a strong smell of urine that permeated the hall from room [ROOM NUMBER] through room [ROOM NUMBER]. During the confidential resident group interview 3 of the 10 residents in attendance revealed there was always a strong smell of urine and the smell was overwhelming. The residents stated the Front Hall was where it smelled the most and at times the dining area. The residents stated housekeeping cleaned the rooms and hallways but do not always clean properly . Interview on 04/04/24 at 4:04 PM with CNA I revealed she was the CNA assigned to the Front Hall. She stated she had not received any complaints regarding any urine smell. She stated housekeeping cleans daily and they spray freshener to reduce the smell when they do notice a urine smell. She stated housekeeping clean the rooms and hallways. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/04/24 at 4:17 PM with ADON B stated she had only been employed for 3 weeks and she had been observing and had concerns of urine odor in the front hall. She stated it was a strong smell. She stated when she does her walk-throughs in the morning, she tried to spray freshener to make the smell go away. However, it was a constant thing. Interview on 04/04/24 at 4:27 PM with the Housekeeping Supervisor revealed she had not had any complaints regarding the Front Hall smell. However, she had noticed a urine smell in the Front Hall by the Station 1. She stated throughout the day she sprayed freshener to reduce the smell. She stated the housekeeping staff clean the rooms once a day, halls and dining area were cleaned through-out the day. She stated things had gotten better, things were worse. Interview on 04/04/24 at 4:58 PM with the Interim DON revealed they were aware of the front hall smell. She stated on Station 1, the front hall, they had heavy wetter's. She stated today 04/04/24 she came upon a room with wet linen and the aides left them in the room. She stated she let the aides know they cannot do that. She stated she expected for housekeeping to be cleaning the rooms daily and for the aides to be rounding correctly and answering call lights . Interview on 04/04/24 at 5:28 PM with the Administrator revealed her expectations were for the facility not to smell of urine. She stated she expects housekeeping to be cleaning every day . 2. Record review of Resident 15's Face Sheet, dated 04/04/24, revealed Resident #15 was [AGE] year-old male, who was admitted to the facility on [DATE]. Resident #15's diagnoses included Diabetes (a group of diseases that affect how the body uses blood sugar (glucose)) and major depressive disorder (a common and serious mood disorder that impacts the way an individual feels, thinks, and acts on a daily basis). Review of Resident #15's quarterly MDS assessment, dated 01/17/24, revealed the resident was moderately cognitively impaired with a BIMS score of 09, and he required assistance for his activity of daily living. Observation of Resident #15's room on 04/02/24 at 11:06 AM revealed the privacy curtain had a dried brown substance on it. Resident #15 stated the curtain does not bother him, but it would be good if they could change or wash it. Review of Resident #59's face sheet dated 04/04/2024 reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included muscle weakness and major depressive disorder (a common and serious mood disorder that impacts the way an individual feels, thinks, and acts on a daily basis). Review of Resident #59's quarterly MDS, dated [DATE], revealed the resident was cognitively intact with a BIMS score of 13, and the resident required assistance with her ADLs. Observation of Resident #59's room on 04/02/24 at 11:57 AM revealed the privacy curtain had a dried brown substance on it. Resident #59 stated the curtain has been like that for a long time and he had not asked the staff to wash or change it because that was their responsibility. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 04/04/24 at 9:41 AM with LVN J revealed she had not noticed soiled curtains in Resident #15 and #59's room while caring for residents. She stated the curtains for both residents were dirty. She stated it was the nurse's responsibility to inform housekeeping so that housekeeping could change the curtain. LVN E stated the resident was supposed to be in a safe, clean, and homelike environment and this would violate the right of living in a clean environment Observation and interview on 04/04/24 at 9:41 AM with the Housekeeping Manager revealed she was responsible of changing the curtains. She stated there was a house technician responsible for washing and changing the curtains. Since there has been a shortage of staff, they have not been able to change the curtains for the last six months. She stated she changed curtains when she did the deep cleaning but since she is experiencing shortage of staffs, she has been behind with her schedule. She stated she has ordered new curtains, but she was yet to receive the full orders so so that she can change all the curtains because they were old and looked dirty. She was asked for the schedule of curtain changes, but she did not provide any. Interview on 04/04/24 at 5:01 PM with the DON revealed she was not aware Resident #15 and #59's curtain had stains. The DON said all staff were responsible for checking the rooms and reporting any problems to the housekeeping staff. She stated the housekeeping department were responsible for cleaning the rooms and changing the curtains to ensure the residents lives were in a safe, clean, and homelike environment. Interview on 04/04/24 at 5:31 PM with the Administrator revealed the housekeeping staff were responsible for cleaning the rooms and washing the curtains. She stated curtains need to be washed when they were visibly soiled. She stated if they were left dirty the risk was that resident would not have a safe, clean, and homelike environment. 3. During the confidential resident group interview 4 out of the 10 residents revealed their wheelchairs were not being cleaned. Five residents were sitting in their wheelchairs. The wheelchairs had dust build up on the wheel spokes, footrest, breaks, and frame. The residents stated they had not seen anyone clean the wheelchair. The residents stated they did not like the wheelchairs being dirty. Interview on 04/04/24 at 4:04 with CNA I revealed resident's wheelchairs were cleaned during the 10PM-6AM shift. She stated she had noticed resident's wheelchairs were dirty. She stated when she noticed a wheelchair smelling she would clean it. She stated she had not cleaned any wheelchairs lately. She stated she was not sure what system was in place. However, the nurses should notify the 10PM-6AM shift regarding which wheelchairs need to be clean. She stated the potential risk of wheelchair being dirty could cause residents to get sick. Interview on 04/04/24 at 4:13 PM with CNA L revealed residents wheelchairs were cleaned during the night shift. She stated she saw several residents' wheelchairs were dirty. She stated when they notice a resident's wheelchair was dirty, they would notify the nurse and the nurse would pass it on to the night shift. CNA L stated she did not know if they had a log or a system of which wheelchair needed to be cleaned. She stated she had notified the nurses regarding the wheelchairs. However, she was unsure if the night shift were notified. CNA L could not recall when she had notified the nurses but it had been a few weeks ago. She stated the dirt on the wheelchair posed a dignity concern. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/04/24 at 4:16 PM with LVN D revealed the night shift staff were responsible to clean resident wheelchairs. LVN D stated she had observed wheelchairs being clean. However, after meals the wheelchairs do get dirty. LVN D stated she was unsure how often the wheelchairs get cleaned. She stated the dirt on the wheelchair posed an infection control concern. Interview on 04/04/24 at 4:17 PM with ADON B revealed she had been employed for 3 weeks and she had observed several residents' wheelchairs being dirty. She stated the night shift staff were responsible for cleaning the wheelchairs. She stated she was unsure if there was a system in place. She stated the dirt on the wheelchairs posed a dignity concern and infection control. Interview on 04/04/24 at 4:58 PM with the Interim DON revealed overnight shift should be cleaning the resident's wheelchair. The Interim DON stated the night shift had been cleaning the some of the wheelchairs. She stated the nurses were responsible for overseeing that the wheelchairs were being cleaned . Interview on 04/04/24 at 5:28 PM with the Administrator revealed the 10:00 PM-6:00 AM shift were responsible for cleaning residents' wheelchairs. She stated the maintenance staff were supposed to monitor to ensure that was being completed. She stated she had not received any complaints that they were not being done. She stated the potential risk would be dignity issues. Interview on 04/04/24 at 5:47 PM with Maintenance Manager revealed the resident's wheelchairs were cleaned during the 10:00 PM-6:00 AM shift. He stated he had not noticed wheelchairs being dirty. While interviewing Maintenance Manager, residents' wheelchairs were observed and he stated wheelchairs needed to be cleaned. He stated usually the nurses would notify the night shift of which wheelchairs needed to be cleaned and he would follow up to ensure they were being completed. He stated he did not have a log of which wheelchairs were completed and unsure if they had one. Review of the facility's Resident Rights policy, dated February 2021, reflected: .8. Safe environment. The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. a. clean, sanitary, and orderly environment 44140

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on interview and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 21 residents (Resident #47) reviewed for abuse. The facility failed to ensure Resident #47 was free from abuse when LVN F sent the resident a mentally/emotionally abusive text message, which caused the resident to experience fear for her personal safety. The noncompliance was identified as PNC. The IJ began on 01/16/24 and ended on 01/17/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of abuse, humiliation, intimidation, fear, shame, agitation, and decreased quality of life. Findings included: Record review of Resident #47's quarterly MDS Assessment, dated 11/07/23, reflected she had a BIMS score of 12, which indicated mild cognitive impairment. Record review of the facility's Provider Investigation Report, signed and dated by the Administrator on 01/19/24, reflected on 01/16/24 at 7:17 PM, LVN F sent Resident #47 a verbally abusive text message that was traced back to the nurse's phone. The Provider Investigation Report reflected the provider response to the incident included notifying the police department and the physician, LVN F was terminated, a complaint was filed with the Board of Nursing, and the resident was assessed. Additionally, the Administrator provided staff with in-service training regarding reporting abuse, verbal and mental abuse, forms of abuse, and the Abuse Coordinator. Further review of the Provider Investigation Report revealed the following investigation summary: Resident has a dx of schizophrenia, bipolar, anxiety, vascular dementia. Resident has a history of verbal and physical abuse towards staff, verbal abuse towards past roommates. Resident has a history of refusing care from staff and only demanding certain staff in room, kicking staff out of room. Resident has history of repeatedly calling the facility. Resident has a history of refusing to see the physician. Resident has refused all psych services. On 01/17/24 at approximately 11:45AM charge nurse LVN G reported to the abuse coordinator that resident [Resident #47] showed her a text message on her phone in which someone had sent the resident a hateful text. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	At about 11:55 AM, Administrator and business office manager .spoke with resident [Resident #47] about the text message she had received. Resident was able to show the message on her phone to Administrator and business office manager. Resident allowed Administrator to take a picture of the text message sent to her showing the text message, date sent, time and number from which it was sent. Resident stated this is why she contacted the police on 01/16/24 and the police have a copy of the text message as well. Resident stated this is not the first text message she had received. The administrator and business office manager reassured the resident that an investigation would be done, and that [the] resident would be safe at the facility. The administrator compared the number to staff phone numbers to rule out any staff. The phone number was found to belong to [LVN F]. The administrator notified the local police department of the allegations of abuse. The administrator was told by dispatch that an office had been out to the resident the night before and would combine complaints as they were similar in nature. The police department provided the contact email for [Officer X] that came to the facility on [DATE]. The administrator contacted [Office X] via email (per police department request) with the information discovered in the facility investigation. On 01/17/24 at about 12:34 PM, the Administrator contacted [LVN F] about the information discovered on [the] resident's phone. [LVN F] denied sending the text message to [Resident #47]. The administrator explained to [LVN F] that her number is seen on the text message and the police have been notified. [LVN F] said it was not her who sent the text and that someone must have taken her phone and sent the message. At approximately 1:15 PM Administrator and Social Worker .checked in on [Resident #47]. The Administrator informed the resident that she has been in contact with [Officer X] and has provided the officer with the information that the facility has regarding the text message that was sent to the resident. The administrator reassured the resident that she is safe, and the person who sent the text message would not be back in the facility and that she was safe Actions Taken by Facility: [LVN F] immediately suspended pending investigation and terminated from employment. Police notified. Texas Board of Nursing notified. Safe surveys were completed on station 2 with all residents that nurse had contact with. Immediate education began with staff over verbal and mental abuse, how residents can receive verbal and mental abuse (via text message). Staff questions regarding messages on residents' personal devices were addressed. Immediate monitoring of resident for any s/s of distress began. Resident asked social worker and other staff to stop checking on her. Observation of the text Resident #47 received revealed the following: You are an ignorant bitch. You are a dope addict. You're just fucking nasty!!!! All you ever do is scream and bitch. You need to just die. Make the world a better place and go to hell where u came from you witch! (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Observation and interview on 04/02/24 at 11:07 AM with Resident #47 revealed the resident was lying in bed. Resident #47 stated that she was scared and frightened since she received the text message. She stated that she did not who sent the text message. Resident #47 also expressed that she felt that there was no one to protect her and that she was in extreme fear since the incident. Interview with LVN G on 04/02/24 at 2:42 PM revealed on 01/17/24 Resident #47 showed her a text she had received on her personal cell phone the evening of 01/16/24. LVN G stated she went and called the administrator, who was the abuse coordinator, immediately to report the incident. LVN G stated she was unaware who sent the text to Resident #47. Interview on 04/04/24 at 2:41 PM with former employee, LVN F, revealed she was unaware of the incident. LVN F stated that she was called by the Administrator and told that texts that were verbally abusive to Resident #47 were sent from her phone. LVN F said that she did not send the texts and often left her personal cell phone lying on the nurse's station desk in addition to loaning her phone to two separate staff. LVN F stated she was terminated on the phone by the Administrator. Interview on 04/04/24 at 5:43 PM with Administrator revealed LVN G called her after seeing the text on Resident #47's personal cell phone. The Administrator stated that she entered the number in her phone and LVN F's name came up matching the phone number. She then called LVN F and terminated her on the phone. The Administrator stated that she referred LVN F to the board of nursing including all supporting documentation. Record review of the facility's policy dated 10/24/22, and titled Abuse, Neglect, and Exploitation reflected: .III. Prevention of Abuse, Neglect and Exploitation; The facility will make every effort to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: B. Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is suspected or identified by: 1. Taking immediate action to correct any issues that can reduce the risk of further harm continuing or occurring to resident or other residents

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on interview and record review, the facility failed to ensure that residents received proper treatment and assisted the resident in making appointments for 1 of 29 residents (Resident #74) whose records were reviewed for vision services. LVN E failed to ensure that Resident #74 was scheduled for an ophthalmologist appointment since February 2024. This failure could affect residents and contribute to a decline in vision. Findings included: Review of Resident #74's face sheet, dated 04/04/24, revealed the resident was initially admitted to the facility on [DATE] with diagnoses to include dementia, seizures, and major depressive disorder. Review of Resident #74's quarterly MDS assessment, dated 03/13/24, revealed the resident had severe cognitive impairment with a BIMS score of 3. Review or Resident #74's orders, dated 03/08/24, reflected: Refer to ophthalmology by prescriber. Review of Resident #74's progress notes reflected no progress notes of any staff member reaching out and attempting to schedule an ophthalmology appointment for the resident. Interview on 04/04/24 at 10:41 AM with LVN E revealed Resident #74 was her resident, and the resident had an order for an ophthalmology referral. LVN E also revealed no ophthalmology appointment had been scheduled since the referral on 02/20/24. LVN E stated she was responsible for scheduling referrals for her residents. Interview on 04/04/24 at 4:05 PM with the Interim DON revealed the referral to ophthalmology for Resident #74 was not made. The Interim DON stated LVN E wrote the order and that usually she would see the order. The Interim DON revealed the expectation was that LVN E ask the Social Worker or the Administrator to make the appointment, or she could make the appointment herself. The Interim DON stated in this case the nurse did not tell the Administrator, as there was not a Social Worker at that time, and the nurse did not make the ophthalmology referral appointment herself. The Interim DON concluded that this could put the resident at risk for eyesight loss and infection. Interview on 04/04/24 at 5:27 PM with the Administrator revealed it was Resident # 74's charge nurse's (LVN E) responsibility to follow-up on the ophthalmology referral. The Administrator stated if the resident did not go to the needed referral, the resident would not get needed services. The Administrator revealed this could result in possible harm to the resident. Review of the facility's Resident's Rights policy, revised 02/23/16, reflected: .11. The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents.

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F 0686 Level of Harm - Minimal harm or potential for 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** 44140 Based on observation, interview, and record review, the facility failed to ensure necessary treatment and services to promote healing for 1 of 3 residents (Resident #86) reviewed for pressure ulcers. The facility failed to ensure Resident #86's Stage 4 pressure ulcer was covered with a dressing. This failure could place residents at risk of severe pain, and lead to systemic infections causing harm for residents. Findings included: Review of Resident #86's face sheet dated 04/04/2024 reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #86 had diagnoses which included quadriplegia, pressure ulcer of sacral region, unstageable, unspecified viral hepatitis C without hepatic coma (prolonged loss of consciousness), and muscle wasting and atrophy. Review of Resident #86's quarterly MDS assessment dated [DATE], revealed Resident #86 had a BIMS score of 11, reflecting the resident's cognition was moderately impaired. Review of Resident #86's care plan revised date 03/11/24 revealed Focus: Pressure Ulcer: The resident has a pressure ulcer and is at risk for infection, pain, and further decline in skin integrity r/t impaired mobility, frequently refusing repositioning, impaired sensation, fragile skin, impaired nutritional status, impaired immune status, and incontinence. Stage 4 Pressure Ulcer to Coccyx. Goal: The resident will be free from of preventable breakdown through the next 90 days. Resident's pressure ulcer will show signs of healing through next 90 days. The residents pressure ulcer will be free from infection and the risk for infection will be minimized through the next 90 days. Resident's pain will be at or below their stated acceptable level in of pain or there will be no signs or symptoms of non-verbal pain through the next 90 days. Interventions: Provide wound care per physician's order. Keep dressing clean, dry, and intact. Replace the dressing as needed for soiling. Review of Resident #89's physician orders dated 04/03/24 revealed Clean Pressure Ulcer Site on Coccyx with Dakin's solution, and pat dry with 4x4 gauze. Apply Santyl collagenase to wound bed, then apply Dakin's moistened fluffed gauze. Cover with a bordered foam dressing. (May use Bordered Gauze dressing as needed) as needed, reapply dressing if it becomes soiled or dislodged. Observation and interview on 04/03/24 at 11:38 AM revealed Resident #86 lying in bed. Resident #86 stated she was doing well. Resident #86 stated she admitted to the facility with a pressure wound on her bottom. Resident #86 stated the Wound Care doctor visited her yesterday and removed her wound vac. Resident #86 stated she should have had a dressing on it but it had come off. Resident #86 stated she told the staff about it but no one had come by to apply a new dressing. Resident #86 could not recall who she notified. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/03/24 at 11:45 AM of Resident #86's pressure ulcer site conducted by LVN C and the State Surveyor Nurse revealed Resident #86's pressure ulcer did not have a dressing on it. LVN C stated she was not aware Resident #86 did not have a dressing on. Observed Resident #86's brief to be wet. The wound was observed to have some Dakin's packaged soaked gauze on one area, the other area of the wound did not, and no dressing to cover the wound. No signs of infection noted. CNA I was in the room assisting LVN C with turning Resident #86. CNA I stated she provided Resident #86's ADL care this morning and she did not observe a dressing on it . Interview on 04/03/24 at 11:55 AM with the Interim DON revealed Resident #89 no longer had a wound vac and was notified Resident #86's wound dressing had come off. She stated her expectations were for her staff to follow orders and prn orders. If the dressing comes off when completing peri care, the aides were to notify the nurse and the nurses were to apply a new dressing. The Interim DON stated she had only been at the facility for 6 weeks and she had not completed any in-services on wound care. She stated the risk of not having a dressing could lead to an infection and prolonged healing. Interview on 04/03/24 at 12:00 PM with the Treatment Nurse revealed Resident #46 admitted to the facility with a Stage 4 pressure ulcer on her coccyx. She stated Resident #86 had a wound vac and yesterday (04/02/24) the Wound Care doctor discontinued the wound vac and they completed a wound care treatment on Resident #86. She stated Resident #86 had a physician's order to apply Santyl and Dakin's gauze. She stated she had not completed Resident #86's wound care today (04/03/24) and was not made aware that Resident #86's dressing had come off. She stated when she completed wound care yesterday on Resident #86, they applied a dressing over it. She stated her expectations were for the nurses to monitor the dressing q -shift and if the dressing comes off, they had PRN treatment orders to follow. She stated the potential risk if the dressing comes off would be a decline in the wound status and infections. Interview on 04/03/24 at 1:15 PM with CNA I revealed she was the CNA assigned to Resident #86. She stated between 9 AM - 9:30 AM she provided incontinent care to Resident #86 and she noticed the resident did not have a dressing on her wound. She stated she was on her way to notify the nurse. However, it slipped her mind and she forgot to notify her. She stated Resident #86 did not complain of pain. CNA I stated she should have notified the nurse. She stated the risk of not having a dressing on would be infection. Review of facility policy Wound Management revised date 02/10/21, reflected the following: To promote wound healing of various types of wounds and provide evidence-based treatments in accordance with current standards of practice and physician orders. 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. .3. Dressing changes may be provided outside the frequency parameters in certain situations: a. Feces has seeped underneath the dressing. b. The dressing has dislodged. c. The dressing is soiled otherwise or is wet. (continued on next page)

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	455475	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Settlement Nursing Center	7820 Skyline Park Dr White Settlement, TX 76108

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Dressings will be applied in accordance with manufacturer recommendations.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observations, interviews, and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, for 2 (Resident #69 and #92) of 4 residents reviewed for dialysis. 1.The facility failed to ensure post-dialysis assessments were completed for Resident #69 after return from dialysis treatment. 2.The facility failed to ensure post-dialysis assessments were completed for Resident #92 after return from dialysis treatment. This failure could place residents at risk of inadequate post dialysis care. Findings included: Review of Resident #69's face sheet dated 04/04/2024 reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #69 had diagnoses which included end stage renal failure (when kidneys suddenly become unable to filter waste products from blood), Type 2 diabetes (increased blood sugar), and essential hypertension (increased blood pressure). Review of Resident #69 quarterly MDS assessment dated [DATE], revealed Resident #69 had a BIMS score of 09, reflecting the resident's cognition was moderately impaired. The MDS section O related to special treatments, procedures, and programs reflected Resident #69 received dialysis. Review of Resident #69's care plan, revised date 04/02/2024, revealed Focus: Dialysis: [Resident #69] receives dialysis related to renal failure and is at risk for the potential complications of dialysis. Resident has an AV fistula. Fluid Restriction 1000 ml in 24 hours Dialysis: M/W/F - Chair Time: 11:00 AM / Transportation / Arrive By: 10:30 AM / Picked Up: 9:45 AM / Transport Return: 3:30 PM. Goal: [Resident #69] will have no complications from routine dialysis through the next review date. Interventions: Obtain vital signs and weight per protocol. Report significant changes in pulse, respirations, and blood pressure to the physician. Use dry weight from dialysis center for any needed weight. Review of Resident 69's physician's order, dated 07/26/23, reflected Hemodialysis treatments to be performed via (Specify AV shunt, central line, etc.) . as indicated on the following days of the week: M-W-F with a chair time of: 2:30PM. Review of Resident #69's EHR reflected no nursing documentation regarding Resident #69's dialysis, monitoring of the resident's post-dialysis vital signs. Record review of Resident #69's dialysis communication forms reflected dialysis communication forms with no information on the resident's assessment and observation post dialysis section completed. For the month of February 2024 eight communications forms were provided and for the month of March 2024 eleven communications forms were provided with only 1 form that had post dialysis vitals completed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 04/02/24 at 11:18 AM revealed Resident #69 was lying in bed watching television. Resident #69 stated she was doing well. Resident denied any pain. Resident #69 stated she was a dialysis patient and her dialysis days were Mondays, Wednesdays, and Fridays. Resident #69 stated her chair time was at 10AM. Resident #69 stated she was unsure if she was provided with any dialysis communication forms; however, she indicated her vitals were taken after she returned from dialysis. Resident #69 reported no concerns. Interview on 04/04/24 at 3:29PM with LVN D revealed she was the nurse assigned to Resident #69. LVN D stated Resident #69 was a dialysis patient and the resident's dialysis days were Monday, Wednesday, and Fridays. She stated Resident #69 would return from dialysis during her shift 2PM-10PM. She stated it was her responsibility to complete post dialysis vitals. LVN D stated she documents the vitals in the Resident #69's MAR, progress notes, and dialysis communication forms. LVN D reviewed Resident #69's clinical records and stated she was unaware Resident #69's post dialysis vitals were not being documented. LVN D stated she could assure Resident #69's vitals were taken. LVN D stated the potential risk of not monitoring and documenting the vital signs could lead to the patient having low blood pressure and shortness of breath. Interview on 04/04/24 at 4:17 PM with ADON A revealed she had been employed for 3 weeks. She stated her expectations were for the nurses to complete the pre and post dialysis communication forms. She stated nurses were expected to check vitals, monitor, and document. ADON A stated after reviewing Resident #69's physician orders she noticed Resident #69 did not have any orders to monitor for pre (before leaving the facility) and post-dialysis vitals upon return to facility. ADON A stated she was not aware her nurses were not monitoring post dialysis vitals. She stated the risk of not monitoring or documenting would lead to infections and vital signs going up. Interview on 04/04/24 at 4:54 PM with the Interim DON revealed her expectations were for her nurses to complete the dialysis communication forms pre and post dialysis vitals. Once the forms were completed the nurses should provide the forms to medical records to upload into the resident's charts. The Interim DON stated she was not aware residents post dialysis vitals were not being completed. She stated the risk would be sign and symptoms of infection, not monitoring vitals and fluid. 2. Record review of Resident #92's, face sheet reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #92 had diagnoses which included end stage renal disease (kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis). Record review of Resident #92's quarterly MDS assessment, dated 02/19/24, reflected a BIMS score of 10, which indicated his cognition was moderately impaired. The MDS section O related to special treatments, procedures, and programs reflected Resident #92 received dialysis. Record review of Resident #92's care plan, dated 01/02/2024, reflected Resident #92 receives dialysis related to renal failure and was at risk for the potential complications of dialysis. Resident has an AV fistula (an irregular connection between an artery and a vein). Refused dialysis even with education. Goals: - Resident #92 have no complications from routine dialysis through the next review date. Interventions: Has a Perma Cath (a piece of plastic tubing used for haemodialysis) located in right chest. Encourage resident to attend scheduled dialysis appointments. Obtain vital signs and weight per protocol. Report significant changes in pulse, respirations, and blood pressure to the physician. Monitor dialysis dressing and change as ordered. Report abnormal bleeding to the physician. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #92's physician's order reflected no orders recording for pre (before leaving the facility) and post-dialysis vitals upon return to facility. Record review of Resident #92's dialysis communication forms reflected dialysis communication forms with no information on the resident's assessment and observation post dialysis section on 02/20/24 and the other 4 communications forms given had no dates and the post dialysis vitals were not documented. Interview on 04/04/24 at 03:13 PM with the Interim DON revealed it was the nurses' responsibility to put orders in the MAR on admission and the ADON to follow up and audit to ensure all the orders were in the MAR. The Interim DON stated the importance of having the physician orders was to ensure the nurses were monitoring the dialysis shunt, infections, and vital signs pre and post dialysis. She stated when she reported she had noticed the admitting nurse was not strong, they hired a seasoned ADON for the position. She revealed she was not aware post dialysis vitals were not being done. She stated failure to monitor vital signs could lead to low blood pressure, bleeding, and shortness of breath. She stated she expected the resident to carry the communication form to dialysis. When the residents arrived back to the facility the nurse was to fill the form with post dialysis vital signs or document them in the MAR. The DON stated failure to have the physician orders for vital signs would lead to the resident not being monitored before and after dialysis. The DON stated she had not done trainings since she had been here in the facility as the interim DON for 6 weeks. Interview on 04/04/24 at 3:13 PM with LVN D revealed she was aware she was supposed to collect the form when Resident #92 returned from dialysis. LVN D stated Resident#92 returned during her shift, and she monitored the vitals, but she could not say whether she was documenting on the communication form or whether the resident had orders for monitoring pre and post dialysis. LVN D stated she was aware of the importance of the communication form being filled out post dialysis. She stated failure to monitor and document the vital signs could lead to the patient having low blood pressure, shortness of breath, and it could lead to death. She stated she had done training on monitoring and documenting the vitals post dialysis. She stated she checked the vitals when resident #92 returned in the facility and she knew to report to doctor in case there was any problem. Interview on 04/04/24 at 4:35 PM with LVN K revealed it was management's responsibility to ensure the staff completed the dialysis communication forms when Resident #1 left and returned to the facility. LVN K stated she was responsible on checking what the nurses were doing since she was the ADON, but she has stepped down to weekend night shift nurse, and the facility has hired a new ADON. LVN K stated she was not aware the form was not being filled and vitals were not being monitored. LVN K stated it was her responsibility to ensure all orders were updated on admission. She stated the importance of the communication form serves as a communication for changes between the facility and dialysis center. She stated she was not aware nurses were not documenting the vitals after dialysis. LVN K stated she was not aware the physician orders were not updated. She stated she had done an in-service on monitoring of residents pre and post dialysis but no documentation was .provided. She stated failure to fill the post dialysis vitals on the communication form could lead to resident having low blood pressure ,bleeding and it will not be noticed . Record review of the facility's current Dialysis Vascular Access Methods policy, dated 11/17/23, reflected the following: . Post Dialysis Care: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.Follow standard precautions. 2.Take vital signs upon return dialysis and record in nurses notes 3.Observe Venous access catheter dressings do not change dressings (dressings are changed during dialysis) Record review of the facility's current Following Physician Orders policy, dated 09/28/21 reflected the following: .2. For consulting physician/practitioner orders received in writing or via fax, the nurse in a timely manner will: a. Document the order by entering the order and the time, date, and signature on the physician order sheet. b. Follow facility procedures for verbal or telephone orders including noting the order, submitting to pharmacy, and transcribing to medication or treatment administration record. 3 . b. Follow facility procedures for verbal or telephone orders including noting the order, submitting to pharmacy, and transcribing to medication or treatment administration record. c. Carry out and implement physician orders. d. Document resident response to physician order in the medical record as indicated. 44140

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42859 Based on observation, 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 on two of three medication carts (Station 1) and 1 of 1 (Resident #4) reviewed for pharmacy services. 1.The facility failed to ensure the station 1 south nurses medication cart contained accurate narcotic record for Residents #4 . 2. The facility failed to ensure a bottle of Aspirin 81mgs tablets that was expired was removed from the station 1 Hall nurse's medication cart. This failure could place residents at risk for drug diversion, delay in medication administration, and at risk of receiving medications that were ineffective. Findings included: Review of Resident #4's EHR reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4's diagnoses included Vertebrogenic low back pain (a specific type of back pain that develops when the vertebral endplates of the spine become damaged). Review of Resident #4 quarterly MDS assessment dated [DATE] revealed a BIMS score of 12 revealed she had moderate cognitive impairment. Review of Resident#4 care plan dated 03/01/24 revealed at risk for pain related to chronic lower back pain, rule out car accident. Goal: pain level will be at or below their acceptable level as verbalized by the resident through the next review. Interventions: Administer pain medications and treatments per physician's orders and when requested. Review of Resident#4 physician's orders dated 01/10/24 revealed Norco Tablet 5-325 mg (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 8 hours as needed for Pain management. Observation on 04/03/24 at 1:41 PM, of the Station 1 nurse's cart revealed a bottled of aspirin 81mgs with expiration date of 09/2023. Interview on 04/03/24 at 1:48 PM with LVN C revealed it was all nurses' responsibility to check the carts for expired medication. She stated she checks the cart every other week. She stated the effects of expired medications might be that they might not be as effective. She stated she had completed training on labeling and storage. Observation on 04/03/24 at 1:54 PM of the nurse's medication cart used for Station 1 South and the narcotic administration record with LVN E revealed the following information: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #4's narcotic administration record sheet for Hydrocodone-Acetaminophen 5-325 mg was last signed off on 04/03/24 for one-tablet dose given at 05:55AM, for a total of 38 pills remaining while the blister pack count was 37 pills. Interview on 04/03/24 at 2:07 PM with LVN E revealed she administered Hydrocodone-Acetaminophen 5-325 mg 1 tablet to Resident #4 as needed for pain and she had not signed off on the narcotic administration log. She stated she gave the resident the medication, but she forgot to sign off on the narcotic administration log. She stated she knew she was to sign-out on the narcotic count sheet after administration and on the medication administration record. She stated she signed on the medication administration, and she forgot on the narcotics record log. She stated failure to do that would cause the narcotic count to show less on the next count and it could lead to a narcotics diversion. She stated she had done an in-service on medication administration. Interview on 04/04/24 at 3:57 PM with the Interim DON revealed nurses were responsible for ensuring there were no expired medications on their carts and the nurses were logging off the narcotics as they administer on the narcoric administration record. The Interim DON stated she had started a program for the night shift to audit the carts on Saturday and Sunday, but the process just kicked in since she has only been in the facility for 6 weeks. She stated the ADON were responsible for auditing after the nurses to ensure there were no expired medications on carts or in medication rooms. She stated she did the first audit and she allocated one of the managers to help on the weekend with auditing. The Interim DON stated failure to remove the expired medications from the cart could cause them to be less effective. She stated she has not done an in-service with staff on expired medications and labeling insulin. She statde failure to log of the narcotic can lead to diversion and resident missing the dose. Interview with LVN K on 04/04/24 at 4:31 PM via phone revealed it was all nurse's responsibility to ensure they audit their carts each shift. LVN K stated it was her responsibility to monitor the carts, but she has already changed her role to weekend night shift nurse. She was no longer able to audit the carts when she shifted from day to night shift she works as a floor nurse. She stated she expected the new ADON to start the auditing of the carts after the nurses. LVN K stated failure to ensure the carts were audited or if they have expired medication, the medication might not be as effective. Review of the facility current Medication - Treatment Administration and Documentation policy, dated 02/02/14, reflected the following: .6. When a controlled medication is administered the licensed nurse obtains the medication from the locked area. The licensed nurse administering the medication immediately enters the following information on the accountability record when removing the dose from controlled storage; date and time of administration, amount administered, signature of the nurse administering the dose. (Also document controlled medication dose administrated on the MAR)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on interview and record review, the facility failed to act upon the recommendations of the pharmacist report of irregularities for one resident (Resident #77) of three residents reviewed for (DRR) Drug Regimen Review. The facility failed to follow-up on a recommendation from the pharmacist regarding Resident #77's psychotropic medication (Cymbalta [Duloxetine HCL]) GDR that was due. This deficient practice could place residents at risk of receiving unnecessary medications and dosages. Findings included: Review of Resident #77's face sheet, dated 04/04/24, reflected the resident was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #77's diagnoses included Type 2 diabetes mellitus with diabetic nephropathy (serious complication of diabetes Type I and Type II affecting the kidneys), osteomyelitis (inflammation of the bone caused by an infection usually in the arms, legs, or spine), peripheral vascular disease, heart failure, and depression. Review of Resident #77's physician orders reflected the following: - Duloxetine HCl Oral Capsule Delayed Release, Sprinkle 30 MG (Duloxetine HCl) Give 1 capsule by mouth one time a day for depression / nerve pain related to depression, unspecified (F32.A). - Duloxetine HCl 30 MG Capsule delayed release, particles Give 1 capsule by mouth in the morning, related to depression, unspecified (F32.A). Record review revealed that the last GDR attempt was on 05/26/23. Interview with the Interim DON on 04/04/24 at 5:09 PM revealed the resident should have had a GDR attempt within the last six months. The Interim DON stated that there was no DON during the time from October 2023 to February 2024. The Interim DON revealed that her expectations were that the ADONs would give the pharmacist recommendations to the doctor to sign, then upload the report to the residents' charts. The Interim DON stated that next the GDR would then be attempted if approved by the physician. She continued by saying that if the GDR goes well, the lower dosage was kept, but if contraindicated the original dose was kept. The interim DON revealed that when this was not done, risks to the resident were over medication with side effects as well as not promoting the highest function of the resident with the lowest dosage of the drug. The Interim DON stated that this procedure had not been completed during the time period that there was no DON at the facility. Record review of the facility's policy, revised October 2018, titled Drug Regimen Reviews reflected: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Monthly Drug Regimen Reviews of each resident .at least monthly and more frequently if deemed necessary . to prevent potential clinically significant medication adverse consequences .Recommendations that require physician response are sent to Physician timely for follow up or the physician contacted by phone as indicated. The DON will maintain a system to review and track all recommendations sent to physician to validate response by physician .The DON will validate that all recommendations sent to physician once returned are acted upon timely .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42859 Based on observation, 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 on three of three medication carts (station 1 south side, and station three) reviewed for pharmacy services. The facility failed to ensure insulin pens that were opened from station 1 South and station 3 nurse's medication cart were dated with an opening date. This failure could place residents at at risk of receiving insulins that were ineffective. Findings included: Observation on 04/03/24 at 1:54 PM, of the nurse's medication cart used for station 1 South with LVN E, revealed the following information: One insulin vial of Novolog Subcutaneous Solution 100 unit/ml vial that had been opened partially used with no opening date. Interview on 04/03/24 at 2:07 PM with LVN E revealed it was all nurses' responsibility to put an opening date on insulins pen when they were opened. She stated she was the one that had removed the insulin from the refrigerator, opened it, and she did not put the date. She stated the risk of not putting the date on insulin when opened was they will not know when it expires, and it will not be as effective. She stated she had completed training on opening dates. Observation on 04/03/24 at 2:11 PM of the nurse's medication cart used for station 3 with LVN J revealed, one insulin vial of Novolog Subcutaneous Solution 100 unit/ml vial and one insulin vial of Humalog Subcutaneous Solution 100 unit/ml vial that were opened partially used with no opening date. Interview on 04/03/24 at 2:21 PM with LVN J revealed it was all nurses' responsibility to put an opening date on insulins pen when they get opened. She stated it was also the nurse's responsibility to check the carts every shift for the expired and opened dates. She stated she was supposed to check when she started her shift, but she forgot. She stated some insulins were good for 28 days. If they do not have opening dates, staff would not know when they expired and when to discard the insulin. She stated the risk of not putting the date on insulin when opened was that they would not know when it expired. They would not be potent and might not be as effective to control high blood sugar levels. She stated she had completed training on medication storage and administration. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/04/24 at 3:57 PM with the Interim DON revealed nurses were responsible for ensuring they dated the insulin after opening with an openning date. The Interim DON stated she had started a program for the night shift to audit the carts on Saturday and Sunday, but the process just kicked in since she has only been in the facility for 6 weeks. She stated the ADON were responsible for auditing after the nurses to ensure the unsulin were dated. She stated she did the first audit and she allocated one of the managers to help on the weekend with auditing. The Interim DON stated failure for the nurses not dating insulin with opened dates, they would not know when they expired and they will not be as effective to control blood sugars. She stated she has not done an in-service with staff on expired medications and labeling insulin. Interview with LVN K on 04/04/24 at 4:31 PM via phone revealed it was all nurse's responsibility to ensure they audit their carts each shift. LVN K stated it was her responsibility to monitor the carts, but she has already changed her role to weekend night shift nurse. She was no longer able to audit the carts when she shifted from day to night shift she works as a floor nurse. She stated she expected the new ADON to start the auditing of the carts after the nurses. LVN K stated failure to ensure the carts were audited and also, if insulins were not being dated after opening, they would not be as potent, and the nurses would not be able to know when they expired. Record review of the facility's current Insulin Management Process policy dated September 2015 did not address the opening dates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455475	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observations, interviews, and record review, the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a centralized staff work area for 1 of 90 residents (Residents #56) reviewed for call lights. The facility did not adequately equip Resident #56 with a call light to allow the resident to call for assistance. This failure could place residents who rely on the call light system to have a delayed response or no way contact staff to meet their needs. Findings included: Review of Resident #56's Face sheet, dated 04/04/24, revealed the resident was a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of nontraumatic subarachnoid hemorrhage (intracranial bleeding), cognitive communication deficit (difficulty thinking and communication), essential hypertension (high blood pressure), hemiplegia (paralysis on one side of the body) and hemiparesis (one-side muscle weakness) following nontraumatic subarachnoid hemorrhage affecting left dominant side. Review of Resident #56's quarterly MDS assessment, dated 03/13/24, revealed a BIMS was unable to be completed due to the resident w as rarely/never understood. The MDS further indicated Resident #56 was total dependent from staff. Review of Resident #56's care plan, revised date 06/15/23, revealed Focus: ADLs: [Resident #56] has an ADL self-care performance deficit and is at risk for not having their needs met in a timely manner. Performance deficit is related to: Cognitive impairment, Hemiplegia/Hemiparesis secondary to a stroke. Goal: [Resident #56] will maintain a sense of dignity by being clean, dry, odor free, and well-groomed through the next review date. Interventions: Ensure/provide a safe environment: Call light in reach, adequate low glare light, bed in lowest position and wheels locked, avoid isolation. Falls: [Resident #56] has the potential for falls related to cognitive impairment r/t subarachnoid hemorrhage and chronic respiratory failure with hypoxia. Goal: [Resident #56] will be free of falls through the next review date. Interventions: Place the resident's call light close to head/cheek. Observation and interview on 04/03/24 at 2:05 PM revealed Residents #56 lying in bed. Resident #56 unable to verbally communicate. Observation further revealed no call light system for Bed B (Resident #56). Interview with Resident #56's roommate revealed Resident #56 has had no call light for a while. Resident #32 stated staff removed the call light due to Resident #56 accidently turning the call light on a lot. Resident #32 stated when Resident #56 screams, she would push her call light to get Resident #56 help. Observation on 04/03/24 at 4:16 PM revealed Resident #56 lying in bed. No call light observed. Observation on 04/04/24 at 11:41 AM revealed Resident #56 in bed sleeping. No call light observed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455475	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/04/24 at 11:53 AM with CNA H revealed she was the CNA assigned to Resident #56. She stated every resident should have a call light in their room and within reach. CNA H stated if a resident was unable to use the call light, they should still have one in the room. CNA H stated she was aware Resident #56 did not have a call light. She stated she had verbally communicated that to the Maintenance Director about a week ago. She stated the potential risk of not having a call light would be residents not being able to ask for help. Interview on 04/04/24 at 12:47 PM with LVN E revealed she was the nurse assigned to Resident #56. She stated all residents should have a call light within reach regardless of if they were unable to use it. LVN E stated she had not noticed Resident #56 did not had a call light until it was pointed out today (04/04/24). She stated the potential risk would be residents would be unable to call for assistance. Interview on 04/04/24 at 12:59 PM with the Maintenance Director revealed each resident should have a call light in their rooms. He stated he was unaware Resident #56 did not have a call light until 15 minutes ago. The Maintenance Director stated he had a maintenance logbook on each nurse's station. Observed the Maintenance Director review the maintenance logbook from station 1 and stated he had not had any requests for call lights. Interview on 04/04/24 at 2:03 PM with the Interim DON revealed each resident should have a call light in their room and within reach. She stated she was unaware Resident #56 did not have a call light. She stated the risk of not having a call light would be not getting help and needs not being met. Interview on 04/04/24 at 3:44 PM with the Administrator revealed her expectations were for each resident to have a call light and to ensure staff were answering call lights as soon as possible. She stated she was unaware Resident #56 did not have a call light. She stated there was no risk for Resident #56 not to have a call light due to resident not having the capacity to push it. However, each resident should have a call light. Review of facility policy Call light Response, dated 2/10/21, reflected the following: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response.