STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Springs Healthcare Center	2003 N Edwards St Mount Pleasant, TX 75455

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview and record review the facility failed to ensure the residents or responsible party had the right to be informed of and participate in his or her treatment which included, the right to be informed in advance, by the physician or other practitioner or other professional, of the risks and benefits of proposed care, treatment, and treatment alternatives or treatment options to choose the alternative or option he or she preferred for 1 of 4 residents (Resident #34) reviewed for psychoactive medications. The facility failed to ensure Form 3713 was filled out completely based on Resident #34's diagnostic criteria, and assessment finding exhibited by the resident for the medication Seroquel, also known as Quetiapine (is an antipsychotic medication that treats several kinds of mental health conditions, including schizophrenia and bipolar disorder. This failure could place residents at risk for receiving unnecessary antipsychotic medications, experiencing potential adverse reactions, and a potential decline in physical and mental health status. Findings included: Record review of Resident #34's face sheet, dated 03/4/25 indicated a [AGE] year-old female who was admitted to the facility on [DATE] with the diagnoses which included stroke, Parkinson (a chronic brain disorder that causes movement problems, including tremors, stiffness, and balance issues), and Dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). Record review of Resident #34's quarterly MDS assessment, dated 02/19/25, indicated Resident #34 was understood and usually was understood by others. Resident #34's BIMS score was 04, which meant she was severely cognitively impaired. The MDS indicated Resident #34 required assistance with toileting, bed mobility, dressing, transfers, personal hygiene, and supervision with eating. The MDS indicated she took an Antipsychotic medication during the 7-day look-back period. Record review of Resident #34's physician;s order dated 09/20/24 reflected, Seroquel oral tablet 25 MG (Quetiapine) Give 1 tablet by mouth two times a day related to depression. (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: 455532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Pleasant Springs Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 N Edwards St Mount Pleasant, TX 75455	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #34's medication administration record dated from 02/01/25 through 02/24/25 revealed, Resident#34 received Seroquel oral tablet 25 MG (Quetiapine) Give 1 tablet by mouth two times a day related to depression. Record review of Resident #34's care plan dated 08/13/24 indicated she required anti-psychotic medications related to night terrors. The intervention of the care plan indicated staff would give medication as ordered. Staff would monitor/record/report to the doctor for side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Record review of Resident #34's consent for the use of psychotropic medication, Seroquel was documented in the chart signed 04/20/24 but was incomplete without diagnostic criteria and assessment finding exhibited by the resident for the use of the medication. During an interview on 02/26/25 at 5:11 p.m., LVN G said consent(s) were obtained to notify the resident or the responsible party of their orders and to verify it was okay to give. She said consent(s) should have been obtained for all psychotropic medication before being given. She said the nurse who took the order for Resident #34's Seroquel should have filled out the form completely and had the doctor review and sign it. LVN G said she did not know the form's name but knew it should have been filled out completely. During interviews on 02/27/25 at 9:33 a.m., Resident #34's RP said she was aware of the Seroquel but was not aware the form 3713 was not filled out completely to explain the benefits and or side effects. During an interview on 02/27/25 at 1:54 p.m., the facility's Physician said he was not aware Resident #34's Form 3713 was not filled out completely. He said the form should have been filled out completely for the medication, the reason she was on the medication, any diagnostic criteria and assessment findings exhibited by the resident for the indication of being on the medication. He said Resident #34 was on the medication prior to being admitted to the facility. He said if the facility would let him know when he or his nurse practitioner were back in the facility, they would get the form completed. During an interview on 02/27/25 at 4:47 p.m., the ADON said the nurse who received the order was responsible for getting the consent. The ADON said the consent for psychotropic medications should have been completed before the resident received the medication. The ADON said the form should have been filled out completely with all the correct diagnosis, criteria, and reason for the medication. She said she would get with the doctor and see what needed to be done to have the form completed. During an interview on 02/27/25 at 5:12 p.m., the Administrator said a consent form should be filled out completely and should be obtained to inform families or residents of the risks and/or benefits of a medication. The Administrator said the DON oversaw that process. She said she was not sure why the form was not completed as it should have been. (continued on next page)

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	455532	A. Building B. Wing	02/27/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Psychoactive Medications, from the Policy and Procedure manual 03-6.20, reflected Policy: The intent of this policy is that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the residents highest practicable mental, physical, and psychosocial well-being. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. This drug includes but are not limited to drugs in the following categories: (1) antipsychotic, (2) antidepressant, etc. The facility must ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record The psychotropic consent form explains the risks and benefits of psychotropic medications. The resident or their representative must provide documented consent prior to administration of a newly ordered psychotropic medication. Consents for anti-psychotic medication must be in a written form. A verbal or phone consent is not allowed. Permission given by or a request made by the resident and or representative does not serve as a sole justification for the medication itself. Use of antipsychotic medications must be thoroughly documented in the medical record.

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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. 46892 Based on observation, interviews and record review, the facility failed to ensure residents had the right to a clean, comfortable, and homelike environment, which included but not limited to receiving treatment and supports for daily living safety, clean bed and bath linens for 1 of 1 facility reviewed for resident rights. The facility failed to ensure bed pads (cloth pads placed on the bed to protect mattresses and bedding from incontinence) were available for the residents to use. This failure could place residents at risk for an uncomfortable, unhomelike environment, and a diminished quality of life. Findings included: During a confidential group interview on 02/25/2025 at 10:00 AM, the residents said the facility did not have enough bed pads. The residents said when they requested best pads the CNAs told them they did not have enough for them to have one. The residents said they needed the bed pads to help protect their sheets when they had increased episodes of incontinence. During an observation and interview on 02/25/2025 at 3:45 PM, the linen cart on hall A had 1 bed pad, the linen cart on hall B had no bed pads, the linen cart on hall C had no bed pads, and the linen cart on hall D had no bed pads. CNA D said there were not enough bed pads for all the residents. CNA D said management was aware of the issues, and they just used what they had. During an observation on 2/26/2025 at 3:35 PM, the Hall C and Hall A linen carts had no bed pads on them. During an interview on 02/27/2025 starting at 9:05 AM, the Housekeeping Supervisor said the CNAs had notified him there were not enough bed pads. The Housekeeping Supervisor said the department heads had morning meetings and it was discussed in the morning meetings that there were not enough bed pads. The Housekeeping Supervisor said in the meetings it was said they would order more bed pads, but they had not been ordered. The Housekeeping Supervisor said that it was probably this month (February 2025) since he heard about the bed pads. During an observation on 02/27/2025 at 5:08 PM, there was 1 bed pad in the facility's linen storage closet, 1 bed pad on the linen care on B hall, and no bed pads on the linen carts in A and D hall. During an interview on 02/27/2025 at 5:10 PM, CNA R said there were not enough bed pads for the residents. CNA R said the staff had reported to management about the lack of bed pads, and they had not said anything to address the issue. During an interview on 02/27/2025 at 5:18 PM, the ADON said nobody had complained to her that there were not enough bed pads. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/27/2025 at 5:24 PM, the Hall C linen cart had 1 bed pad on it. During an interview on 02/27/2025 at 5:45 PM, the Regional Compliance Nurse said they typically did not use bed pads if the resident used a brief. The Regional Compliance Nurse said if a resident requested a bed pad the staff should not tell the resident they did not have enough. The Regional Compliance Nurse said they would not say they did not have enough, and they would get one for the resident. The Regional Compliance Nurse said it was important to provide the bed pads for the residents because it was their home, and if they wanted to have one, they could. During an interview on 02/27/2025 at 6:13 PM, the Administrator said the staff had not reported to her that there were not enough bed pads. The Administrator said she was not aware there had been discussion in the morning meetings about the facility needing to order more bed pads. The Administrator said they tried to accommodate the residents the best they could. Record review of the facility's undated policy titled, Resident Rights, indicated, The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right . 3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. 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. The facility must provide- . 3. Clean bed and bath linens that are in good condition .

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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** 47612 Based on interview and record review, the facility failed to ensure prompt efforts were made to resolve grievances for 1 of 23 residents (Resident #23) reviewed for grievances. The facility did not ensure a grievance was filed and Resident #23 was appropriately apprised of progress toward a resolution when Resident #23's white pants with black trim, denim shirt with pink cuffs, a blue shirt, and white socks with black and red around the top were not returned from the laundry. This failure could place residents at risk for a decreased quality of life, and grievances not being addressed or resolved promptly. Findings included: Record review of a face sheet dated 02/27/2025 indicated Resident #23 was a [AGE] year-old female initially admitted to the facility on [DATE] with diagnoses which included senile degeneration of the brain (a group of conditions characterized by a progressive decline in cognitive functions, such as memory, reasoning, and judgment), paroxysmal atrial fibrillation (a type of irregular heartbeat that occurs intermittently), essential (primary) hypertension (a condition characterized by persistently elevated blood pressure without an identifiable underlying cause). Record review of Resident # 23's quarterly MDS assessment dated [DATE], indicated Resident #23 had a BIMS score of 09, which indicated moderate cognitive impairment. During an interview on 02/24/2025 at 2:52 p.m., Resident #23 stated she had told the laundry aide she was missing a pair of white pants with black trim, a denim shirt with pink cuffs, a blue shirt, and a white pair of socks with black and red around the top. Resident #23 stated the laundry aide found her red pajama bottoms that were missing, in another resident's room. Resident #23 stated she had been telling the laundry aide about her missing clothing for several months. During an interview on 02/26/2025 at 3:45 p.m., Laundry Aide U stated Resident #23 had reported to her she was missing a pair of white pants with black trim, a denim shirt with pink cuffs, a blue shirt, and a white pair of socks with black and red around the top. Laundry Aide U stated Resident #23 reported the items missing in October 2024. Laundry Aide U stated when the residents were missing clothing, they would look through the clothes, the lost and found, and if she was unable to find the missing item, tell the resident she was still looking for the clothes. Laundry Aide U stated she had notified her supervisor, the Environmental Services Manager, that Resident #23 was missing a pair of white pants with black trim, a denim shirt with pink cuffs, a blue shirt, and a white pair of socks with black and red around the top. Laundry Aide U sated she did not know she was supposed to fill out a grievance when a resident's clothing was not found. Laundry Aide U stated it could make the residents feel like no one cared if their clothing was returned or not. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/26/2025 at 4:40 p.m., the Environmental Services Manager stated if the resident was missing clothing the laundry staff would look for the items until it was found. The Environmental Services Manager stated he did not know anything about Resident #23's missing a pair of white pants with black trim, a denim shirt with pink cuffs, a blue shirt, and a white pair of socks with black and red around the top. The Environmental Services Manager stated he had never filed a grievance or replaced missing items in the past. The Environmental Services Manager stated it was important for the residents to get their clothing back because they needed them, and it was their personal property. During an interview on 02/27/2025 at 4:38, the Administrator stated if clothes were missing, they would look for them and then write a grievance. The Administrator stated if the missing clothes were not found they would replace them. The Administrator stated a grievance should have been filed for Resident #23's missing clothing, and anybody could have filed the grievance. The Administrator stated whoever took the residents grievance should write it up. The Administrator stated it was important for the residents to have their clothing returned so they had something to wear. The Administrator stated she would do an in-service to explain grievances and would monitor during champion rounds. Record review of the facility's, Grievance Policy, revised 11/02/2016, indicated, . The resident has the right to voice grievances to the facility or other agency or entity that hear grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to, and the facility must make prompt efforts by the facility to resolve grievance the resident may have.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care for 1 of 4 residents (Resident #174) reviewed for baseline care plans. The facility failed to develop a baseline care plan that addressed Resident #174's use of oxygen. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: Record review of Resident #174's face sheet dated 02/26/2025 indicated she was a [AGE] year-old female admitted on [DATE] with diagnoses which included combined systolic and diastolic congestive heart failure (the heart is not pumping blood efficiently which results in fluid buildup in the lungs and body), obstructive sleep apnea (airflow blockage during sleep), and asthma. Record review of Resident #174's Nursing Home PPS MDS assessment dated [DATE] indicated she was understood by others and understood others. The MDS assessment indicated Resident #174's BIMS score was a 15, which indicated her cognition was intact. The MDS assessment indicated Resident #174 received oxygen while a resident of the facility. Record review of Resident #174's Order Summary Report dated 02/26/2025 indicated, may use oxygen at 2-4 liters per minute viva nasal canula with a start date of 02/15/2025. Record review of Resident #174's care plan with date initiated 02/17/2025 did not indicate Resident #174's use of oxygen. Record review of Resident #174's Admission Nurse Note dated 02/15/2025 indicated oxygen was in use at 2 liters per minute via nasal canula. During an observation on 02/24/2025 at 11:08 AM, Resident #174 was in her bed, and she was wearing oxygen at 2 liters per minute via nasal canula. During an observation and interview on 02/27/2025 starting at 8:28 AM, LVN P said the admitting nurse was responsible for completing the baseline care plan. LVN P said the baseline care plan was included in the nurse's admission note. LVN P attempted to demonstrate where the baseline care plan was located in the nurse's admission note in Resident 174's electronic health record, and she was unable to locate it. LVN P said she was not sure where it would be located, she thought it was on the admission note. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/2025 at 4:56 PM, the MDS Coordinator said the baseline care plan was completed by the nurses within 48 hours of a resident's admission. The MDS Coordinator said the nurses should complete the admissions assessment and then go to the care plan and pull the triggers to complete the baseline care plan. The MDS Coordinator said the day after a resident admitted the IDT reviewed the care plans in the morning meetings. The MDS Coordinator said Resident #174's use of oxygen was added to the care plan yesterday (02/26/2025). The MDS Coordinator did not say why it was not added prior to then. The MDS Coordinator said the use of oxygen should be included in the baseline care plan. The MDS Coordinator said it was important for the use of oxygen to be included so the staff could see what the residents needed. During an interview on 02/27/2025 at 5:35 PM, the Regional Compliance Nurse said the admitting nurse was responsible for completing the baseline care plan, and then nurse managers reviewed it in the morning meetings. The Regional Compliance Nurse said the use of oxygen should be included in the baseline care plan. The Regional Compliance Nurse said it was important for the use of oxygen to be included in the resident's care plan because it was part of their care. During an interview on 02/25/2025 at 6:01 PM, the Administrator said the baseline care plan should be completed upon admission by the charge nurse, and the use of oxygen should be included on the baseline care plan. The Administrator said the baseline care plans were reviewed the day after a resident admitted in the morning meetings by the DON, ADON, wound care nurse, MDS Coordinator, unit manager, and herself. The Administrator said it was important for the baseline care plan to include the use of oxygen, so everybody knew how to take care of the resident and what was needed to take care of the resident. Record review of the facility's undated policy titled, Base Line Care Plans, indicated, This facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan will- o Be developed within 48 hours of a resident's admission. o Include the minimum healthcare Information necessary to properly care for a resident including, but not limited to- Initial goals based on admission orders. Physician orders . Any services and treatments to be administered by the facility and personnel acting on behalf of the facility .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46892 Based on observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan to meet resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment for 3 of 23 residents (Resident #7, Resident #8, and Resident #44) reviewed for care plans. 1. The facility failed to ensure a care plan was developed for Resident #8's left arm fracture, use of a sling to the left arm, and refusal to wear her sling. 2. The facility failed to implement Resident #7's care plan for staff to remain outside of the shower for safety. 3. The facility failed to ensure Resident #44's care plan reflected he had weight loss. These failures could place the residents at increased risk of not having their individual needs met and a decreased quality of life. Findings included: 1. Record review of a face sheet dated 02/26/2025 indicated Resident #8 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included displaced oblique fracture of shaft of humerus left arm subsequent encounter for fracture with routine healing (care following a left arm fracture). Record review of Resident #8's Comprehensive MDS assessment dated [DATE] indicated she was understood by others and was able to understand others. Resident #8's MDS assessment indicated she had a BIMS score of 5, which indicated her cognition was severely impaired. Resident #8's MDS assessment indicated she had an impairment on one upper extremity. The MDS assessment indicated Resident #8 was dependent on staff for upper and lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS assessment did not indicate rejection of care. Record review of Resident #8's Order Summary Report dated 02/26/2025, indicated: Apply splint to left hand during therapy only per OT with a start date of 02/19/2025. Non-weight bearing to left upper extremity with a start date of 02/03/2025. Resident to keep left upper extremity in arm sling, may remove for skin checks and bathing every shift with a start date of 02/12/2025. During an observation and interview on 02/25/2025 at 3:06 PM, Resident #8 was in her room. Resident #8's sling was laying on her nightstand. Resident #8 said she did not like to wear it all the time because it hurt her arm. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's care plan last reviewed 02/28/2025 did not indicate care for her left arm fracture or her refusal to use the arm sling. During an interview on 02/26/2025 at 8:47 AM, COTA X said Resident #8 was supposed to wear the sling to her left arm daily, but she was noncompliant. COTA X said she had educated the nurses regarding Resident #8 wearing the sling during the day. COTA X said she did not know who was responsible for putting this in the care plan. During an interview on 02/27/2025 at 4:56 PM, the MDS Coordinator said Resident #8's fracture, use of sling, and refusal to wear the sling was not in Resident #8's care plan because it had been resolved when the surgical wound to her left arm had healed. The MDS Coordinator said Resident #8's fracture, use of a sling, and refusal to wear a sling should be included in her care plan, so the staff knew what she needed. 2. Record review of Resident #7's face sheet dated 02/27/2025 indicated she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease (disease that causes irreversible damage to memory, thinking, and behavior), essential tremor (shaking), and seizures. Record review of Resident #7's Quarterly MDS assessment dated [DATE], indicated she was able to make herself understood and understood others. The MDS assessment indicated Resident #7's BIMS score was a 5, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #7 was independent for eating, toileting, dressing, and personal hygiene, and required set-up or clean-up assistance with bathing/showering self. Record review of Resident #7's care plan last reviewed 12/23/2024 indicated she was at risk for falls related to impaired cognition and weakness. Resident #7's care plan indicated she had an ADL self-care performance deficit, and she preferred to shower independently. Resident #7 was educated that staff will remain outside of the shower for safety. During an interview on 02/27/2025 at 10:45 AM, Resident #7 said she showered by herself, and the staff did not help her or wait outside the door. Resident #7 said if the staff were around, she would let them know she was going to take a shower, but if they were not she would go ahead and shower. During an interview on 02/27/2025 at 10:57 AM, LVN L said Resident #7 was independent with ADLs for the most part. LVN L said Resident #7 may ask for assistance to make her bed or if she needed extra help. LVN L said Resident #7 took showers by herself. LVN L said the CNAs monitored her and checked on her by seeing if she needed any towels or supplies to shower. LVN L said the CNAs did not stay with her while she showered. LVN L said she was not sure if Resident #7 had any cognitive issues. LVN L said it was important for the residents to have adequate supervision in the showers, so they did not hurt themselves. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pleasant Springs Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 N Edwards St Mount Pleasant, TX 75455	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/27/2025 at 1:27 PM, CNA S said on 02/24/2025 around 10:10 PM she was charting when Resident #7 wanted to take a shower. CNA S said then she went to make Resident #7's bed because she was trying to finish up due to her shift was ending. CNA S said she was not sure when Resident #7 went in the shower room or when she came out of the shower room. CNA S said Resident #7 took showers by herself, and she was able to let herself in the shower room. CNA S said Resident #7 was independent for her ADLs and mostly did everything for herself. CNA S said she did not know Resident #7 had any cognitive issues because it did not seem like she did. CNA S said Resident #7 did not need a lot of assistance just when she got tired or her back hurt. CNA S said sometimes Resident #7 asked for help, but she did not like for people to help her out. CNA S said she was not aware that Resident #7 required someone to be standing with her while she showered. During an interview on 02/27/2025 at 5:41 PM, the Regional Compliance Nurse said they had some residents that wanted to shower independently, but for safety the staff needed to be within view of the resident that they were not supposed to be left alone. The Regional Compliance Nurse said she expected for the care plan to be followed and the CNAs or nurses should wait outside while Resident #7 showered. The Regional Compliance Nurse said the CNA should look at the Kardex (electronic health record which indicates the level of assistance a resident requires with ADLs and can also detail information from the resident's care plan) or ask the nurses if they were not aware of the level of assistance a resident required for their ADLs. The Regional Compliance Nurse said Resident #7 used a rollator (walker with wheels) and she was kind of impulsive. She would let go of the rollator and walk without it, but she was pretty high functioning as far as her ADLs. During an interview on 02/25/2025 at 6:04 PM, the Administrator said she expected for the staff to follow the resident's care plan. The Administrator said it was important for Resident #7's care plan to be followed so they knew how to take care of her, and she was taken care of. 45879 3. Record review of Resident #44's face sheet, dated 02/26/25, indicated an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson, Parkinson's disease also known as PD (a progressive neurological disorder that affects movement, balance, and coordination), Malnutrition (a state of poor nutrition that occurs when the body does not receive enough or the right nutrients to function properly), depression (low mood), and high blood pressure. Record review of Resident #44's quarterly MDS assessment, dated 01/29/25, indicated Resident #44 understood and was understood by others. Resident #44's BIMS score was 04, which meant he was severely cognitively impaired. The MDS indicated Resident #44 required help with toileting, bed mobility, dressing, transfers, personal hygiene, and supervision with eating. The MDS did not indicate he had weight loss. Record review of Resident #44's physician's orders dated 02/13/25, indicated, weekly weight x 4 weeks every 7 days. Record review of Resident #44's physician's orders dated 02/13/25, indicated, Med Pass 2.0 120 milliliters three times a day for weight management. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #44's physician's orders dated 02/13/25, indicated, Remeron Oral Tablet (Mirtazapine) Give 7.5 mg by mouth at bedtime for appetite stimulant. Record review of Resident 44's electronic medical records of weights dated 01/02/25 indicated a weight of 121 pounds, 2/07/25 indicated a weight of 108 pounds, 02/14/25 indicated a weight of 107.8 pounds and 02/21/25 indicated a weight of 109.8 pounds. Record review of Resident #44's care plan (no date) did not indicate weight loss. Record review of Resident 44's progress notes dated 02/01/25 through 02/25/25 did not indicate a nutrition/dietary department note. A note was indicated on 02/13/25 to add to the Weight Watchers program by an unknown author. During an interview on 02/25/25 at 1:42 p.m., the MDS Coordinator said she and the IDT were responsible for care planning. The Coordinator said Resident #44's weight loss should have been care planned after the last Weight Watchers meeting. The MDS nurses said they were training the new ADON to update weights today (02/25/25), but before today, she should have ensured the weight loss was on the care plan. The MDS said if weight loss was not care planned, then the nurses might not know about the weight loss or follow up on it. The MDS nurse said the purpose of the care plan was to let everyone know of the weight loss. Record review of the facility's policy title, Comprehensive Care Plan, from the Nursing Procedure [NAME] 03. 18-0, indicated, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan The resident's care plan will be reviewed after each Admission, Quarterly, Annual, and/or Significant Change MOS assessment, and revised based on changing goals, preferences, and needs of the resident and in response to current interventions.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47708 Based on observations, interviews, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living receives necessary services to maintain personal hygiene were provided for 2 of 72 residents reviewed for ADLs (Resident #58, Resident #70). 1. The facility did not ensure Resident #58 received fingernail care. 2. The facility did not ensure Resident #70 received her showers. These failures could place residents at risk of not receiving services or care, decreased quality of life, and decreased self-esteem. The findings included: 1. Record Review of Resident #58's face sheet dated 2/26/25 at 1:43 p.m., indicated Resident #58 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of vascular dementia (reduce blood flow to the brain) with behavioral disturbance, Muscle weakness (a lack of muscle strength, meaning the muscles may not contract or move as easily as they used to), Pneumonia (an infection that affects one or both lungs), essential hypertension (high blood pressure). Record Review of Resident #58's MDS assessment dated [DATE] indicated, Resident #58 usually understood others and made himself understood. The MDS assessment indicated Resident #58 had a BIMS score of 10, which indicated Resident #58 was moderately impaired. The MDS assessment indicated Resident #58's need for assistance with bathing, dressing, using the toilet, or eating was not coded on the MDS assessment. Record Review of Resident #58's care plan, dated on 2/7/25, indicated Resident #58 had an ADL Self Care Performance Deficit Stroke. The care plan goals indicated: the resident will improve current level of function in ADL's through the review date. The care plan interventions included bathing: requires staff x1 for assistance, Bed Mobility: requires staff x1 for assistance, Dressing: requires staff x1 for assistance, Eating: supervision as needed, the resident uses a wheelchair, Toilet use: requires staff x1 for assistance, encourage the resident to discuss feelings about self-care deficit and BATHING: Avoid scrubbing & pat dry sensitive skin. During observation on 2/24/25 at11:20 a.m., Resident #58 fingernails were long and had not trimmed; fingernails had black debris underneath his nails. During observation on 2/25/25 at 10:01 a.m., revealed Resident #58's fingernails were long and had not been trimmed. Resident #58's fingernails had black debris underneath his nails. During an interview on 2/24/25 at 11:20 a.m., Resident #58 stated he would like to have his fingernails trimmed. Resident #58 stated he couldn't remember the last time his fingernails were trimmed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record Review of Resident #70's face sheet dated 2/26/25 at 1:40 p.m., indicated Resident #70 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus without complications (chronic condition that affects the way the body processes blood sugar), Muscle weakness (a lack of muscle strength, meaning the muscles may not contract or move as easily as they used to), Hypothyroidism (thyroid gland does not produce enough thyroid hormone), essential hypertension (high blood pressure). Record Review of Resident #70's MDS assessment dated [DATE] indicated, Resident #70 understood others and made herself understood. The MDS assessment indicated Resident #70 had a BIMS score of 5, which indicated Resident #70 was severely impaired. The MDS assessment indicated Resident #70 need for assistance with bathing, dressing, using the toilet, or eating was coded as independent on the MDS assessment. Record Review of Resident #70's care plan, dated on 1/15/25, indicated Resident #70 had an ADL Self Care Performance Deficit. The care plan interventions included Bathing: requires staff x1 for assistance; Dressing: requires staff x1 for assistance; Eating: supervision as needed; Praise all efforts at self-care; Physical Therapy/Occupational Therapy evaluation and treatment as per MD orders. During an interview on 2/24/25 at 10:19 a.m., Resident #70 stated she had shingles, and she did not get a shower. Resident #70 stated she would like her shower. Resident #70 stated her last shower was more than over a week and a half. Resident #70 stated she was supposed to get her showers on Monday, Wednesday and Friday. Resident #70 stated, it made her feel terrible when she did not get a shower because she feels nasty all the time. During an interview on 2/26/25 at 10:15 a.m., Resident #70 stated to LVN G that she had not been receiving her showers. Resident #70 stated to LVN G, I thought I was supposed to give myself a shower because staff had not been giving me my showers. Resident #70 stated she started to get a rash on her stomach from not having a shower. Resident #70 stated, Showers help me with getting rid of rashes, but I have not had a shower in a while. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25 at 10:15 a.m., LVN G stated she was the charge nurse on the B hall. LVN G stated she worked the 6 am to 6 p.m. shift. LVN G stated the shower aides were responsible for giving Resident #70 her showers. LVN G stated if the shower aide was not available then the CNAs were responsible for giving showers on the B hall. LVN G stated Resident #70 was supposed to be showered on Monday, Wednesday and Friday. LVN G stated the CNAs were to bring the residents to the shower aide and then the shower aide was to shower each resident. LVN G stated she followed up with the CNAs and shower aide to ensure the residents got their showers. LVN G stated she was not always 100 percent sure with making sure the residents got their showers. LVN G stated Resident #70 had not ever refused showers since being admitted . LVN G stated she was not sure when her last in-service was last completed on ADL care. LVN G stated the ADON oversaw her. LVN G stated she oversaw the shower aide and CNAs. LVN G stated, It was important for the residents to get their showers for hygiene and to prevent skin breakdown, rashes and dignity so the resident felt good about themselves. LVN G stated she was not aware of Resident #70 not receiving her showers. LVN G stated that she was not aware of staff documenting that they were giving showers to the residents when the resident did not receive a shower LVN G stated if the resident was a diabetic that the charge nurse would be responsible for trimming the resident's nails. LVN G stated if the resident was not diabetic then the CNAs would be responsible for trimming the resident's nails. LVN G stated if a resident was a diabetic that their nails are trimmed on Sunday's. LVN G stated if the resident was not a diabetic that their nails were trimmed on shower days or as needed. LVN G stated she never notice that Resident #58 had long nails that needed to be trimmed and cleaned. LVN G stated the CNAs and shower aides were to let her know if the residents needed their nails trimmed. LVN G stated she did not remember the last time Resident #58's fingernails were trimmed and cleaned. LVN G stated to her knowledge the resident had not ever refused nail care. LVN G stated it was important to ensure the resident nails were trimmed and cleaned for hand hygiene and to prevent self-inflected injuries. During an interview on 2/26/25 at 12:47 p.m., CNA A stated she normally worked the 6 am to 2 pm shift at the facility. CNA A stated she was not aware of Resident #70 not getting her showers. CNA A stated she was supposed to shower at least 3 times a week. CNA A stated the shower aid was responsible for giving the showers. CNA A stated the CNAs were responsible for bringing the residents to the shower room to be showered. CNA A stated in-services on ADL's was last completed about 3 weeks ago. CNA A stated Resident #70 had not ever refused a shower. CNA A stated it was important for resident to get showers because it helped with their health and mental status. CNA A stated if the resident was a diabetic that the charge nurse was supposed to trim and clean the resident's nails. CNA A stated if the resident was not a diabetic that the CNAs were responsible for trimming and cleaning the resident's nails. CNA A stated she was not aware of Resident #58 nails being long and having a black substance underneath his nails. CNA A stated, It was important to ensure the residents nails were timed and cleaned because its dirty, the resident hands goes to their mouth, and it can cause skin tears and infection control. During an interview on 2/26/25 at 1:06 p.m., the ADON stated she had been employed at the facility for 3 weeks. ADON stated she was not aware of the showers not being provided to the residents. ADON stated she was not aware of Resident #58's nails not being trimmed. ADON stated in-services were completed a few weeks agoand she could not remember the exact date. ADON stated she had no knowledge of Resident #70 ever refusing her showers. ADON stated she had no knowledge of Resident #58 refusing nail care in the past. ADON stated CNAs could trim nondiabetic residents and RN staff could trim the diabetic residents' nails. ADON stated the DON oversaw her. ADON stated she oversaw the CNA's, charge nurse and shower aides. ADON stated it was important for ADL care to be provided to the residents for appearance and because she did not want the residents to feel unclean. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25 at 1:19 p.m., the Administrator stated she was not aware of the residents not getting their shower and fingernails were not being trimmed. The Administrator stated the last in-service on ADL's was conducted today (2/26/25). The Administrator stated Resident #70 had refused care in the past when she first admitted because she was very ill. The Administrator stated since Resident #70's family member talked with Resident #70 that Resident #70 had not refused care. The Administrator stated Resident #58 had never refused care. The Administrator stated the DON oversaw the nursing department. The Administrator stated the DON and herself were responsible for ensuring the residents received ADL care. The Administrator stated, It was important to ensure the residents received ADL care so the resident was healthy and so the residents would not decline medically. During an attempted interview on 2/26/25 at 1:31 p.m., the Shower Aide was unavailable for an interview at the facility. Record Review of the facility's Resident Rights policy, undated, indicated, the resident has a tight to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy. A facility must treat each resident with respect and dignity and care for each resident in a manner. and m an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. The facility will provide the Resident Rights to each newly admitted resident and upon any revision to the Resident Rights to each resident and/or resident representatives. The facility did not provide a policy on ADL care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46892 Based on observations, interviews, and record reviews the facility failed to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Resident #47) reviewed for accidents and supervision. The facility failed to ensure razors were not kept in Resident #47's bathroom. This failure could place residents at an increased risk for injury. Findings included: Record review of Resident #47's face sheet dated 02/27/2025 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (deterioration of memory, language, and other thinking abilities without behaviors). Record review of Resident #47's Quarterly MDS assessment dated [DATE], indicated she was rarely/never understood and rarely/never understood others. The MDS assessment indicated Resident #45's BIMS score was 0, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #47 was dependent on staff for all ADLs. Record review of Resident #47's care plan last reviewed 02/25/2025 indicated she had impaired cognitive function or impaired thought processes. Resident #47's care plan indicated she had an ADL self-care performance deficit and required assistance of 2 staff for bathing. During an attempted interview on 02/24/2025 at 11:13 AM, Resident #47 was non-interviewable. During an observation on 02/26/2025 at 9:41 AM, there were multiple razors in Resident #47's bathroom in a plastic bag hanging off the handrail. During an interview on 02/26/2025 at 2:07 PM, CNA Y said she did not think the residents were supposed to keep razors in their rooms. CNA Y said she was not aware Resident #47 had razors in her bathroom. CNA Y said Resident #47 was on hospice and maybe the hospice left them in her bathroom or maybe the razors were her family members. CNA Y said razors should not be in the residents' rooms because they could cut their skin. During an interview on 02/26/2025 at 3:15 PM, Hospice Aide O said she did not know Resident #47 had razors in her bathroom. Hospice Aide O said she had just started shaving Resident #47 on Monday (02/24/2025). Hospice Aide O said she did not think it would be okay for the residents to have razors in their bathrooms because anybody could go in the room and use them and get the blade. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/2025 at 5:16 PM, the ADON said she would have to find out what the policy was on the residents having razors in their rooms. The ADON said the residents having razors in their rooms could be a safety issue. During an observation and interview on 02/27/2025 at 5:22 PM, LVN P said she was not aware Resident #47 had razors in her bathroom. LVN P and the state surveyor went to Resident #47's bathroom and there were multiple razors in a bag hanging off the handrail in Resident #47's bathroom. LVN P said hospice may have brought the razors and left them in the bathroom, but the residents should not have them. LVN P said the CNAs should be checking the residents' rooms for any razors and removing them. LVN P said the residents could cut themselves or be at risk for bleeding and bleeding out. During an interview on 02/27/2025 at 5:48 PM, the Regional Compliance Nurse said the residents should not have razors in their room. The Regional Compliance Nurse said anybody that went into the residents' rooms should be monitoring for the residents not to have razors in their rooms. The Regional Compliance Nurse said the staff reported the razors could have been Resident #47's family members, but the razors should not be left in the resident's bathroom. The Regional Compliance Nurse said razors should not be kept in the residents' rooms because they were hazardous. During an interview on 02/27/2025 at 6:09 PM, the Administrator said she would like for the razors to be kept in the shower room. The Administrator said the residents should not have razors in their rooms. The Administrator said when management did their champion rounds and the nurse aides should be looking to ensure the residents did not have razors in their rooms. The Administrator said it was important for the residents not to keep razors in their room so they could not hurt themselves or cut themselves. Record review of the facility's Resident Admission Packet Form #21a, added May 6, 2004, titled, Nursing Home List of Items Not Allowed in Resident Room (This list is not all inclusive), indicated, .Safety Hazards . Razors and blades .

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46892

Based on observation, interview, and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 3 of 4 residents (Resident #9, Resident #29, and Resident #61) reviewed for respiratory care.

1. The facility failed to ensure Resident # 9's oxygen concentrator did not have a thin layer of white particles on it, and the vents did not have a thick layer of a gray fuzzy material on them.

2. The facility failed to ensure Resident #61 oxygen concentrator filter was clean on 02/24/2025 and 02/27/2025.

3. The facility failed to ensure Resident #29 oxygen concentrator filter was clean on 02/24/2025.

These failures could place residents requiring respiratory care at risk for shortness of breath, respiratory distress, or complications.

Findings included:

1. Record review of Resident #9's face sheet dated 02/27/2025 indicated Resident #9 was an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included acute on chronic combined systolic and diastolic congestive heart failure (the heart is not pumping blood efficiently which results in fluid buildup in the lungs and body) and chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow in the lungs).

Record review of Resident #9's Comprehensive MDS assessment dated [DATE] indicated she was understood by others and understood others. The MDS assessment indicated Resident #9's BIMS score was an 8, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #9 used oxygen while at the facility.

Record review of Resident #9's Order Summary Report dated 02/26/2025 indicated she had an order for may use oxygen at 2-4 liters per minute via nasal canula with a start date of 12/03/2024. Resident #9's Order Summary Report did not address care of the oxygen concentrator.

Record review of Resident #9's care plan last reviewed 12/23/2024 indicated she had oxygen therapy at 2-4 liters per minute via nasal canula as needed. Resident #9's care plan did not address care of the oxygen concentrator.

During an observation and interview on 02/24/2025 at 10:00 AM, Resident #9 had oxygen at 4 liters per minute via nasal canula, and her oxygen concentrator had a thin layer of white particles on it and the vents had a thick layer of a gray fuzzy material on it. Resident #9 said she guessed the staff cleaned it (the concentrator) when they put water in it.

During an observation on 02/26/2025 at 8:59 AM, Resident #9's oxygen concentrator had a thin layer of white particles on it and the vents had a thick layer of a gray fuzzy material on them.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 02/27/2025 starting at 8:28 AM, LVN P said the night shift was responsible for cleaning the oxygen concentrators and changing the nasal canula tubing. LVN P said she had checked Resident #9's oxygen settings in the morning, and she had not noticed the concentrator was not clean. LVN P along with the state surveyor went to check Resident #9's oxygen concentrator. Resident #9's oxygen concentrator still had a white layer on it and thick layers on the vents of gray fuzzy material. LVN P said Resident #9's oxygen concentrator should have been cleaned. LVN P said Resident #9's oxygen concentrator having the white layer and gray fuzzy material could cause it to overheat, and then the resident could desat (oxygen levels go low). LVN P said it could also cause upper respiratory infections, and allergies. During an interview on 02/27/2025 at 9:05 AM, the Housekeeping Supervisor said he conducted champion rounds (daily rounds made to check with the resident and the residents' rooms) on Resident #9, and at times he had noticed the oxygen concentrator was dirty. The Housekeeping Supervisor said housekeeping should clean the concentrators and make sure the tubing was not on the floor. The Housekeeping Supervisor said, he may not have caught Resident #9's oxygen concentrator having gray fuzzy material on the vents and a white layer on it. The Housekeeping Supervisor said it was important for the oxygen concentrators to be clean for the resident's health. 45879 2. Record review of Resident #61's face sheet, dated 01/29/25 indicated she was an [AGE] year-old female admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included Respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body), Dementia (memory loss), and diabetes. Record review of Resident #61's quarterly MDS assessment, dated 12/04/24, indicated Resident #61 usually understood and was understood by others. The MDS assessment indicated she had a BIMS score of 03 indicating she was severely cognitively impaired. Resident #61 required total assistance with bathing, toileting, dressing, bed mobility, personal hygiene, and eating. The MDS indicated she required oxygen. Record review of Resident #61's physician's order dated 10/04/24 indicated: May have Oxygen at 2-4 liters per minute as needed for shortness of breath to keep sats above 90%. Record review of Resident #61's comprehensive care plan, dated 01/20/25, indicates Resident #61 required oxygen therapy related to ineffective gas exchange. The intervention of the care plan was for staff to administer oxygen as ordered and change the resident's position every 2 hours to facilitate lung secretion movement and drainage. During an observation on 02/24/25 at 10:34 a.m., revealed Resident #61 was lying in her bed with oxygen at 3 liters per nasal cannula. Resident #61 had some grey-like substance on her concentrator filter. During an observation and interview on 02/27/25 at 1:48 p.m., revealed Resident #61 was lying in her bed with oxygen tubing placed in her nose. LVN G came into the room and verified her oxygen concentrator filter was dirty. She said the concentrator was supposed to be cleaned on the Sunday night shift. She said the filters should be cleaned to prevent infection control issues. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47612 3. Record review of a face sheet dated 02/27/2025 indicated Resident #29 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #29 was usually able to understand others and was usually understood by others. The MDS assessment indicated Resident #29 had a BIMS score of 13, which indicated her cognition was intact. The MDS assessment indicated Resident # 29 required oxygen. Record review of Resident #29's care plan date initiated 12/31/2024 indicated she had oxygen therapy with settings for oxygen via nasal cannula at 3 liters per minute. Record review of Resident #29's Order Summary Report dated 02/27/2025 indicated oxygen at 2 liters per minute via nasal cannula every shift. During an observation and interview on 02/24/2025 at 1:30 p.m., revealedResident #29 was lying in bed wearing her oxygen via nasal cannula. Resident #29s oxygen was set at 3 liters per minute with gray fuzzy material on oxygen concentrator filter. Resident #29 stated she did not know if the nursing staff cleaned the filter on her oxygen concentrator or not. During an interview on 02/27/2025 at 9:55 a.m., LVN Q stated the nursing staff was responsible for cleaning the oxygen concentrator and changing the tubing on Sunday nights. LVN Q stated it was important to make sure the oxygen concentrators were clean to decrease the risk of infection. LVN Q stated the risk to the resident was possible respiratory infection. During an interview on 02/27/2025 at 4:20 p.m., the ADON stated she had only worked at the facility for three weeks. The ADON stated she did not know who was responsible for cleaning the oxygen concentrators or when they should be cleaned, and she would have to refer to the policy. The ADON stated it was important for the oxygen concentrators to be cleaned to reduce the risk of infection. The ADON stated the harm to the resident could be infection of the respiratory system. The ADON she would monitor by doing check offs. During an interview on 02/27/2025 at 4:38 p.m., the Administrator stated the night shift nursing staff was responsible for cleaning the oxygen concentrators and changing the tubing on Monday, Wednesday, Friday nights. The Administrator stated it was important to clean oxygen concentration and change the tubing to prevent respiratory infections. The Administrator stated the harm to the was possible pneumonia or bronchitis. The Administrator stated she would monitor by doing in-service with the nursing staff, champion rounds, and spot check with the DON. During an interview on 02/27/2025 at 4:50 p.m., the Maintenance Supervisor stated the nurse was responsible for cleaning the oxygen concentrator filters until about six months ago then it became maintenance responsibility. The Maintenance Supervisor stated he had an app on his phone from the facility that told him to clean the oxygen concentrator filters monthly. The Maintenance Supervisor stated he did not know why it was important to clean the oxygen concentrators filters unless it was to keep the oxygen pure. The Maintenance Supervisor stated he guessed if the filters were not clean, they could cause the resident to have a respiratory infection. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/27/2025 at 5:15 p.m., the Regional Compliance Nurse stated it was the nursing staff's responsibility to clean the oxygen concentrator, filters and change out the tubing weekly. The Regional Compliance Nurse stated it was important to clean the oxygen concentrator, filters and change out the tubing weekly to prevent respiratory infections. The Regional Compliance Nurse stated she would monitor by in-service on responsibility and assigning a monitoring tool to the night shift. Record review of the facility's undated policy titled, Oxygen Administration, revealed The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen. The resident will maintain an effective breathing pattern with administration of oxygen. The resident will be free from infection Oxygen concentrators should be cleaned according to manufacture recommendations. Change or clean oxygen concentrator filters according to manufactures recommendations.

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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** 47612 Based on interviews, 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 2 of 23 residents (Resident # 20 and Resident # 26) reviewed for pharmacy services. The facility failed to ensure Resident #20's blood pressure met the parameters for the administration of an anti-hypertensive medication on 02/06/2025 and on 02/08/2025. The facility failed to ensure Resident #26's blood pressure met the parameters for the administration of an anti-hypertensive medication on 01/12/2025, 01/25/2025, 01/30/2025, 02/08/2025 and on 02/20/2025. These failures could place residents at risk of serious harm, not receiving their medications as ordered, illnesses, hospitalization s, and exacerbation of their disease processes. Findings included: 1.Record review of the face sheet dated 02/26/2025, indicated Resident #20 was an [AGE] year-old female admitted to the facility on [DATE], with diagnoses which included Alzheimer's disease (a progressive, neurodegenerative disorder that affects memory, thinking, and behavior), bradycardia, unspecified (a slow heart rate without a known underlying cause), hypertensive urgency (a condition where blood pressure was significantly elevated). Record review of Resident #20's comprehensive MDS assessment dated [DATE], indicated Resident #20 had a BIMS score of 03, which indicated severe cognitive impairment. Record review of the care plan dated 02/25/2025, indicated Resident #20 was at risk for hypertension with interventions: Give anti-hypertensive medications as ordered. Observe for side effects such as orthostatic hypotension (a condition where blood pressure drops significantly when a person stands up from a sitting or lying position), and increased heart rate (Tachycardia) and effectiveness. Observe for and document any edema (swelling caused by fluid trapped in your body's tissues). Notify Medical Doctor. Observe, document, report any signs and symptoms of malignant hypertension: headache, visual problems, confusion, disorientation, lethargy, nausea and vomiting, irritability, seizure activity, difficulty breathing (Dyspnea). Record review of the order summary dated 02/07/2025, indicated Resident #20's Hydralazine 25 mg give one table by mouth two times a day related to essential primary hypertension. Hold if systolic blood pressure (the pressure in the arteries when the heart contracts and pumps blood throughout the body. It is the upper number in a blood pressure reading), less than 110 or diastolic (the pressure in the arteries when the heart is at rest between heartbeats. It is the lower number in a blood pressure reading) less than 60 or heart rate less than 55. Record review of the Medication Administration Record dated February 2025 indicated on: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/06/2025 blood pressure was 137/56, and the heart rate was 52, Hydralazine 25 mg was administered by MA T at 9:00 a.m. 02/08/2025 blood pressure was 152/54, and the heart rate was 52, Hydralazine 25 mg was administered by MA T at 9:00 a.m. 2.Record review of the face sheet dated 02/26/2025, indicated Resident # 80 was an [AGE] year-old female admitted to the facility on [DATE], with diagnoses which included paroxysmal atrial fibrillation (a type of irregular heartbeat that starts and stops suddenly), chronic diastolic (congestive) heart failure (a condition where the left ventricle of the heart becomes stiff and cannot relax properly between beats, leading to a buildup of fluid in the lungs and other symptoms of heart failure), unspecified dementia (a condition where a person exhibits symptoms of dementia but the specific underlying cause cannot be determined). Record review of Resident # 26's comprehensive MDS assessment dated [DATE], indicated Resident #26 had a BIMS score of 06, which indicated severe cognitive impairment. Record review of the care plan dated 02/18/2025, indicated Resident #26 hypertensive medications were not mentioned. Record review of the order summary dated 02/26/2025, indicated Resident #26's Losartan 50 mg give one table by mouth one time a day for hypertension. Hold if systolic blood pressure less than 110 or diastolic less than 60 or heart rate less than 60. Metoprolol 50 mg give one table by mouth one time a day for hypertension. Hold if systolic blood pressure less than 110 or diastolic less than 60 or heart rate less than 60. Record review of the Medication Administration Record dated February 2025 indicated on: 01/12/2025 blood pressure was 130/59, Losartan 50 mg and Metoprolol 50 mg was administered by MA T in the a.m. 01/25/2025 blood pressure was 113/58, Losartan 50 mg and Metoprolol 50 mg was administered by MA T in the a.m. 01/30/2025 blood pressure was 144/58, Losartan 50 mg and Metoprolol 50 mg was administered by MA T in the a.m. 02/08/2025 blood pressure was 127/59, Losartan 50 mg and Metoprolol 50 mg was administered by MA T in the a.m. 02/20/2025 blood pressure was 127/59 and heart rate was 57, Losartan 50 mg and Metoprolol 50 mg was administered by MA T in the a.m. During an interview on 02/26/25 at 12:27 p.m., MA T stated she should have held the medication but when the reading was close to the parameter, she would give the medication and notify the nurse. MA T stated it was important to stay inside the doctor's ordered parameters for the safety of thee resident. MA T stated the harm to the resident was the resident could end up in the hospital. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/25 at 12:40 p.m., LPN P stated the MA should have held the medication and notified the nurse. LVN P stated it was the MA's responsibility to notify the nurse if the blood pressure was to low to give the blood pressure medication. LVN P stated it was important to hold the blood pressure medication because it could cause the blood pressure and the heart rate to drop to low. LVN P stated when blood pressure medication was given and the residents blood pressure was already low it could cause the resident to become dizzy. During an interview on 02/27/25 at 4:20 p.m., the ADON stated the MA should have held the medication and went and told her charge nurse. The ADON stated it was the MA's responsibility to notify the charge nurse if the resident's blood pressure was outside to the ordered parameters. The ADON stated it was important because the physician put the blood pressure parameters in place for a reason. The ADON stated the risk to the resident could be cardiac arrest. The ADON stated she did a one-on-one in-service with all the MA's and nurses. During an interview on 02/27/25 at 4:38 p.m., the Administrator stated if the resident's blood pressure was out of the ordered parameters the MA should have held the medication and reported to the charge nurse. The Administrator stated it was important to hold the medication because the blood pressure was not therapeutic. The Administrator stated the harm to the resident was a possible adverse reaction. During an interview on 02/27/25 at 5:10 p.m., the Regional Compliance Nurse stated the MA was responsible for notifying the charge nurse of the resident's blood pressure reading and the charge nurse could take it from there. The Regional Compliance Nurse stated it was important not to give blood pressure medication outside of parameters because it could make the blood pressure drop to low. The Regional Compliance Nurse stated the ADON did one on one in-service with the MA's and nurses. The Regional Compliance Nurse stated they would monitor in morning meetings. Record review of the facility's undated policy titled, Medication Administration, revealed when ordered or indicated, include specific items to monitor (e.g., blood pressure, pulse, blood sugar, weight), frequency (e.g., weekly, daily), timing (e.g., before or after administering the medication), and parameters for notifying the physician.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 45879 Based on observations, interviews, and record review, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 4 of 23 (Residents #64, #38, #12, and #13) residents and 1 of 3 meals reviewed. The facility failed to provide palatable food served at an appetizing temperature or taste to Resident #64, Resident #38, Resident #12, and Resident #13, who complained the food was bland and did not taste good. The dietary staff failed to provide food that was palatable for 1 of 3 meals observed on 02/25/25 (lunch) meal. This failure could place residents at risk for weight loss, altered nutritional status, and diminished quality of life. Findings included: During an interview on 02/24/25 at 10:39 a.m., Resident #64 said the food was too salty. During an interview on 02/24/25 at 10:58 a.m., Resident #38 said sometimes the food was not fully cooked; like this morning (02/24/25) the breakfast croissants were not cooked all the way because the bread was doughy. She also said the ham and beans had a lot of salt in them. During an interview on 02/24/25 at 11:45 a.m., Resident #12 said the kitchen needed a new cook. She said she did not like the food because it tasted like garbage and was inedible. During an interview on 02/24/25 at 2:17 p.m., Resident #13 said the food did not have any flavor and it did not look good. During a confidential group interview on 02/25/25 at 10:00 a.m., the confidential group said the food was pitiful, horrible, and it did not have any taste, it was just bland. They also said some of the cooks used too much spice, which made it too spicy. During an observation and interview on 02/25/25 at 12:34 p.m., the Dietary Manager and four surveyors sampled a lunch tray. The sample tray consisted of meat loaf with barbeque sauce, which was good and warm. The garlic mashed potatoes were good and warm. The green bean casserole was bland. The Dietary Manager said she felt all the food tasted good and was at a good temperature. During an interview on 02/26/25 at 2:00 p.m., the Dietician said she was aware of a few food complaints in the past, but the kitchen staff were doing much better. The Dietician said she had a test tray this month. The Dietician said the dietary cook was responsible for ensuring the residents received food that was palatable and the appropriate temperature. The Dietician said the Dietary Manager's responsibility was to follow up to ensure the food was palatable and temperatures were correct. The Dietician said it was important for the residents to receive food that was palatable and the appropriate temperature for nutritional status. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/25 at 2:22 p.m., the Dietary Manager said she had a lot of food complaints when she started working at the facility about seven months ago. She said they had changed up the menu some to accommodate for the residents. She said she still had food complaints about the food, either being too bland or too spicy, but she tried to make alternate choices as much as she could. The Dietary Manager said if the food did not look and taste appetizing, the residents would not eat it and it could cause weight loss. During an interview on 02/25/25 at 11:40 a.m., [NAME] W said she had never had any food complaints. [NAME] W said she tried to taste the food to ensure it was seasoned correctly. [NAME] W said it was important for the meals to be appetizing and tasty because otherwise the residents would not want to eat it. During an interview on 02/27/25 at 5:12 p.m., the Administrator said they have had food complaints, but they started a food committee and things were better. She said she ate out of the kitchen often and the food was good to her. She said if the food were not good or appealing, it could cause a resident not to eat it and potentially lead to weight loss. Record review of the policy titled, Preparation of Foods from the Dietary Services Policy & Procedure Manual 2012 indicated, We will establish safe and nutritional preparation of food. Food is to be prepared in such a manner as to maximize flavor, appearance, and nutritional value. Procedure. All food will be prepared by methods that preserve nutritive value, flavor, and appearance with a variety of color, and will be attractively served at the proper temperature and in a form to meet the individual needs of the resident. The Dietary Service Manager and cooks will taste and test meals daily. The administrator and DON may taste test meals if requested.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interviews and record review, the facility failed to conduct and document a facility-wide assessment to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies for 1 of 1 facility reviewed for facility assessment. The facility failed to ensure they followed the assessment information about the level of staff needed to meet each resident's needs. This failure could place residents at risk of inadequate care or treatment. Findings Included: A record review of the facility's CMS 802 Resident Matrix dated 02/24/25 revealed the facility census to be 72 residents. During a record review of the facility's assessment dated [DATE] and reviewed by QAPI on 08/21/24, revealed the staffing ratio was for the facility to have 5 aides for 6 am-2 pm, 4 aides for the 2 pm-10 pm, and 4 aides for the 10 pm-6 am shift. During a record review of the Resident's roster given by the Administrator on 02/24/25, it indicated Hall A had 19 residents, Hall B had 20 residents, Hall C had 16 residents, and Hall D had 18 residents. During a record review of the facility's Payroll-Based Journal, also known as PBJ (a system that nursing homes use to report staffing information to the Centers for Medicare and Medicaid Services), Staffing Data Report for Quarter 4 2024, dated July 1 through September 30, indicated they had a 1-star staff rating. During an interview on 02/25/25 at 1:15 p.m., the Administrator said they had completed the facility assessment on 07/24/24 and it was the latest assessment done. She said all the information contained in the book was correct. During an interview on 02/26/25 at 3:00 p.m., CNA M said she worked the 2 pm-10 pm shift. She said they usually had 3 aides and it was hard to get everything done. During a phone interview on 02/26/25 at 3:45 p.m., CNA B said she worked 6 a.m.- 2 p.m. She said most days, they had 3 aides. She said they had 4 halls, and each aide would take a full hall, and then they would split the fourth hall. She said one aide took hall A, one aide took hall C, the other aide took hall D, and they split hall B. She said they worked hard but did not feel they gave the residents the care they deserved. During an interview on 02/26/25 03:00 p.m., CNA M said she worked the 2 pm-10 pm shift. She said they usually had 3 aides and it was hard to get everything done. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/25 05:11 p.m., LVN G said she worked 6 am- 6 pm and they had 3 aides most days on her 6 am-2 pm and 2 pm-6 pm shifts. She said it was hard some days, but they were able to get things done. During an interview on 02/26/25 10:19 p.m., CNA E said he had been working at the facility about 2 years. He said he worked the 10 pm-6 am shift. He said they usually had 2-3 aides on his shift. He said when they had 2-3 aides it was very hard, and he felt they did not attend to every resident like they needed to. He said in other words, he could not make rounds every 2 hours like they should have been doing. He said the nurses tried to help when they could, but they were busy doing their work. He said sometimes it took them a while to answer the call lights because they were so busy. He said they had worked with 2-3 aides for the past 4-5 months. He said when there were 2 aides it was extremely hard, but they did the best they could. He said management would tell him they had no applications. He said the DON was aware and nothing had changed. During an interview on 02/26/25 10:42 p.m., CNA C said she had worked at the facility for 6 months. She said she worked the 10 pm-6 am shift. She said most nights they had 2-3 aides, and only a handful of times they had 4 aides. She said when they had 2-3 aides, it was hard, and she said they could not make every 2-hour rounds like they should have been doing. She said call lights would stay on for long periods because they were busy helping other residents. She said they did answer the call lights as soon as they could. She said 1 night she was the only aide after the DON left about midnight. She said management was aware of how many staff they had to help the residents, but nothing had changed yet. During an interview on 02/26/25 10:49 p.m., CNA F said she had been employed at the facility about 6-7 months. She said she worked the 10 pm-6 am shift. She said they usually had 2-3 aides on her shift. She said tonight (02/26/25) they had 4 because a PRN person came to work. She said when CNA E was on the schedule, there were only 2 aides most nights because they had not hired anyone for that rotation. She said when they had 2 aides, things were not getting done like rounding every 2 hours or answering call lights timely. She said when there were 3 aides, she felt she had time to better care for the residents, but it was still hard. She said she did the best she could each day she worked. She said she had not personally said anything to management but said management was aware of the staffing issue and nothing had changed. During an interview on 02/26/25 at 10:55 p.m. LVN K said she was the charge nurse for the 10 pm-6 am shift. She said they usually had 3 aides on her shift, sometimes 2 aides. She said it was hard when they had 2-3 aides, but she did help the aides and they got things done. During an interview on 02/27/25 09:20 a.m., MA N said she had been working at the facility for over 5 years. She said she usually worked 6 am- 8 pm as the medication aide. She said she was sometimes late with her morning medications because they did not have enough staff to help pass breakfast trays in the morning. She said she would stop passing her medications to help with breakfast because she thought nutrition was important. Record review of facility staff punch sheets revealed: On 02/01/25, the following aides: 4 on 6 am-2 pm, 3 on 2 pm-10 pm, and 3 on 10 pm- 6 am, On 02/02/25, the following aides: 3 on 6 am-2 pm, 3 on 2 pm-10 pm, and 3 on 10 pm- 6 am, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Springs Healthcare Center	2003 N Edwards St Mount Pleasant, TX 75455

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/03/25, the following aides: 4 on 6 am-2 pm, 4 on 2 pm-10 pm, and 3 on 10 pm- 6 am, On 02/04/25, the following aides: 3 on 6 am-2 pm, 4 on 2 pm-10 pm, and 2 on 10 pm- 6 am, On 02/05/25, the following aides: 3 on 6 am-2 pm, 4 on 2 pm-10 pm, and 3 on 10 pm- 6 am, On 02/09/25, the following aides: 2 on 6 am-2 pm, 3 on 2 pm-10 pm, and 2 on 10 pm- 6 am, On 02/10/25, the following aides: 4 on 6 am-2 pm, 4 on 2 pm-10 pm, and 2 on 10 pm- 6 am, On 02/15/25, the following aides: 3 on 6 am-2 pm, 3 on 2 pm-10 pm, and 3 on 10 pm- 6 am, On 02/16/25, the following aides: 3 on 6 am-2 pm, 3 on 2 pm-10 pm, and 2 on 10 pm- 6 am, On 02/22/25, the following aides: 4 on 6 am-2 pm, 4 on 2 pm-10 pm, and 2 on 10 pm- 6 am, On 02/23/25, the following aides: 3 on 6 am-2 pm, 3 on 2 pm-10 pm, and 3 on 10 pm- 6 am, During an interview on 02/27/25 at 5:42 p.m., the Administrator and the Area Director of Operations said the Administrator had pulled the wrong sheet about staffing and placed it in the facility assessment book. The Area Director of Operations said they did not used any type of staffing sheet. She said they used the PPD formula daily (PPD stands for Per Patient Day, and calculations are determined by the number of residents in a skilled nursing facility and the number of clinical staff caring for them during each shift) and not the spreadsheet that was in the facility's assessment book. The Administrator said she was unaware she pulled the wrong sheet and placed it in the facility's assessment binder. She said they were supposed to be using the PPD formula and her PPD was supposed to be 3.0. She said she was using the PPD formula based off the staffing sheets and the punch sheets to ensure she had the correct number of staff daily. She said the software she was using would let her know if she was using enough staff per day. The Administrator said she could not let the surveyor see the software to verify what she was saying. The Administrator said she was not using the correct sheet related to staffing in the facility assessment binder. (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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled, Facility Assessment, dated 11/2017, indicated, Purpose: The Facility Assessment a complete review of internal human and physical resources required by the facility to care for residents competently during day to day and emergency operations. The facility assessment identifies our capabilities as a skilled nursing services provider. The Facility Assessment will be the basis for surveyors to ascertain whether you are prepared to competently take care of the population you have identified that you serve. There are three components to the review: 1. Resident profile including numbers, diseases/conditions, physical and cognitive disabilities, acuity, and ethnic/cultural/religious factors that impact care 2. Services and care offered based on resident needs (includes types of care your resident population requires; the focus is not to include individual level care plans in the facility assessment) 3. Facility resources needed to provide competent care for residents, including staff, staffing plan, staff training/education and competencies, education and training, physical environment and building needs, and other resources, including agreements with third parties, health information technology resources and systems, a facility-based and community-based risk assessment, and other information that you may choose. Guidelines for Conducting the Assessment: 2. The facility must review and update this assessment annually or whenever there is/the facility plans for any change that would require a modification to any part of this assessment. For example, if the facility decides to admit residents with care needs who were previously not admitted , such as residents on ventilators or dialysis, the facility assessment must be reviewed and updated to address how the facility staff, resources, physical environment, etc., meet the needs of those residents and any areas requiring attention, such as any training or supplies required to provide care.