STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455565	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palestine Healthcare Center	1816 Tile Factory Rd Palestine, TX 75801

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49017 Based on interview and record review, the facility failed to notify the resident's physician and responsible party when there was a significant change in the physical status for 1 of 14 residents (Resident #15) reviewed for notification of changes. The facility failed to ensure that the physician and the responsible party was notified of resident #15's change in condition when the resident experienced a choking incident on 4/1/2024. An IJ was identified on 04/04/2024. The IJ template was provided to the facility on [DATE] at . While the IJ was removed on 04/05/2024, the facility remained out of compliance at a scope of isolated and severity of no actual harm with the potential for more than minimal harm because of continued monitoring the effectiveness of the corrective systems. This deficient practice could place residents at risks for a delay in medical treatment, which could lead to worsening of their condition, hospitalization , or death. The findings include: Review of resident #15 face sheet reflect that he is an [AGE] year-old male admitted on [DATE]. His diagnosis include unspecified dementia with other behavioral disturbances (dementia is characterized by a decline in cognitive abilities that impacts a person's ability to perform everyday activities and behavioral disturbances can include verbal or physical aggression, incontinence, agitation, sleep disturbances or changes in appetite), dysphagia, oropharyngeal phase (a swallowing disorder that affects the mouth and throat characterized by difficulty initiating a swallow, coughing, choking or aspiration.) , cognitive communication deficit (difficulty with communication that is caused by a problem with thinking), and gastro-esophageal reflux disease (when stomach acid repeatedly flows back into the tube connecting your mouth and stomach). Record review of resident#15 Quarterly MDS dated [DATE], indicated that the resident had a BIMS score of 06, indicating severely impaired cognition. It indicated that resident requires substantial/maximal assistance with eating (helper does not than half the effort) and that he is dependent on staff for all activities of daily living. (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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the care plans for resident #15 dated 4/1/2024 indicated that resident had the potential for weight loss related to dementia, feeding difficulties. Diet change was noted in care plan on 4/1/2024 for dysphagia puree with thickened liquids and on 4/2/2024 dysphagia puree with nectar thickened liquids. Nursing approaches included provide physical help assistance for meals dated 12/21/2023. Resident also has a care plan dated 3/27/2024 for risk for respiratory distress related to history of aspiration pneumonia (an infection of the lungs caused by inhaling saliva, food, liquid, or vomit). Record review of nurse's progress notes dated 4/1/2024 at 08:02 AM entered by LVN A, indicated that the resident had choked on every single bite of food .at breakfast the nurse charted that the MDS coordinator gave the OK to downgrade the residents diet to pureed with thickened liquids until speech can assess the resident. There was not any documentation that resident primary care provider was notified of incident and no documentation of responsible party notified. During dining room observation on 4/1/2024 at 12:00 PM, resident #15 was observed sitting at a table alone. Staff served resident his meal that was pureed and thickened liquids, the tray card indicated that resident diet was correct. Observed resident #15 feeding himself without staff assistance or verbal cueing. Resident remained at the dining room table alone. Staff assisted resident out of dining room when he finished eating. During dining room observation on 4/2/2024 at 8:30 AM and 12:00 PM, resident #15 was observed sitting at table alone, staff served his meal and resident ate both meals without assistance and verbal cueing. Resident was observed eating quickly, taking large bites of pureed food, and occasionally coughing when he swallowed. During an interview on 4/3/2024 at 2:30 PM, MDS coordinator said she was an LVN. She said she was in the facility on 4/1/2024 during the time that resident #15 was eating his breakfast. She said that LVN A reported to her that the resident was choking and coughing during breakfast, and she instructed her to change his diet to pureed with thickened liquids until speech therapy could evaluate him. She said that nurses are allowed to downgrade resident diets if needed. She said that the doctor should have been notified and that the nurse should have documented notification in the nurse's progress notes. She said that the resident has a history of eating too fast and requires staff to remind him to slow down when eating. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/4/24 at 2:47 PM, the DOR said she was a COTA. She said she was present on 4/1/2024 in the dining room when Resident #15 was eating. She said I feel like the nurses note is an over exaggeration. He was not choking. She said that the resident takes large bites and swallows his food without chewing. She said that the resident eats too fast. Prior to the pureed diet, the resident was on a mechanical soft diet with thin liquids. She said that the resident was put on the mechanical soft diet after a modified barium swallow (an analysis of swallowing) was done in November 2023. She said that the resident was scheduled for the speech therapist to evaluate on Friday (4/5/2024) or Monday (4/8/2024). She said that the speech therapist was in the facility daily but had not evaluated the resident yet because it would take treatment time from residents that are already scheduled. She said that she educated the nurse on Monday, 4/1/2024 during breakfast. She said that because the nurse was a traveler, she was not familiar with the resident. She said that the resident was not choking on every bite and that the resident was eating fast and cough one time after swallowing and would continue to eat and cough after each swallow. She said that she believed that she was able to recognize if the resident had aspirated (when food or liquid enters the lungs) due to her experience and familiarity with the residents. During an interview on 4/4/24 at 2:50 PM, LVN A said that she was an agency nurse and had only worked in the facility a few times. She said that she worked on Monday 4/1/2024 and Tuesday 4/2/2024. She said that on Monday, 4/1/2024 she was in in the dining room when Resident #15 was eating breakfast. She said that Resident #15 was eating scrambled eggs, hash browns, softened rice crispies cereal with milk. She said that the Resident #15 was choking on every bite that he consumed . She said that the resident was shoveling food into his mouth. She said that she made a nursing judgement and downgraded the resident's diet from mechanical soft to a pureed diet. She said that she spoke with the MDS Coordinator, and she had told her to downgrade his diet. She said that she thought that the MDS coordinator was going to notify the doctor and anyone else that needed to be notified. The nurse said that while the resident was coughing, he had a runny nose and watery eyes. During an interview on 04/04/24 at 4:42 PM , DON said that she would consider a medical emergency constituting immediate physician notification to include: a resident not breathing, bleeding profusely, having no pulse, unable to awaken, or anything that could constitute an immediate threat to life or anything that could cause a loss of life. During an interview on 4/4/24 at 4:52 PM, the NP said that the facility notified her earlier in the week and reported that Resident #15 was having difficulty swallowing. She said that she ordered a downgrade of diet at that time from a mechanical soft to a pureed diet and for speech to evaluate and treat as indicated . When asked if it was reported that Resident #15 was choking during his meal, she said No, if they would have reported choking while eating, I would have ordered a chest x-ray to rule out aspiration. The NP said that swallowing difficulties were the only thing reported. During an interview on 04/04/24 at 4:46 PM, LVN C said that she would consider a resident choking to be a medical emergency. During an interview on 4/5/2024 at 3:00 PM, the Regional Nurse said that the nurses in the facility were allowed to downgrade a resident's diet using nursing judgement. She said that the doctor and the speech therapy were involved in evaluating residents that have a change in condition like the ability to swallow. (continued on next page)

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F 0580

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

During an interview on 4/5/24 at 3:53 PM, the DON said that her expectations were that the charge nurse was to report any changes in the resident's baseline. She expected that significant changes as well as minor changes from baseline should be reported to the MD. She said that failure to notify the physician of any changes in condition could result in improper and or timely treatment for the resident.

During an interview on 4/5/24 at 4:26 PM, the Administrator said that his expectations were that the physicians are notified, the event was charted, the responsible party to be notified of changes in condition and any new orders, that the changes and any orders be placed on the 24-hour report. He expected that any changes be reported and discussed in the morning meetings. He said that failures to notify the doctor of changes in condition can result in the resident not getting the appropriate care.

Record review of the facility policy titled Change in a Resident's Condition or Status dated 4/20/2023, the policy statement is our facility promptly notifies the resident, his attending physician, health care provider and the resident representative of changes in the resident's medical condition and/or status. Policy interpretation and implementation included a significant change of condition is a major decline . that will not normally resolve itself without intervention by staff . and except in medical emergencies, notifications will be made within twenty-four hours of a change .

Record review of facility document titled Emergency Procedure- Choking revised March 2011 indicated report results promptly to the supervisor and attending physician.

This was determined to be an Immediate Jeopardy (IJ) on 4/4/2024 at 4:45PM. The facility's Administrator and Director of Regulatory Compliance were notified. The Administrator was provided with the IJ template on 4/4/2024 at 5:27 PM.

The plan of removal was accepted 04/05/2024 at 5:20 PM.

Plan of Removal:

580- Notification of Changes

Date Initiated: 4/4/2024

Today's Date: 4/4/2024

The facility failed to immediately consult with the resident's physician when Resident #15 who is aspiration risk had a possible choking incident.

All residents that can be at risk for aspiration can be affected by the alleged deficiency.

Action: Speech Therapist assessed Resident #15 on 4/4/2024 and notes no concerns and is evaluating resident to return to mechanical soft diet. Resident is upgraded to Mechanical Soft. Will continue to have Resident #15 on caseload.

Therapy to order a Modified Barium Swallow study on 4/5/2024.

(continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Sudden in onset OR a marked change (for example, much more severe or frequent) compared to usual (baseline) status, AND are b. Unrelieved by measures which have already been prescribed and/or attempted. For example, consistent with criteria a) and b) above, abdominal pain with distension or fever; chest pain, pressure or tightness; new or worsening confusion; new or progressive gait or balance problem; persistent severe headache; persistent or recurrent nausea and vomiting; new onset of slurred or incoherent speech; suicidal thoughts with expressed plan; abrupt or rapidly progressive vision changes; new onset weakness of an arm or leg. 4. The following signs: The following list of physical signs is not meant to be all-inclusive. Depending on the situation, other physical findings may warrant physician notification. a. Change in vital signs. Follow these general guidelines: Temperature >101 Degrees rectally, or the parameters indicated by the physician Respiratory rate >28/min or a lower rate with respiratory distress or the parameters indicated by the physician? Pulse >110 or <55/min or the parameters indicated by the physician Blood Pressure >210 or <90 systolic; or >120 diastolic or the parameters indicated by the physician? b. Sudden loss of consciousness. c. Seizure activity. d. More than minimal bleeding, for example: o Persistent nosebleed o Gross hematemesis o Bright red blood in stool (not due to known hemorrhoids) o Profuse vaginal bleeding o Gross hematuria e. Fall with an identified or suspected injury (e.g., fracture or laceration). f. New and/or severe gastrointestinal signs, including: o Prolonged and/or progressive nausea and vomiting o Painful, persistent abdominal distention (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	g. Sudden or rapid onset of new confusion, paranoia and delusions, and/or physical aggression, or progressive worsening of existing condition. h. New onset of, or progression of usual, tachypnea and dyspnea with a pulse oximetry below 90% or at least 3% below usual pulse oximetry range. Significant medication error a. If it involves a medication with significant side effects, risks, or adverse consequences. b. If the nature of the medication or severity of the reaction to the medication warrants discussion with the physician.5. Laboratory results a. Any lab result for which the physician requests immediate or STAT reporting. b. For guidance on reporting results, see Appendix B: Guidelines for Reporting Abnormal Test Results to Physicians and related to policy on Lab and Diagnostic Test Results: Physician Role and Follow-Up.? All Charge Nurses will be educated prior to working their next shift. Person(s) Responsible: Director of Nursing, Assistant Director of Nursing Date: 4/5/2024 by 1:30PM Action: Progress notes will be reviewed for the last 30 days to audit for any significant changes that the physician and/or the physician extender may have not been notified of. Any findings will be immediately reported to the physician and/or the physician extender, RP (if applicable) Person(s) Responsible: Director of Regulatory Compliance Date: 4/5/2024 by 12PM Action: Ad hoc QAPI performed with Medical Director and Nurse Practitioner, and they have been made aware of the template and plan to remove the immediacy. Person(s) Responsible: Administrator Date: 4/4/2024 by 7PM Surveyors monitored Plan of Removal as follows: Record review of nurses note dated 4/5/2024 notifying resident #15 physician and obtaining order for barium swallow study and notifying responsible party of the barium swallow study. Reviewed speech therapy note dated 4/4/2024. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of an inservice dated 4/5/2024 titled coughing/choking issues with 15 of 29 employee signatures. Record review of inservice dated 4/4/2024 titled Change of condition with 15 of 29 employee signatures. Received attestation statement by director of regulatory compliance indicating that progress notes were reviewed for significant changes dated 4/5/2024. Record review of an Adhoc QAPI: dated 4/4/2024 indicated the Administrator, DON, ADON, MDS, DM and Medical Director were in attendance. Interviews on 4/5/2024 from 3:18 PM to 4:52 PM included: Staff: LVN's- 5 RN's- 2 CMA's- 1 CNA's- 4 Administrator - 1 Interview on 4/5/2024 at 3:18 pm CMA B said that if a resident is coughing or choking during meals that she would make sure that the resident is safe and notify a nurse immediately. She said if she could not leave the resident she would call for help. Interview on 4/5/2024 at 3:38 pm DON said that she expected the staff to make sure any resident coughing or choking while eating is stable. She said that the charge nurse is responsible for ensuring the resident is stable and notifying the physician. She said the charge nurse should also notify nursing administration and the responsible party of the resident. She said that if there is a change in condition, the charge nurse is to assess the resident and the notify the physician, DON and ADON must be notified and documentation of notification should be done in the chart. She said that a change in condition are changes in residents established baseline. Interview on 4/5/2024 at 3:58 pm CNA K was able to verbalize that if a resident is coughing or choking during meals that she would make sure that the resident is safe and notify a nurse immediately. She said if she could not leave the resident she would call for help. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 4/5/2024 at 4:00 pm ADON said she expected the staff to make sure any resident coughing or choking while eating is stable. She said that the charge nurse is responsible for ensuring the resident is stable and notifying the physician. She said the charge nurse should also notify nursing administration and the responsible party of the resident. She said that if there is a change in condition, the charge nurse is to assess the resident and the physician and DON must be notified and documentation of notification should be done in the chart. She said that a change in condition are changes in residents established baseline. Interview on 4/5/2024 at 4:09 pm MDS verbalized that she expected the staff to make sure any resident coughing or choking while eating is stable. She said that the charge nurse is responsible for ensuring the resident is stable and notifying the physician. She said the charge nurse should also notify nursing administration and the responsible party of the resident. She said that if there is a change in condition, the charge nurse is to assess the resident and the physician, DON and ADON must be notified and documentation of notification should be done in the chart. She said that a change in condition are changes in residents established baseline. Interview on 4/5/2024 at 4:18 pm LVN L verbalized that if a resident is coughing or choking while eating or drinking she would make sure the resident is stable and breathing. She would tell the DON or ADON and call the physician or send the resident to the hospital depending on if the resident was having breathing difficulties. She said that she would document the event in the progress notes. She said that any changes in a residents condition is reported to the residents physician and the responsible party and that the DON and ADON are notified. She said that a change in condition is a change from the residents baseline. Interview on 4/5/2024 at 4:24 pm Administrator verbalized that he expects the charge nurse on duty to assess residents for any changes in conditions and that any changes be documented in the progress notes. He expects the charge nurse to notify the physician with any changes and the responsible party and document the contact and communication in the residents chart. He said that any changes in condition needed to be reported to the DON and ADON. Interview on 4/5/2024 at 3:17 pm LVN D said if a resident is coughing or choking while eating or drinking she would make sure the resident is stable and breathing. She would tell the DON or ADON and call the physician or send the resident to the hospital depending on if the resident was having breathing difficulties. She said that she would document the event in the progress notes. She said that any changes in a residents condition is reported to the residents physician and the responsible party and that the DON and ADON are notified. She said that a change in condition is a change from the residents baseline. Interview on 4/5/2024 at 3:19 pm CNA F said if a resident is coughing or choking while eating she would not give them any more to eat or drink and notify the charge nurse immediately. Interview on 4/5/2024 at 3:23 pm CNA J said if a resident is coughing or choking while eating she would not give them any more to eat or drink and notify the charge nurse immediately. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety 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** 46273 47339 49017 Based on observations, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs for 4 of 14 residents (Residents #15, Resident #24, Resident #25, and Resident #33) reviewed for care plans. On 4/1/24 the facility failed to implement care plan interventions for Resident #15 of providing physical help with meals and notifying MD of changes in abilities . On 4/2/24 the facility failed to implement care plan interventions for Resident #25 of their therapeutic diet of fortified foods during the lunch meal. On 4/3/24 the facility failed to implement care plan interventions for Resident #24 of required supervision and 1 person assistance with meals. The facility failed to implement care plan interventions for Resident #24 of weekly weights x4 weeks. Resident #24 was missing weekly weights on weeks of 1/22/24 and week of 2/5/24. The facility failed to implement care plan interventions for Resident #33 of weekly weights x4 weeks. Resident #33 was missing weekly weights on weeks of 2/12/24 and week of 2/26/24. These This failures could place residents in the facility at risk of not receiving the necessary care to meet their identified needs.nutritional needs. An Immediate Jeopardy (IJ) was identified on 04/04/2024 at 9:57 a.m. The IJ template was provided to the facility on [DATE] at 9:57 A.M. While the IJ was removed on 04/05/2024 at 05:20 p.m., the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy, because all staff had not been trained on weights, dietician recommendations, preferences versus orders, meal cards, the dietary process, pulling up resident profiles, and comprehensive care planning. Findings include: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455565	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palestine Healthcare Center	1816 Tile Factory Rd Palestine, TX 75801

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Review of resident #15 face sheet reflect that he is an [AGE] year-old male admitted on [DATE]. His diagnosis include unspecified dementia with other behavioral disturbances (dementia is characterized by a decline in cognitive abilities that impacts a person's ability to perform everyday activities and behavioral disturbances can include verbal or physical aggression, incontinence, agitation, sleep disturbances or changes in appetite), dysphagia, oropharyngeal phase (a swallowing disorder that affects the mouth and throat characterized by difficulty initiating a swallow, coughing, choking or aspiration.) , cognitive communication deficit (difficulty with communication that is caused by a problem with thinking), and gastro-esophageal reflux disease (when stomach acid repeatedly flows back into the tube connecting your mouth and stomach). Record review of resident#15 Quarterly MDS dated [DATE], indicated that the resident had a BIMS score of 06, indicating severely impaired cognition. It indicated that resident requires substantial/maximal assistance with eating (helper does not than half the effort) and that he is dependent on staff for all activities of daily living. Record review of the care plans for resident #15 dated 4/1/2024 indicated that resident had the potential for weight loss related to dementia, feeding difficulties. Diet change was noted in care plan on 4/1/2024 for dysphagia puree with thickened liquids and on 4/2/2024 dysphagia puree with nectar thickened liquids. Nursing approaches included provide physical help assistance for meals dated 12/21/2023. Record review of resident #15 physician orders with a start date of 4/02/2024 diet of dysphagia puree with nectar thick liquids. 2. Record review of a facility face sheet dated 4/2/24 for Resident #25 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] with diagnosis of dementia. Record review of a Quarterly MDS assessment dated [DATE] for Resident #25 indicated that Brief Interview for Mental Status should not be conducted due to resident being rarely/never understood. Question C1000 indicated that resident had severely impaired cognition. Record review of physician orders for Resident #25 indicated that she had the following order: Diet: Regular diet, fortified foods; Texture: Mechanical soft; Fluid consistency: Thin dated 2/2/24. Record review of a comprehensive care plan for Resident #25 dated 3/31/24 indicated that she had experienced weight loss and was to receive fortified food with all meals. Record review of Resident #25's weights located in her electronic medical record indicated that on 10/05/2023, the resident weighed 138.5 lbs. On 04/03/2024, the resident weighed 110.8 pounds which is a -20.00 % loss in 180 days. 3. Record review of a face sheet for Resident #24 dated 4/03/2024 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: Hemiplegia following cerebral infarction affect left non-dominant side (paralysis or partial or total body function on left side of the body), partial loss of teeth, abnormal weight loss, and cognitive communication deficit (difficulty with thinking and how someone uses language). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Palestine Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1816 Tile Factory Rd Palestine, TX 75801	

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a Quarterly MDS assessment dated [DATE] for Resident #24 indicated that he had a BIMS score of 14, indicating his cognition was intact. Section GG of same MDS assessment indicated that he had received setup or clean-up assistance with eating. Record review of a care plan dated 4/04/2023 for Resident #24 indicated had a problem with nutritional status with interventions that included: Weigh me at least once a month and weekly if I show a significant weight loss. Resident #24 had a problem with ADL's Functional Status/Rehabilitation Potential with interventions that included: Resident requires supervised assist-limited x1 with eating. Record review of facility weight variance report dated 9/01/2023 to 3/10/2024 revealed Resident #24's weights were: 10/05/2023- 241.4 11/02/2023- 243.2 12/05/2023- 248.6 01/03/2024- 210.0 indicating a 15.5% loss in 29 days. 01/18/2024- 215.6 01/25/2024- 214.0 02/01/2024- 218.2 03/03/2024- 218.2 4.Record review of face sheet for resident #33 indicated that he was a [AGE] year old male admitted on [DATE] with diagnosis of unspecified dementia (symptoms that affect memory, thinking and social skills), dysphagia, oropharyngeal phase (a swallowing disorder that affects the mouth and throat characterized by difficulty initiating a swallow, coughing, choking or aspiration.), cognitive communication deficit (difficulty with communication that is caused by a problem with thinking), and gastro-esophageal reflux disease (when stomach acid repeatedly flows back into the tube connecting your mouth and stomach). Record review of resident #33 significant change MDS dated [DATE] indicated that resident has a BIMS score of 14 indicating that he is cognitively intact. It indicated that he was independent with eating and required supervision or set up assistance with activities of daily living. Record review of care plan for resident #33 dated 01/30/2024 resident was care planned for undesired weight loss with approach of weekly weights. Nutritional status care plan of mechanically altered diet with ground meat. Care plan dated 3/13/2024 for fortified foods. Care plan for set up assistance with meals reviewed. Record review of resident #33's physicians orders dated 3/13/2024 diet order for fortified foods, mechanical soft with ground meat. Review of order dated 11/28/2023 to discontinue double portions. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of facility weight variance report dated 12/12/2023 to 3/3/2024 revealed resident #33 weights were: 12/12/2023- 233.0 1/3/2024- 184.00- indicating a 21.2% loss in 22 days. 2/1/2024- 204.00 indicating a 11.0% gain in 29 days. 2/19/2024- 197.00 3/3/2024- 196.8 Record review of facility weight variance report revealed that resident was not weighed weekly as ordered on 1/30/2024 with weight not obtained during the week of 2/12/2024 and 2/26/2024. During dining room observation on 4/1/2024 at 12:00 PM, resident #15 was observed sitting at a table alone. Staff served resident his meal that was pureed and thickened liquids, the tray card indicated that resident diet was correct. Observed resident #15 feeding himself without staff assistance or verbal cueing. Resident remained at the dining room table alone. Staff assisted resident out of dining room when he finished eating. During dining room observation on 4/2/2024 at 8:30 AM and 12:00 PM, resident #15 was observed sitting at table alone, staff served his meal and resident ate both meals without assistance or verbal cueing. Resident was observed eating quickly, taking large bites of pureed food and occasionally coughing when he swallowed. During an observation and interview on 4/2/24 at 12:30 pm Resident #25 was observed sitting up in wheelchair in dining room being assisted with lunch meal by staff member. Her tray card was observed to say fortified food but there was no fortified food with resident's meal. Dietary manager said that Resident #25's fortified food must have gotten missed. She went to kitchen and returned to dining room with a cup of fortified soup for Resident #25. During an observation on 4/03/2024 at 08:50 AM Resident #24 observed eating breakfast in room with door closed and no supervision or assistance. During an observation of Resident #24's lunch meal on 4/03/2024 at 12:00 PM revealed Resident #24 was pushed via wheelchair to the main dining room by therapy. Resident #24 requested a hamburger for lunch. The Administrator verbally communicated residents request to the dietary staff. Resident was served a hamburger with potato chips, yogurt, and fortified mashed potatoes. Resident #24 picked up hamburger and put the entire hamburger in his mouth at one time, he then started placing potato chips in his mouth with the hamburger. Resident #24 took approximately 10-15 minutes to swallow the food in his mouth. Resident did not touch his fortified mashed potatoes. Resident #24 was not assisted by staff, no verbal cues were given by staff, and fortified food was never encouraged by staff. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with the MDS coordinator on 4/3/2024 at 2:30 PM, she said she was an LVN. She said she was in the facility on 4/1/2024 during the time that resident #15 was eating his breakfast. She said that LVN A reported to her that the resident was choking and coughing during breakfast, and she instructed her to change his diet to pureed with thickened liquids until speech therapy could evaluate him. She said that nurses are allowed to downgrade resident diets if needed. She said that the doctor should have been notified and that the nurse should have documented notification in the nurse's progress notes. She said that the resident has a history of eating too fast and requires staff to remind him to slow down when eating. The MDS Coordinator said she reviewed and updated care plans with every MDS assessment. She said any nurse could update the resident care plans based on physician orders, and interactions or observations of the resident. A telephone interview with RP H (family member of Resident #25) was attempted on 4/4/24 at 3:11 pm. No answer was received, a voicemail requesting a return phone call was left. No return phone call was received before exiting the facility. During an interview 04/05/24 at 10:05 AM The DM said the proper procedure for plating resident meals is using the proper scoop sizes. She said when the cook plates residents' meals he determined the diet, preferences and if the resident wants extra food from the resident's tray card. She said once the food is plated it is put on the rack for dining room, 100 hall, and secure hall rack. She said then they pushed the carts to the nurse's station for the nurses to check and dietary staff returned to the kitchen before the check is completed. She said if there is a problem with the trays then the nurses take it back to the kitchen. The DM said for the dining room they waited till the nurse and aides were in the dining room to serve the meal. She said the dietary aide handed the trays to the nurse to be checked, then the nurse handed the tray to the CNAs to pass to the resident. She Said before 4/01/2024 the nurses did return 1 or 2 trays to the kitchen that did not have large or double portions. She said the tray cards where then reviewed for accuracy for those 1-2 residents. She said she did not know how many residents had large portions listed as preferences but knows it is a large number. She said her expectations is for her staff to follow the diets and preferences listed on the tray cards. She said she receives a communication form from the ADON for any diet changes. The DM said if she doesn't get a communication form for 2 weeks then she will ask the ADON/DON if there had been any diet changes. She said in the morning meetings they talked about what the meals would be for that day, any new orders, or anything pertaining to meals. She said other than the communication form on Resident #15 on 4/1/24 she had not received any dietary communication forms since 10/20/23 . During an interview on 04/05/24 at 04:29 PM with the Administrator, he said when a new order is received for a diet change, nursing is to fill out a dietary communication form. He said the ADON was responsible for overseeing the weights. He said as of 3/29/2024 CMA B was responsible for weighing all residents. He Ssaid his expectations were for care plans to be updated by the MDS Coordinator and are all changes of condition are added to the care plan during the morning QA meeting. He said the potential negative outcome for the resident if care plans were not accurate was the resident could possibly not receive the proper amount of care and nutrition. Record review of a facility policy titled Nutrition Supplementation dated 2018, read .Use of fortified foods at each meal could be used to provide additional calories for residents unable to meet estimated calorie and needs with current intake . (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a facility policy titled Nutrition Interventions dated October 1, 2018 read .Nutritional interventions will be implemented as recommended by the Nutrition and Foodservice Manager, dietitian and/or Nutrition and Dietetics Technician Registered (NDTR) to ensure the best possible nutritional status for residents of the facility . Record review of the facilities policy titled Comprehensive Care Plans dated 1/26/2024 revealed: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the resident's comprehensive assessment. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. This was determined to be an Immediate Jeopardy (IJ) on 04/04/2024 at 9:57 a.m. The Administrator was notified. The Administrator was provided with the IJ template on 04/04/2024 at 9:57 a.m. The following Plan of Removal submitted by the facility was accepted on 04/05/2024 at 11:51 a.m. and included: Action: The care plans for Resident #24, #25, and #33 have been reviewed and updated to reflect residents' comprehensive person centered care. Resident #24's care plan updated to reflect current needs of set up assistance and not 1 person assistance with meals??? to reflect resident's current needs. Resident #24 is on therapy services and the evaluation completed on 2/16/2024 states resident only requires set up or clean up assistance, care plan reflects this evaluation. Resident #24 is currently on Speech Therapist services and nursing will provide the assistance recommended by Speech. ? Person(s) Responsible: MDS Coordinator and Director of Reimbursement and Speech Therapy ? Date: 4/4/2024 by 3PM???? ?? Action: Reestablish all residents weights on 4/3/2024. Continue to weigh each resident x4 weeks. Designated employee will weigh residents, if employee is unavailable, Assistant Director of Nursing and/or Director of Nursing will complete. Educate employee(s) responsible for weighing residents (Designated CMA/CNA, Assistant Director of Nursing, and Director of Nursing). ?Charge Nurse has been educated on obtaining weight process. ?? Person(s) Responsible: Assistant Director of Nursing, Director of Nursing, and/or Designee ??? Date: 4/4/2024 completed by 5PM? ?? (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Action: Reviewed significant weight loss and weight gain for residents at 30 days (5% or greater), 90 days (7. 5% or greater), and 180 days (10% or greater). Communicated weight variances to the dietitian, following any new orders received. Notification to dietitian, physician, and/or RP/resident. which residents were identified ??? Person(s) Responsible: Assistant Director of Nursing, Director of Nursing, and/or Designee ??? Date: 4/4/2024 by 5PM??? ?? Action: Care plans updated to reflect current residents with significant weight loss and weight gain for residents at 30 days (5% or greater), 90 days (7.5% or greater), and 180 days (10% or greater). ??? Person(s) Responsible: MDS Coordinator and/or Designee ??? Date: 4/4/2024 by 5PM??? ? Action: The Administrator, Director of Nursing, Assistant Director of Nursing, and the Dietary Manager have been educated over the process of dietitian recommendations and communication regarding orders and meal tray tickets, resident preferences vs. Dietitian/Speech Language Pathologist recommendations, following preferences and orders, dietary communication forms, checking trays- (texture, diet, preferences, portion size), and communication to the MDS nurse so care plans can be updated to reflect residents' current needs. ??? Person(s) Responsible: Director of Regulatory Compliance ??? Date: 4/4/2024 by 5PM? ? Action: Dietary Department educated on Dietary Process to include:??? Dietary Manager: Ensure orders in Matrix match tray cards in Menu Matrix and use of dietary communication forms. ??? Ensure all dietary staff understands the plated meal must match the tray card. ??? Proper scoops for portions. Verify portions on tray card vs. the plated tray. Fortified Foods. Following Recipes. Following Menu/substitution log. ??? All dietary employees will be educated prior to working their next shift. ??? Person(s) Responsible: Administrator??? (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Date: 4/5/2024 by 11AM??? Action: Resident #15's care plan updated to reflect resident's current needs for assistance. Audited care plan to ensure only 1 form of assistance is listed. Person(s) Responsible: MDS Coordinator?? Date: 4/5/2024 by 12PM Action: Care plans' problems and approaches audited to ensure approaches are not contradictory so staff can follow the residents' plan of care to avoid contradictory approaches. Care plans are also being reviewed for accuracy during this audit. Person(s) Responsible: MDS Coordinator?and/or Designee ? Date: 4/5/2024 1PM? ? Action: Charge Nurses, CNAs, and CMAs will be educated on how to pull the resident profile in which will indicate the supervision/assistance needs for the residents. ? All staff on-site will be educated. Staff, temporary and permanent will be educated prior to working their next shift. ? Person(s) Responsible: Director of Nursing, Assistant Director of Nursing, and/or Designee ? Date: 4/5/2024 by 10AM ? ? Action: The Interdisciplinary Team, to include Director of Nursing, Assistant Director of Nursing, and MDS Coordinator educated over care planning to meet the needs according to the MDS assessment and resident observations and interactions. ? Person(s) Responsible: Director of Reimbursement ? Date: 4/5/2024 by 12PM?? ???? Action: Ad hoc QAPI performed with Medical Director regarding IJ template and the facility's plan to remove the immediacy. ??? Person(s) Responsible: Administrator ??? (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Date: 4/4/2024 by 11AM???? Monitoring of the plan of removal was completed on 04/05/2024 and revealed the following: 1. Record review of Resident #24's care plan revealed it was revised on 4/4/24, record review of Resident #25's care plan revealed it was revised on 4/5/24, record review of Resident #24's care plan revealed it was revised on 4/4/24. 2. Record review of Inservice titled weights dated 4/3/24 with DON, ADON, and CMA B signatures. Weight log dated 4/3/24 with 34 out of 34 residents reviewed for weight loss. Inservice dated 4/1/24-4/5/24 with all staff titled weights 24 employee's signatures. 3. Record review of Weight variance report 10/4/23 to 4/4/24 for 34 out of 34 residents reviewed for weight loss or gains. 4. Record review of Resident #15, Resident #24, Resident #25, and Resident #33 care plans updated to reflect current residents with significant weight loss and weight gains for residents at 30 days (5% or greater), 90 days (7.5% or greater), and 180 days (10% or greater). 5. Record review of Inservice dated 4/02/24 on dietician recommendations, orders, preferences versus orders, and meal cards with the signatures of the Administrator, DON, ADON, and DM. 6. Record review of Inservice dated 4/03/24 titled Dietary Process that included the DM, and cooks. 7. Record review of Resident #15's care plan that was updated on 4/05/24. 8. Record review of attestation dated 4/05/24 that 34 of 34 residents care plans updated signed by the MDS Coordinator. 9. Record review of Inservice dated 4/04/24 titled Pulling up a Resident Profile with 21 employee signatures. 10. Record review of Inservice dated 4/05/24 titled Comprehensive Care Planning signed by the MDS Coordinator, DON, ADON, SW, Administrator, DM, and DOR. 11. Record review of Ad Hoc QAPI dated 4/05/24 with signatures of the Administrator, DON, ADON, MDS Coordinator, DM, and Medical Director. 12. During interviews on 4/05/24 between 3:15 PM and 5:20 PM The DM, Cook, Cook M, and DA were able to verbalize understanding of the Dietary Process. 13. During interviews on 4/05/24 between 3:15 PM and 5:20 PM the DON, ADON, MDS Coordinator, LVN L, LVN D, LVN N, LVN P, and CMA B were able to verbalize understanding of the weight process. 14. During interviews on 4/05/24 between 3:15 PM and 5:20 PM the DON, ADON, MDS Coordinator, LVN L, LVN D, LVN N, LVN P, CMA B, CNA O, CNA K, CNA F, and CNA J were able to verbalize understanding of the Resident Profile. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	15. During interviews on 4/05/24 between 3:15 PM and 5:20 PM the MDS Coordinator, DON, ADON, SW, Administrator, DM, and DOR were able to verbalize understanding of the Comprehensive Care Planning process. The Administrator was informed the Immediate Jeopardy was removed on 4/05/2024 at 5:20 p.m. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 46273 47339 49017 Based on observations, interviews, and record review the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range, and offered a therapeutic diet when there was a nutritional problem and the healthcare provider orders a therapeutic diet for 15 of 34 residents (#33, #24, #29, #9, #25, #34, #22, #17, #15, #18, #35, #6, #13, #31, and #1) reviewed for weight loss and nutrition. 1. The facility failed to communicate with dietary staff on dietary changes. 2. The facility failed to ensure systems were in place to monitor for weight changes. 3. The facility failed to ensure residents were weighed according to physician orders and dietary recommendations for Resident #33, #24, #29 and #9. 4. The facility failed to provide assistance and supervision with meals as indicated by resident care plans for Resident #24 on 4/3/2024. 5. The facility failed to provide residents with therapeutic meals as indicated by the physician orders, dietary recommendations, and dietary special preferences for Residents #34 on 4/1/2024; Residents #25, #9, #31, #17, #1, #24, #15, #18, #35, #6, #13, #33 on 4/2/2024; and Resident #22 on 4/3/2024. 6. The facility failed to obtain updated baseline weights after the facility scale was replaced on 3/12/2024 until state surveyor intervention. On 4/4/2024 at 8:15 AM an Immediate Jeopardy (IJ) situation was identified. While the IJ was removed on 4/5/2024 at 5:20 PM, the facility remained out of compliance at a potential for harm with a scope identified as a pattern due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures placed all residents at risk of severe weight loss, delayed interventions, hospitalization , worsening health condition, and death. Findings included: (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 0692

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

1.Record review of face sheet for Resident #33 indicated that he was a [AGE] year-old male admitted on [DATE] with diagnoses of unspecified dementia (symptoms that affect memory, thinking, and social skills), dysphagia, oropharyngeal phase (a swallowing disorder that affects the mouth and throat characterized by difficulty initiating a swallow, coughing, choking, or aspiration.), cognitive communication deficit (difficulty with communication that is caused by a problem with thinking), and gastro-esophageal reflux disease (when stomach acid repeatedly flows back into the tube connecting your mouth and stomach).

Record review of Resident #33's significant change MDS dated [DATE] indicated that resident had a BIMS score of 14 indicating that he was cognitively intact. It indicated that he was independent with eating and required supervision or set up assistance with activities of daily living.

Record review of care plan for Resident #33 dated 01/30/2024 revealed resident care planned for undesired weight loss with approach of weekly weights. Nutritional status care plan of mechanically altered diet with ground meat. Care plan dated 3/13/2024 for fortified foods. Care plan for set up assistance with meals reviewed.

Record review of Resident #33's physicians orders dated 3/13/2024 revealed diet order for fortified foods, mechanical soft with ground meat. Review of order dated 11/28/2023 to discontinue double portions.

Record review of facility weight variance report dated 12/12/2023 to 3/3/2024 revealed Resident #33's weights were:

12/12/2023- 233.0

1/3/2024- 184.00- indicating a 21.2% loss in 22 days

2/1/2024- 204.00 indicating a 11.0% gain in 29 days

2/19/2024- 197.00

3/3/2024- 196.8

Record review of facility weight variance report revealed that the resident was not weighed weekly as ordered on 1/30/2024 with weight not obtained during the week of 2/12/2024 and 2/26/2024 .

During an observation on 4/01/2024 at 12:00 PM in the main dining room during lunch service, Resident # 33 received double portions at the lunch meal. 14 Residents with large portions on tray card received the same size portions as regular diets.

During an observation on 4/3/2024 at 12:00 PM of the lunch meal service revealed Resident # 33 was served double portions due to tray card indicating double portions.

2. Record review of a facility face sheet dated 4/4/24 for Resident #13 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of dementia.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a Comprehensive MDS assessment dated [DATE] for Resident #13 indicated that he had a BIMS score of 9, indicating that he had moderately impaired cognition. Record review of a comprehensive care plan dated 3/21/24 for Resident #13 indicated that large portions were not addressed . During an observation and interview on 4/1/2024 at 12:42 PM Resident # 13 was observed in the dining room on a secured unit feeding himself. He seemed to be having problems getting the food to his mouth on the spoon, said everything tasted great, but did not seem to be eating much. LVN D said he normally ate really slow and fed himself. He normally does not require assistance with meals. They just let him eat at his own pace. His tray card indicated that he was to have large portions, but his portions appeared to be the same size as all the residents received. During an observation on 4/2/24 at 12:00 pm of the lunch meal in the kitchen while meals were being plated and sent out of the kitchen revealed that Resident #13 did not receive large portions per instructions on the tray card. During an observation on 4/3/2024 at 12:00 PM of lunch meal service revealed Resident # 13's tray was returned to the kitchen due to no large portions served by the kitchen. 3. Record review of a face sheet for Resident #18 dated 4/4/2024 indicated he admitted to the facility on [DATE] and was an [AGE] year-old with diagnoses of dementia (loss of thinking, remembering, and reasoning), schizoaffective disorder, bipolar type (episodes of mood swings and sometimes depression), type 2 diabetes, and GERD (acid reflux disease). Record review of active physician orders dated 3/4/2024 to 4/4/2024 for Resident #18 indicated a diet order for a regular diet, thin consistency, and fortified foods with all meals that was discontinued on 4/2/2024. Record review of active orders for Resident #18 indicated a diet order for low concentrated sweets, regular, thin consistency, fortified foods with all meals with a start date of 4/2/2024. Record review of a Quarterly MDS dated [DATE] for Resident #18 indicated he had moderate impairment in thinking with a BIMS score of 12 and required set up/clean up assistance with eating. Record review of a care plan for Resident #18 dated 10/10/2022 indicated nutritional status with a regular diet, fortified food with all meals . During an observation on 4/01/2024 at 12:05 PM Resident #18 was observed in common area in the secured unit, eating lunch. Lunch consisted of a smothered pork chop, turnip greens, mashed potatoes, corn bread, and cake. Larger portions noted on tray which had larger portions on his plate than the other residents. During an observation on 4/2/2024 at 12:40 PM, the lunch trays in the secure unit revealed tray cards for some residents indicated fortified, some residents had a bowl of mashed potatoes added, and two residents had a cup of soup. Resident #18's tray card indicated large portions, but no large portions noted on his tray. He did have a bowl of mashed potatoes. His lunch consisted of Salisbury steak, new potatoes, broccoli and cauliflower, and a roll. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Record review of a facility face sheet dated 4/4/24 for Resident #6 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior). Record review of a Quarterly MDS assessment dated [DATE] for Resident #6 indicated that Brief Interview for Mental Status interview could not be conducted due to the resident being rarely/never understood. Question C1000 indicted that resident had severely impaired cognition. Record review of a comprehensive care plan dated 3/21/24 for Resident #6 indicated that it did not address receiving large portions . During an observation and attempted interview on 4/1/24 at 9:46 am Resident #6 was observed lying in bed. Resident would not speak to the state surveyor. During an observation on 4/2/24 at 12:00 pm of the lunch meal in the kitchen while meals were being plated and sent out revealed that Resident #6 did not receive large portions per instructions on the tray card. 5.Record review of face sheet for Resident #9 reflect that he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included cerebral palsy (a group of conditions that affect movement and posture), mild intellectual disabilities (a condition that limits intelligence and disrupts abilities necessary for living independently), dysphagia, oral phase (a swallowing disorder that affects the mouth and throat characterized by difficulty initiating a swallow, coughing, choking or aspiration.), bulimia nervosa (eating large amounts of food in one sitting), and gastro-esophageal reflux disease (when stomach acid repeatedly flows back into the tube connecting your mouth and stomach). Record review of Resident #9's quarterly MDS dated [DATE], indicated that the resident had a BIMS score of 15, indicating he was cognitively intact. It indicated that he required supervision for eating and was dependent or required substantial/ maximal assistance from staff for activities of daily living. Record review of care plans for Resident #9 dated 01/31/2024 indicated that the resident had experienced weight loss with an approach to monitor and record weight weekly for 4 weeks. And nutritional status care plan dated 2/21/2024 for regular diet with fortified foods with breakfast. Record review of Resident #9's physician orders with start date of 1/30/2024 for regular diet. New order dated 4/2/2024 for regular diet with fortified foods at breakfast. Record review of facility weight variance report dated 12/12/2023 to 3/3/2024 revealed resident #9's weights were: 12/12/2023- 184.0 1/3/2024- 171.2 indicating a 7.0% loss in 22 days 2/1/2024- 182.2 indicating a 6.8% gain in 29 days (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2/12/2024- 196.6 indicating a 7.5% gain in 11 days 2/19/2024- 200.1 3/3/2024- 188.4 indicating a 5.8% loss in 13 days Record review of facility weight variance report revealed that the resident was not weighed weekly as ordered on 1/31/2024 with weight not obtained during the week of 2/26/2024 . 6.Record review of a facility face sheet dated 4/4/24 for Resident #31 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (right side weakness/paralysis following a stroke). Record review of a Comprehensive MDS assessment dated [DATE] for Resident #31 indicated that he had a BIMS score of 7, which indicated severe cognitive impairment. Record review of a comprehensive care plan for Resident #31 dated 3/6/24 indicated that care plan did not address resident receiving large portions. During an interview on 4/1/24 at 10:03 am Resident #31 answered I don't know. to most questions and did not want to talk with the state surveyor. Resident #31 continued to watch television and ignored the state surveyor. During an observation on 4/2/2024 at 12:00 PM of the lunch meal in the kitchen while meals were being plated and sent out revealed Resident # 31 did not receive large portions per instructions on the tray card. 7. Record review of a face sheet for Resident #24 dated 4/03/2024 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: Hemiplegia following cerebral infarction affect left non-dominant side (paralysis or partial or total body function on left side of the body), partial loss of teeth, abnormal weight loss, and cognitive communication deficit (difficulty with thinking and how someone uses language). Record review of a Quarterly MDS assessment dated [DATE] for Resident #24 indicated that he had a BIMS score of 14, indicating his cognition was intact and he required setup or clean-up assistance with eating. Record review of a care plan dated 4/04/2023 for Resident #24 indicated he had a problem with nutritional status with interventions that included: Weigh me at least once a month and weekly if I show a significant weight loss. Resident #24 had a problem with ADL's Functional Status/Rehabilitation Potential with interventions that included: Resident requires supervised assist-limited x1 with eating. Record review of RD progress note dated 1/15/2024 the RD recommended reweighing Resident #24 for accuracy and weekly weights for 4 weeks. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of facility weight variance report dated 9/01/2023 to 3/10/2024 revealed Resident #24's weights were: 10/05/2023- 241.4 11/02/2023- 243.2 12/05/2023- 248.6 01/03/2024- 210.0 indicating a 15.5% loss in 29 days. 01/18/2024- 215.6 01/25/2024- 214.0 02/01/2024- 218.2 03/03/2024- 218.2 During an observation and interview on 4/03/2024 at 08:50 AM Resident #24 was observed eating breakfast in his room with the door closed and no supervision or assistance. Resident #24 was not able to answer questions due to cognitive communication deficit. During an observation on 4/03/2024 at 12:00 PM, Resident # 24 was pushed via wheelchair to the dining room by therapy. Resident #24 requested a hamburger for lunch. The Administrator verbally communicated resident's request to the dietary staff. Resident was served a hamburger with potato chips, yogurt, and fortified mashed potatoes. Resident #24 picked up the hamburger and put the entire hamburger in his mouth at one time, he then started placing potato chips in his mouth with the hamburger. Resident #24 took approximately 10-15 minutes to swallow the food in his mouth. Resident did not touch his fortified mashed potatoes. Resident #24 was not assisted by staff, no verbal cues were given by staff, and fortified food was never encouraged by staff. 8. Record review of a facility face sheet dated 4/2/24 for Resident #25 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of dementia. Record review of a Quarterly MDS assessment dated [DATE] for Resident #25 indicated that Brief Interview for Mental Status could not be conducted due to the resident being rarely/never understood. Question C1000 indicated that resident had severely impaired cognition. Record review of physician orders for Resident #25 indicated that she had the following order: Diet: Regular diet, fortified foods; Texture: Mechanical soft; Fluid consistency: Thin dated 2/2/24. Record review of a comprehensive care plan for Resident #25 dated 3/31/24 indicated that she had experienced weight loss and was to receive fortified food with all meals. Record review of Resident #25's weights located in her electronic medical record indicated that on 10/05/2023, the resident weighed 138.5 lbs. On 04/032024, the resident weighed 110.8 pounds which was a -20.00 % loss in 180 days. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on 4/2/2024 at 12:30 pm, Resident #25 was observed up in a chair in the dining room being assisted with lunch meal by staff member. Tray card said, fortified food, but no fortified food was on the meal tray for resident. Dietary manager came to dining room and said that Resident # 25's fortified foods must have gotten missed. She returned to the dining room with a cup of fortified soup for Resident #25. A telephone interview with RP H of Resident #25 was attempted on 4/4/24 at 3:11 pm. No answer was received, a voicemail requesting a return phone call was left. No return phone call was received before exiting the facility on 4/5/2024. 9. Record review of a facility face sheet dated 4/3/24 for Resident #34 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of vascular dementia (a condition caused by the lack of blood that carries oxygen and nutrients to a part of the brain. It causes problems with reasoning, planning, judgment, and memory). Record review of a Comprehensive MDS assessment dated [DATE] for Resident #34 indicated that he had a BIMS score of 6, which indicated he had severe cognitive impairment. Record review of physician orders for Resident #34 indicated that he had the following order dated 11/28/23: Diet: Regular diet; Texture: Regular; Fluid Consistency: Thin; Fortified foods TID. During an observation and interview on 04/01/24 at 12:47 PM during lunch, Resident #34 was observed in his room eating lunch at 12:15 pm after CNA E who worked for hospice served him a tray. Resident #34 was served the wrong tray. Resident #34 was served Resident #25's tray, which was a mechanical soft (chopped meat). Resident #25 was observed in the dining room when staff realized her tray was not on the cart. Resident #34's tray was on the cart, but it was a regular tray, with a full pork chop. Staff went to the kitchen and got another tray made for Resident #25. Resident #25 received her tray at 12:30 pm in the dining room. Interview with CNA F said that CNA E had passed Resident #34 the wrong tray. She said that they should check the tray card before passing trays. She said that CNA E was working for hospice that day and not the facility, but she also worked for the facility. During an interview on 04/03/24 at 10:50 AM, CNA E said that she does not normally help pass trays when she comes in as a hospice aide, but she was trying to help on Monday 4/1/2024. She said that she had looked at the cart and Resident # 5 (another resident) had started talking to her and she got distracted and turned the cart around and accidentally gave Resident #34 the incorrect tray (Resident #25). She said that residents could be at risk of allergic reactions or choking if they received the wrong type of food. 10. Record review of a facility face sheet dated 4/3/24 for Resident #22 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis of autistic disorder (a condition related to brain development that impacts how a person perceives and socializes with others, causing problems in social interaction and communication. The disorder also includes limited and repetitive patterns of behavior). Record review of a Quarterly MDS assessment dated [DATE] for Resident #22 indicated that Brief Interview for Mental Status interview could not be conducted due to the resident being rarely/never understood. Question C1000 indicated that the resident had severely impaired cognition. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a care plan dated 4/02/2024 for Resident #1 indicated he had a problem with nutritional status with interventions that included: Weight as ordered. Resident #1 had a problem with ADL 's Functional Status/Rehabilitation Potential dated 6/14/2023 with interventions that included: Resident requires extensive x1 assist with eating . Record review of the facility Medical Nutrition Therapy Assessment for Skilled Nursing Facilities 11/2019 dated 10/27/2023 indicated Resident #1 had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. The same assessment indicated Resident #1 was not on physician-prescribed weight-loss regimen. During an observation on 4/3/2024 at 12:00 PM of the lunch meal service revealed Resident # 1's tray was returned to the kitchen due to no large portions served by the kitchen . 15. Record review of a facility face sheet dated 4/4/24 for Resident #29 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease. Record review of a Quarterly MDS assessment dated [DATE] for Resident #29 indicated that Brief Interview for Mental Status could not be conducted due to resident being rarely/never understood. Question C1000 indicated that she had severely impaired cognition. Record review of a comprehensive care plan for Resident #29 dated 3/13/34 indicated that the resident had experienced weight loss and a new order was received on 12/23/23 to weigh weekly for 4 weeks. Record review of Resident #29's weights in her electronic medical record indicated that she was weighed on 1/4/24 and 1/15/24, indicating that she was not weighed the week of 12/24/23 through 12/30/23, nor the week of 1/7/24 through 1/13/24. During an interview on 04/02/24 at 10:45 AM, the DM said she was responsible for updating the tray cards to reflect the current diet. She said she updated the tray cards when she received a dietary communication form from nursing. During an interview on 4/2/2024 at 3:14 PM, the RD said she had been going to the facility monthly for the past two months. She said when she arrived at the facility, she checked in with the DON/ADON to ask if there was anyone that needed to be seen. She said each visit, she screened for weight loss in the past 180 days. She said she would see new admissions during the visits. She said residents that were on dialysis would be seen quarterly. If a resident had a weight loss would be seen monthly along with pressure injuries and tube feedings. She said she ran an audit report from the electronic health record system and looked for weight variances and it calculated the percentages of weight loss. She said her last visit at the facility was on 3/12/2024. She said during her visits, she conducted an audit of the recommendations from the previous month to ensure they were followed. She said if they were not, she would let the DON know that they were not done and would review the following month. She said during her monthly visits, she did not visit every resident in the facility, only the ones that were screened. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Palestine Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1816 Tile Factory Rd Palestine, TX 75801	

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/2/2024 at 04:00 PM, the ADON said she had been in the ADON position since December 2023. She said that she was responsible for reviewing the residents' weights and entering the information into the electronic record. She said that she reviewed the weights and was responsible for re-weights and assuring that orders for weekly weights were done. She said that if a resident had a significant weight loss she notified the Registered Dietician, the PCP, and the resident's responsible party. She said that until March 2024, different staff were responsible for weighing residents monthly. She said that the issue of resident weight loss and weighing residents was part of a performance improvement plan and that the actions included had a designated employee to weigh the residents. She also said that a new scale was purchased. She said that residents on weekly weights were now being done by the designated employee and that a new tracking system was being developed. The ADON said that she was also responsible for reviewing the dietary recommendations and making sure that recommendations were communicated to the PCP. She said that she was responsible for writing any orders related to the registered dieticians' recommendations and communicating any changes to the dietary

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49017 Based on observation, interview, and record review, the facility failed to ensure that licensed nurses have the specific competencies and skill sets necessary to care for the residents' needs, as identified through resident assessments, and described in the care plan and responding to resident's need for 1 of 14 residents (resident #15) reviewed for competent nursing. The facility MDS coordinator failed to perform an assessment on Resident #15 following a choking incident and changed Resident #15 diet from mechanical soft to dysphagia pureed with thickened liquids diet without assessment or notifying the physician. These failures could place residents at risk of not receiving appropriate care resulting in deterioration in condition. The findings include: Review of resident #15 face sheet reflected that he is an [AGE] year old male admitted on [DATE]. His diagnosis included unspecified dementia with other behavioral disturbances (dementia is characterized by a decline in cognitive abilities that impacts a person's ability to perform everyday activities and behavioral disturbances can include verbal or physical aggression, incontinence, agitation, sleep disturbances or changes in appetite), dysphagia, oropharyngeal phase (a swallowing disorder that affects the mouth and throat characterized by difficulty initiating a swallow, coughing, choking or aspiration.) , cognitive communication deficit (difficulty with communication that is caused by a problem with thinking), and gastro-esophageal reflux disease (when stomach acid repeatedly flows back into the tube connecting your mouth and stomach). Record review of resident#15 Quarterly MDS dated [DATE], indicated that the resident had a BIMS score of 06, severely impaired cognition. It indicated that resident requires substantial/maximal assistance with eating (helper does more than half the effort) and that he is dependent on staff for all activities of daily living. Record review of the care plans for resident #15 dated 3/27/2024 for risk for respiratory distress related to history of aspiration pneumonia, 04 /1/2024 indicated that resident had the potential for weight loss related to dementia and feeding difficulties. Diet change was noted in care plan on 4/1/2024 for dysphagia puree with thickened liquids and on 4/2/2024 dysphagia puree with nectar thickened liquids. Nursing approaches included provide physical help assistance for meals dated 12/21/2023. Record review of nurse progress notes dated 4/1/2024 at 08:02 AM LVN A said Resident #15 had choked on every single bite of food .at breakfast LVN A charted that the MDS coordinator gave the OK to downgrade the residents diet to pureed with thickened liquids until speech can assess the resident. There was not any documentation that Resident #15's primary care provider was notified of incident and no documentation of responsible party notified. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During dining room observation on 4/1/2024 at 12:00 PM, Resident #15 was observed sitting at a table alone. Staff served resident his meal that was pureed and thickened liquids. The tray card indicated that Resident #15's diet was correct. Observed resident #15 feeding himself without staff assistance or verbal cueing. Resident remained at the dining room table alone. Staff assisted resident out of dining room when he finished eating . During dining room observation on 4/2/2024 at 8:30 AM and 12:00 PM , resident #15 was observed sitting at table alone, staff served his meal and resident ate both meals without assistance or verbal cueing. Resident #15 was observed eating quickly, taking large bites of pureed food and occasionally coughing when he swallowed. During an interview on 4/1/2024 at 12:15 PM, the director of rehab said Resident #15 recently had his diet changed to pureed with thickened liquids and he was being observed to see how well he tolerated the diet. During an interview on 4/3/2024 at 2:30 PM, the MDS coordinator said she was in the facility on 4/1/2024 during the time that Resident #15 was eating his breakfast. She said LVN A reported to her that Resident #15 was choking and coughing during breakfast and she instructed her to change his diet to pureed with thickened liquids until speech therapy could evaluate him. She said that nurses are allowed to downgrade resident diets if needed . She said that the doctor should have been notified and that the nurse should have documented notification in the nurses' progress notes. She said Resident #15 has a history of eating too fast and requires staff to remind him to slow down when eating. During an interview on 4/3/2024 at 4:43 PM, the director of rehab said she was in the dining room on 4/1/2024 during the breakfast meal service. She said Resident #15 was coughing during the meal because he often takes bites that are too large and does not chew his food. She said that the resident eats fast and requires reminders to slow down when eating. She said that the resident had a modified barium swallow (an analysis of swallowing) done last year to evaluate his swallowing and was seen by speech therapy until last month (March 2024). She said that she educated the nurse on duty 4/1/2024 on the residents need for smaller bites and need to slow down when eating. She said that the nurse's progress note was an exaggeration on the incident that occurred and that the resident was not choking. She said that nurses are allowed to modify a resident's diet if needed. She said that she did not make a clinical note in the resident's chart about what she observed. She said that the speech therapist was scheduled to evaluate the resident on 4/5/2024 or 4/8/2024. She said that the therapist did not evaluate resident #15 due to her schedule. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/24 at 2:47 PM, the DOR said she was a COTA. She said she was present on 4/1/2024 in the dining room when Resident #15 was eating. She said I feel like the nurses note is an over exaggeration. He was not choking. She said that the resident takes large bites and swallows his food without chewing. She said that the resident eats too fast. Prior to the pureed diet, the resident was on a mechanical soft diet with thin liquids. She said that the resident was put on the mechanical soft diet after a modified barium swallow was done in November 2023. She said that the resident was scheduled for the speech therapist to evaluate on Friday (4/5/2024) or Monday (4/8/2024). She said that the speech therapist was in the facility daily but had not evaluated the resident yet because it would take treatment time from residents that are already scheduled. She said that she educated the nurse on Monday, 4/1/2024 during breakfast. She said that because the nurse was a traveler, she was not familiar with the resident. She said that the resident was not choking on every bite and that the resident was eating fast and cough one time after swallowing and would continue to eat and cough after each swallow. She said that she believed that she was able to recognize if the resident had aspirated due to her experience and familiarity with the residents. During an interview on 4/4/24 at 2:50 PM, LVN A said that she was an agency nurse and had only worked in the facility a few times. She said that she worked on Monday 4/1/2024 and Tuesday 4/2/2024. She said that on Monday, 4/1/2024 she was in in the dining room when Resident #15 was eating breakfast. She said that the resident was eating scrambled eggs, hash browns, softened rice crispies cereal with milk. She said that the resident was choking on every bite that he consumed. She said that the resident was shoveling food into his mouth. She said that she made a nursing judgement and downgraded the resident's diet from mechanical soft to a pureed diet. She said that she spoke with the MDS Coordinator, and she had told her to downgrade his diet. She said that she thought that the MDS coordinator was going to notify the doctor and anyone else that needed to be notified. The nurse said that while the resident was coughing, he had a runny nose and watery eyes. During an interview on 04/04/24 at 04:00 PM, the speech therapist said she has been coming to the facility for about a month. She said she visits 4-5 times per week. The director of rehab services will leave a list of residents to see. She said she has about 14 residents on her current caseload. She said that she does not know Resident #15 and that just before she came into the interview with the surveyors the director of rehab services told her to evaluate him tomorrow and she does not know why as of now. She has not been given any further information on Resident #15. She said that dysphagia residents should be evaluated immediately. She said signs of dysphagia/aspiration can include: coughing/throat clearing and silent signs include eyes watering/sneezing while eating, gagging, cold like symptoms. She said that depending on the texture that a resident is choking on, they may need to have nothing by mouth until a swallow study was done. She said that a resident could be sent to hospital for swallow study if needed. She said her steps for evaluating residents are: first start with a sip of water to evaluate how he was swallowing. puree/nectar thick is safest to start, but she doesn't usually order that unless she knows that they are not aspirating. She said that the facility can send out to urgent ER for assessment if needed. She said that immediate response needs to be done if resident could possibly be aspirating and if choking, should be treated/evaluated immediately. During an interview on 04/04/24 at 4:42 PM, DON said that she would consider a medical emergency constituting immediate physician notification to include: a resident not breathing, bleeding profusely, having no pulse, unable to awaken, or anything that could constitute an immediate threat to life or anything that could cause a loss of life. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/04/24 at 4:46 PM, LVN C said that she would consider a resident choking to be a medical emergency. During an interview on 4/4/24 at 4:52 PM, the NP said that the facility notified her earlier in the week and reported that Resident #15 was having difficulty swallowing. She said that she ordered a downgrade of diet at that time from a mechanical soft to a pureed diet and for speech to evaluate and treat as indicated. When asked if it was reported that Resident #15 was choking during his meal, she said No, if they would have reported choking while eating, I would have ordered a chest x-ray to rule out aspiration. The NP said that swallowing difficulties were the only thing reported. During an interview on 4/5/2024 at 3:00 PM, the Regional Nurse said that the nurses in the facility were allowed to downgrade a resident's diet using nursing judgement. She said that the doctor and the speech therapy were involved in evaluating residents that have a change in condition like the ability to swallow. During an interview on 4/5/24 at 3:53 PM, the DON said that her expectations were that the charge nurse was to report any changes in the resident's baseline. She expected that significant changes as well as minor changes from baseline should be reported to the MD. She said that failure to notify the physician of any changes in condition could result in improper and or timely treatment for the resident. During an interview on 4/5/24 at 4:26 PM, the Administrator said that his expectations were that the physicians are notified, the event was charted, the responsible party to be notified of changes in condition and any new orders, that the changes and any orders be placed on the 24-hour report. He expected that any changes be reported and discussed in the morning meetings. He said that failures to notify the doctor of changes in condition can result in the resident not getting the appropriate care. Record review of the facility policy titled Change in a Resident's Condition or Status dated 4/20/2023, the policy statement is our facility promptly notifies the resident, his attending physician, health care provider and the resident representative of changes in the resident's medical condition and/or status. Policy interpretation and implementation included a significant change of condition is a major decline . that will not normally resolve itself without intervention by staff . and except in medical emergencies, notifications will be made within twenty-four hours of a change Record review of facility Dysphagia Clinical Protocol revised September 2017, the treatment indicated, If a modified consistency diet or other restrictions are indicated, nursing will obtain an order for such restrictions from the physician. and the physician and staff will coordinate documentation in the medical record to identify the rationale for any restrictions . Record review of facility document titled Emergency Procedure- Choking revised March 2011 indicated report results promptly to the supervisor and attending physician.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49017 Based on interview and record review, the facility failed to use the services of a registered nurse for at least eight consecutive hours a day, 7 days a week for 1 of 92 days reviewed. (October 2023, November 2023, and December 2023). The facility did not have RN coverage for 1 day in December 2023. This failure could place residents at risk by leaving staff without supervisory coverage for RN specific nursing activities and for coordination of events such as emergency care and disasters. Findings: Record review of the CMS PBJ (Payroll Based Journal) report for the fourth quarter of 2023 (October 1 through December 31, 2023) indicated there were no RN hours for the following dates: 10/21/23, 10/22/2023, 10/28/2023, 10/29/2023, 11/25/2023, 12/17/2023, 12/30/2023, 12/31/2023. Record review of the monthly staffing schedules for October 2023, November 2023, and December 2023 revealed that there was a RN scheduled for the weekends. Time sheets provided for proof of RN coverage on all dates except for 12/17/2023. During an interview on 04/02/2024 at 12:20 p.m., the Administrator said that he had been employed here since August of 2023. He said that he expected a licensed registered nurse to be on the schedule for 8 hours a day. He said that the DON and ADON were to provide RN coverage if there was not an RN on the schedule and that a time sheet was completed if the DON or ADON was the RN coverage on the weekend. During an interview on 04/02/24 at 4:00 p.m., the ADON said that she had been in this position since December of 2023, and she was responsible for scheduling. She said that she had been hired in December and was learning her roll and responsibilities at that time. She said that she now has a RN scheduled for every weekend and that if the RN is not available, she or the DON comes into the building to provide 8 hour coverage. During an interview on 04/02/24 at 4:15 p.m., the DON said that she had been employed here since August of 2023. She said that she was not aware that RN coverage was not provided on 12/17/2023. She said that she or the ADON come in to provide coverage when there is not an RN in the building. She said that she expects there to be an RN in the building as required and that a new RN staff has been hired recently to help meet the hours required daily. Record review of a facility policy titled Staffing dated 9/28/23 read .The facility utilizes the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observations, interviews, and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles and the expiration date when applicable for 1 of 2 medication carts (nurse medication cart on secured unit) were reviewed for labeling and storage. The facility failed to properly label an insulin vial for Resident #18. This failure could place residents who receive medications at risk for receiving outdated medications and could result in residents not receiving the intended therapeutic effects of their medications and health decline. Findings included: Record review of a face sheet for Resident #18 dated [DATE] indicated he admitted to the facility on [DATE] and was an [AGE] year-old with diagnoses of dementia (loss of thinking, remembering, and reasoning), schizoaffective disorder, bipolar type (episodes of mood swings and sometimes depression), type 2 diabetes, and GERD (acid reflux disease). Record review of a Quarterly MDS assessment dated [DATE] for Resident #18 indicated that he had a BIMS score of 12, indicating that he had moderately impaired cognition. Medication section indicated that he had received insulin injections 7 of the previous 7 days. Record review of physician orders for Resident #18 indicated that he had the following order dated [DATE]: Levemir (Insulin Detemir) solution; 100 unit/ml; amt: 60 units; subcutaneous. Hold dose if Blood sugar is <90 Scheduled once daily between 6:00 am and 9:00 am. Record review of a comprehensive care plan dated [DATE] for Resident #18 indicated that he was diabetic and was receiving Levemir. During a medication cart observation and interview on [DATE] at 12:00 pm a vial of Levemir insulin was found opened and not labeled with an open date. LVN D said that she did not know when it would expire because she did not know when it had been opened. She said the nurses were responsible for checking for expired and undated medications on their carts daily. She said it must have gotten missed. She said that if a resident were to get insulin that was past the expiration date, they could have a reaction, or the medication could be not as effective. During an interview on [DATE] at 12:20 pm the ADON said that the insulin should have been dated by the nurse who opened it, and she would put a new vial on the cart. She said if the residents were given insulin that was out of date, they could possibly have a reaction to it, or it could not be as effective in controlling the resident's blood sugars. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:14 am, the Regional Nurse said that the nurse who opens the insulin was responsible for dating it. She said there could be several risks to residents receiving medications that could possibly be out of date or past the use by date, including not getting the therapeutic effect of the medications. Going forward, she will be educating the staff on checking their carts daily and she will be implementing weekly cart audits and she will expect her staff to follow proper policy of dating insulin vials once opened. During an interview on [DATE] at 4:37 pm the Administrator said that he would expect the nurses who are administering the medications to ensure that medications were not out of date. He said that the medications may not be as effective if they are past the expiration date. He said that he would be ensuring that the nurses receive education regarding medication administration and ensuring proper labeling, storage, and administration. Record review of drug manufacturer website accessed on [DATE] at https://www.mynovoinsulin.com/insulin-products/levemir/taking-levemir.html, read .Dispose after 42 days, even if there is insulin left in the pen or vial . Record review of a facility policy titled Storage of Medications dated 2001, revised in [DATE], read .The facility stores all drugs and biologicals in a safe, secure, and orderly manner . Record review of facility policy titled Medication Administration Subcutaneous Insulin dated 2007, read .date vial or device after first use .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen (Main Kitchen). On [DATE] the facility failed to ensure food was discarded by the expiration date. This deficient practice could place residents who ate food from the kitchen at risk for foodborne illness. The findings included: During an observation, in the dry storage area inside of the kitchen, on [DATE] at 09:30 a.m., revealed white frosting 4.5 pounds in plastic bag with open date [DATE] with expiration date [DATE], in the same plastic bag bread pudding 18 ounces with no open date, yellow cake mix 5 pounds unopened expired on [DATE], large plastic bag of pasta 10 pounds opened with no date, 2 bags grits 5 pounds opened with no date and not bagged, large plastic bag of 33 thickened coffee 0.42 ounce individual packets with the expiration date [DATE], soy sauce 1 gallon bottle with plastic wrap covering top that was falling off due to no lid with no open date and a received date of [DATE], and 1 container labeled flour 12 liters with use by date [DATE]. During an observation of the refrigerator on [DATE] at 09:25 a.m., Flip Almond [NAME] Loco yogurt 4.5 ounce expired [DATE], prune Juice 46 ounces was opened on [DATE] and expired on [DATE], Strawberry Topping opened and stored in a 1-liter bowl with plastic wrap covering bowl dated [DATE], and an Energy Drink 12oz. belonging to employee dated [DATE]. During an observation and interview on [DATE] at 09:35 a.m. the DM confirmed, by observations, that the items in the dry storage area, and refrigerator were not discarded by the expiration dates. The DM said anything that was opened in the refrigerator should have an open date and expires on day 7 after opening. During an interview on [DATE] at 10:05 a.m., the DM said she had worked at the facility for about ,d+[DATE] months. She said it was all the dietary staff's responsibility to check the fridge, freezer, and dry storage for expired foods. She said the fridge and freezer were checked daily to make sure everything was labeled, and not expired. She said usually when she came in on Mondays she checked the fridge, freezer, and dry storage for expired foods, but she was short on staff last week. She said prior to [DATE] the last time the fridge, freezer, and dry goods had been checked would have been that prior Monday, [DATE]. She said consuming expired foods could put the residents at risk of food borne illnesses. She said the facility policy was all expired food was to be discarded by the expiration dates. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 04:29 p.m. the Administrator said he had worked at the facility for about 8 months. He said his expectations was for all expired food to be thrown away or sent back to the food company. He said it was the responsibility of the DM to make sure all expired food was removed from the kitchen. The Administrator said, the potential negative outcome for residents consuming expired foods could be food borne illnesses. Record review of facility policy titled Food Storage dated 2018, revealed To ensure that all food served by the facility is of good quality and safe for consumption, etc . 1. Dry storage rooms. D. To ensure freshness, store opened, and bulk items is tightly covered containers. All containers must be labeled and dated. 2. Refrigerators. D. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. E. Use all leftovers within 72 hours. Discard items that are over 72 hours old.