STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455613	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Nursing and Rehabilitation	7499 Stanwick Dr Houston, TX 77087

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47215 Based on interviews and record review, the facility failed to properly discharge and include all other necessary information, including a copy of the resident's discharge summary, and any other documentation, to ensure a safe and effective transition of care for 1 of 5 residents (Resident #61) reviewed for transfer and discharge requirements. The facility failed to provide all necessary information and/or documentation for a safe and effective transition to the resident, responsible party (RP), ombudsman, or the home health agency upon discharge for Resident #61. This failure could place residents at risk of not receiving the necessary care and services when discharged to meet their physical and psychological needs. Findings included: Record review of Resident #61's Face sheet revealed an [AGE] year-old male who admitted to the facility on [DATE] with the following diagnoses, osteomyelitis (a bone infection that causes inflammation and swelling in the bone), essential hypertension (a form of hypertension without an identifiable physiologic cause), mixed hyperlipidemia (a generic condition that causes higher than normal levels of certain fats in the blood), muscle wasting and atrophy (a gradual process that causes muscles tissue to decrease in size and waste away), and pressure ulcer of right heel, stage 4. Record review on Resident #61's Admission MDS assessment dated [DATE], revealed he had a BIMS score of 12 out of 15, indicating he had moderate cognitive impairments. Further record review revealed he was independent for oral hygiene. He required partial/moderate assistance for roll to the left and the right. He used a walker and a manual wheelchair for mobility. Record review on of Resident #61's Baseline Plan of Care revised on 5/09/2024, Focus, Goal and interventions were blank. There was no initiated date or revision date for a discharge. There was no discharge summary found in Resident #61's medical record. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #61's Progress Notes dated 06/18/2024 created by RN A revealed; Resident was transported via stretcher by the ER for noncompliance/refusal of medications and wound care. When EMS arrived to put resident on stretcher he refused, stating he is not going on stretcher but by wheelchair, explained the wheelchair will be taken with him in the ambulance, then he started demanding two of his social security checks from writer, I'm not leaving without those damn checks Bitch informed resident writer knew nothing about any checks, he then raised his cane as if he was going to hit writer who stood her ground and informed the resident he does not scare her, he put cane down and called writer a Bitch again, this is normal behavior this resident exhibits toward staff who has not provoked him in any way. Resident then got on the stretcher after two male medics helped him onto the stretcher, resident left facility with medications and medical records and was transported to ER, he refused to have assessment, including vital signs taken prior to discharge. Interview on 8/14/2024 at 11:01a.m., with the Administrator, he said the normal procedure for a discharge, was for the social worker to contact the guardian. He said if it was an emergency discharge, or if the resident was causing issues, they would do an emergency discharge and contact the responsible party. He said Resident #61 was sent to the hospital. He said there should have been more documentation regarding Resident #61's discharge. He said the documentation should have told what happened and that Resident #61 was not coming back to the facility due to his behaviors he exhibited at the facility. He said it was not documented that it was discussed with the hospital that Resident #61 was not to return to the facility. He said it was important to have a proper discharge to make sure the resident was in a safe place. He said a proper discharge and documentation was the general reason what it was important to make sure Resident #61 maintained services. Interview on 8/14/2024 at 11:23a.m., with the ADON, she said the way the facility would do a proper discharge would be to let the doctor know the issues that were going on with the resident, request an order for the resident to transferred out of the facility, notify the family, set up transportation, and to call and report the discharge to the hospital to give the hospital a heads up on what was going on and who was coming in. She said she could not give a reason as to why the discharge was not done. She said she was not in the building when the discharge took place. She said when a proper discharge happens, it was best to notify the family and the doctor so they would understand what was going on with the resident. The ADON said they should have given the hospital a full and accurate report on Resident #61's behaviors and diagnoses so they could have adequate staff to handle his discharge . She said once the facility hangs up with the hospital, they do not check back in with the resident. She said it was important to make sure Resident #61 was in a safe place. She said moving forward she would check to make sure the family had been called and notes have been put into place. She said she would call the hospital to make sure the resident was under their care and arrived safely. Interview on 8/14/2024 at 11:33a.m., with the MDS Coordinator, she said the proper way to have discharged Resident #61 would have been to document, no return not anticipated and provided information on who was notified about the discharge. She said the social worker should have contacted the family, and RP. She would complete paperwork and document the reason for discharge, and where Resident #61 was going. She said if it was not done it there could be a problem with following through with his care and safety. She said next time she would make sure the resident has a proper discharge and would be make sure they have the proper people in place to check everything and to make sure the documentation was there. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Follow-up interview at 4:03p.m., with the MDS Coordinator, she said she considered yelling, shouting, refusing medication, and care from Resident #61 to be considered as a behavior. She said she was not sure if they told the resident that he cannot return to the facility. She said it was protocol to tell the resident that he was not able to return to the facility . Record review of the facility's policy titled Transfer, Discharge, and Return revision date not listed, read in part . Preparation and orientation of the resident is essential to ensure safe and orderly transfer or discharge from the facility. Sufficient preparation means that the facility will inform the resident where he/she is going and takes steps under its control to ensure safe transportation. The facility will involve the resident and the resident's family in selecting the new residence. All information will be in the manner in which they can understand; The facility will provide the resident or representative with the following information: The reason for transfer or discharge; The effective date of transfer or discharge; The location to which the resident is transferred or discharged ; If a Medicaid Eligible resident: A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain and appeal form and assistance in completing the form and submitting the appeal hearing request, If PASRR positive residents or those with a mental disorder or related disability: mailing and email address and telephone number of the agency responsible for the protection and advocacy of such residents. A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman if the discharge is considered involuntary and does not apply to residents who request a discharge .

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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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47215 Based on interviews and record review the facility failed to establish and follow a written policy on permitting residents to return to the facility after they were hospitalized for 1 of 5 residents (Resident #61) reviewed for return to the facility. - The facility failed to readmit Resident #61 after sending the resident to the hospital and refusing to readmit him back to the facility. -The facility failed to provide evidence they notified Resident #61's Responsible Party or the physician about his discharge to the hospital. These failures could place residents, who transfer to the hospital, at risk of being denied readmission to the facility and could result in a decreased quality of life and resident rights violations. Findings included: Record review of Resident #61's Face sheet revealed an [AGE] year-old male who admitted to the facility on [DATE] with the following diagnoses, osteomyelitis (a bone infection that causes inflammation and swelling in the bone), essential hypertension (a form of hypertension without an identifiable physiologic cause), mixed hyperlipidemia (a generic condition that causes higher than normal levels of certain fats in the blood), muscle wasting and atrophy (a gradual process that causes muscles tissue to decrease in size and waste away), and pressure ulcer of right heel, stage 4. Record review on Resident #61's Admission MDS assessment dated [DATE], revealed he had a BIMS score of 12 out of 15, indicating he had moderate cognitive impairments. Further record review revealed he was independent for oral hygiene. He required partial/moderate assistance for roll left and right. He uses a walker and a manual wheelchair for mobility. Record review on of Resident #61's Baseline Plan of Care revised on 5/09/2024, Focus, Goal and interventions were blank. There was no initiated date or revision date for a discharge. There was no discharge discharge summary for Resident #61 in his medical record. Record review of Resident #61's Progress Notes dated 06/18/2024 created by RN A revealed; Resident was transported via stretcher by the ER for noncompliance/refusal of medications and wound care. When EMS arrived to put resident on stretcher he refused, stating he is not going on stretcher but by wheelchair, explained the wheelchair will be taken with him in the ambulance, then he started demanding two of his social security checks from writer, I'm not leaving without those damn checks Bitch informed resident writer knew nothing about any checks, he then raised his cane as if he was going to hit writer who stood her ground and informed the resident he does not scare her, he put can down and called writer a Bitch again, this is normal behavior this resident exhibits toward staff who has not provoked him in any way. Resident then got on the stretcher after two male medics helped him onto the stretcher, resident left facility with medications and medical records and was transported to the ER, he refused to have an assessment, including vital signs taken prior to discharge . (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/14/2024 at 11:01a.m., with the Administrator, said the normal procedure for a discharge, was for the social worker to contact the guardian. He said if it was an emergency discharge, or if the resident was causing issues, they would do an emergency discharge and contact the responsible party. He said Resident #61 was sent to the hospital. He said there should have been more documentation regarding Resident #61's discharge. He said the documentation should have told what happened and that Resident #61 was not coming back to the facility due to his behaviors he exhibited at the facility. He said it was not documented that it was discussed with the hospital that Resident #61 was not to return to the facility. He said it was important to have a proper discharge to make sure the resident was in a safe place. He said a proper discharge and documentation was the general reason what it was important to make sure Resident #61 maintained services. Interview on 8/14/2024 at 11:23a.m., with the ADON, said the way the facility would do a proper discharge would be to let the doctor know the issues that was going on with the resident, request an order for the resident to transferred out of the facility, notify the family, set up transportation, call and report the discharge to the hospital to give the hospital a heads up on what was going on and who was coming in. She said she could not give a reason as to why the discharge was not done. She said she was not in the building when the discharge took place. She said when a proper discharge happens, it was best to notify the family and the doctor so they would understand what was going on with the resident. She said they should have given the hospital to where Resident #61 was being discharged , information about his behavior so the hospital could have adequate staff. She said once the facility hangs up with the hospital, they do not check back in with the resident. She said it was important to make sure Resident 61 was in a safe place. She said moving forward she would check to make sure family had been called and notes have been put into place. She said she would call the hospital to make sure the resident was under their care and arrived safely. Interview on 8/14/2024 at 11:33a.m., with the MDS Coordinator, said the proper way to have discharged Resident #61 would have been to document, no return not anticipated and provided information on who was notified about the discharge. She said the social worker should have contacted family, and RP. She would complete paperwork and document the reason for discharge, and where Resident #61 was going. She if it was not done it there could be a problem with following through with his care and safety. She said next time to make sure to a resident has a proper discharge would be make sure they have the proper people in place to check everything and to make sure the documentation is there. Follow-up interview at 4:03p.m., with the MDS Coordinator, said she considered yelling, shouting, refusing medication and care from Resident #61 to be considered as a behavior. She said she is not sure if they told the resident that he cannot return to the facility. She said it is protocol to tell the resident that he is not able to return to the facility. (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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Transfer, Discharge and Return revision date not listed, read in part . Preparation and orientation of the resident is essential to ensure safe and orderly transfer or discharge from the facility. Sufficient preparation means that the facility will inform the resident where he/she is going and takes steps under its control to ensure safe transportation. The facility will involve the resident and the resident's family in selecting the new residence. All information will be in the manner in which they can understand; The facility will provide the resident or representative with the following information: The reason for transfer or discharge; The effective date of transfer or discharge; The location to which the resident is transferred or discharged ; If a Medicaid Eligible resident: A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain and appeal form and assistance in completing the form and submitting the appeal hearing request, If PASRR positive residents or those with a mental disorder or related disability: mailing and email address and telephone number of the agency responsible for the protection and advocacy of such residents. A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman if the discharge is considered involuntary and does not apply to residents who request a discharge .

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47215 Based on observations, interviews, and record review the facility failed to conduct initial and periodical and comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity for 2 (Residents #46, #113) of 16 residents reviewed for accuracy of resident assessments. Residents #46 and #113 were not assessed accurately on their annual comprehensive MDS assessments. These failures could place residents at risk of not receiving the care needed to maintain their highest, practicable, physical, social, and psychosocial level of well-being. Findings included: Resident # 46 Record review of Resident #46's electronic face sheet, revealed an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included Type 2 diabetes, pulmonary emphysema, benign prostate hyperplasia (a condition in which the flow of urine is blocked due to the enlargement of prostate gland), essential hypertension (high blood pressure), muscle weakness, and lack of coordination. Record review of Resident #46's annual comprehensive MDS assessment dated [DATE] indicated Resident #46 had a BIMS score of 11 out of 15 indicating he had moderate cognitive impairment. Record review of section L for Oral\Dental status revealed he was checked as having no problem on his oral cavity. Observation and interview on 08/12/24 at 01:29 PM, Resident #46 said he had dentures. He said his dentures were new because he broke the first ones while in the hospital and he had to get new ones. He said he had his dentures on and pointed to his dental care products on his nightstand. Resident #113 Record review of Resident #113's face sheet dated 08/14/24, revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included, essential hypertension (primary) (high blood pressure), fall on same level from slipping, tripping, and stumbling without subsequent striking against object, neuropathy diseases, fracture of first lumbar (Fractures), heart failure, heart disease with heart failure, chronic obstructive pulmonary disease, generalized muscle weakness, muscle wasting and atrophy, and other abnormalities of gait and mobility. Record review of Resident #113's annual comprehensive MDS assessment dated [DATE] indicated Resident #113 had a BIMS score of 13 out 15 indicating her cognition was intact. Record review of section L for Oral\Dental status revealed she was checked as having no problem on her oral cavity. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 08/12/24 at 09:31 AM, revealed resident #113 had no teeth in her oral cavity. In an interview she said she had dentures, and they don't fit. Resident #113 said they hurt when she wears them. She pointed to her dentures in two separate containers and stated, they make me sick and they hurt bad. She said no one at the facility had asked her about them and she managed to eat what she could. In an interview on 08/13/24 at 3:45PM, the MDS Coordinator said Resident #113 had no teeth in her oral cavity. She said Resident # 113 had dentures but did not wear them. She looked at the MDS coding and said it was coded wrong which was an inaccurate assessment. She said inaccurate assessments may lead to delay in providing needed services. She said she remembered Resident # 46 telling her about his dentures. She said she would modify both MDS assessments. In an interview with the facility Administrator on 08/14/24 at 1:50 PM, he said he expected all MDS assessments to accurately reflect resident's conditions. HE said the MDS staff was responsable to ensure that all assessment accuretly reflected Residents condition . He said inaccurate assessment may delay services. Policy on Accuracy of MDS assessment was requested on 08/13/24 at 3:50PM and on 08/13/24 at 1:00PM. Provided Policy did not address MDS accuracy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867 Based on observations, interviews, and record review, the facility failed to provide appropriate care, treatment, and services to maintain or improve his or her ability to carry out the ADLs for 1 of 16 residents (Resident #23) reviewed for ADL care. The facility failed to assist and provide Resident #23 nail care. This failure could lead to self-injuries and diminish health conditions. Resident # 23 Record review of Resident #23's Admission Record dated 08/14/24 revealed he was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included cerebrovascular diseases (a condition that affect blood flow and blood vessel in the brain), blindness, essential hypertension, osteoarthritis of knee (deterioration of the knee joints), and depression. Record review of Resident #23's Annual MDS dated [DATE] revealed he was cognitively intact, with a BIMs score of 14 out of 15. Section B of the MDS related to Vision, was coded as highly impaired. Section GG of the MDS related to Functional Abilities and goals revealed he required supervision/touching assistance for personal hygiene. Record review of Resident #23's care plan dated 05/16/24 with a revision date of 9/13/24 revealed Resident #23 was care planned as Resident has an ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner requiring supervision and limited assistance with ADLs. Intervention Resident #23 will maintain a sense of dignity by being clean, dry, odor free, and well-groomed through the next review date of 09/12/24. Observation and interview on 08/12/24 at 1:00 PM, revealed resident #23 was in his room sitting up on his bed. Observation revealed he was blind and eating with his hands. He was alert and oriented. He said he was doing fine. Observation revealed he had long dirty fingernails. Observation on 08/13/24 09:58 AM revealed Resident #23 had long dirty fingernails. In an interview he said has asked for his nails to be trimmed down but he was always told that they would come back and they never returned. He said he had nail clippers but he could not see well enough to trim them himself. He said he had scratched himself several times especially his eyes. Resident #23 said that trimming his fingernails was one thing he needed help with because he knew how his room was arranged and where most of his things were located but struggled with some ADL care. In an interview with RN A on 08/12/24 at 10:00AM, she observed Resident # 23's fingernails and assured Resident #23 that she would personally trim his fingernails. She did not say how long it had been since his fingernails had been trimmed and did not say who was responsible for trimming them or ensuring they had been trimmed. She said untrimmed long fingernails could caused injuries by scratching himself. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's undated policy on ADL care to dependent's residents titled Fingernails and Toenails, read in part . Basic Responsibility Licensed Nurse, Nursing Assistant. PURPOSE: To clean the nail bed, to keep nails trimmed, and to prevent infections. To aid in the prevention of skin problems around the nail bed. To prevent accidental scratching and injuring skin from rough/jagged nails. ASSESSMENT GUIDELINES: May contain, include, but not limited to: Any diagnoses of Diabetes and/or circulatory impairments. Condition of nails, nail bed, and surrounding skin. Any scratches or skin injury caused by nails .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** 36918 Based on observations and interview, the facility failed to ensure that drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional principles reviewed for medications, 1 of 2 medication aide carts, and 2 out 3 of nurse's carts. Station 1 nurse medication cart A had a blister packet of Lorazepam, 0.5mg for a discharged Resident control medication, was still in the medication cart in station 1 nurse's cart. Station 1 medication aide cart B had 6 blister packets of medications: Lipitor 40 mg, sertraline HCL 25 mg, LevETIRAcetarn 75 mg, metoprolol tartrate 25mg, baclofen 10mg, gabapentin 100mg, Sertraline HCL 25 mg was left in the cart, and the resident was discharged from the facility on [DATE]. fluticasone propionate nasal spray that was open and not dated. Station 2 nurse medication cart B had opened and undated: Imodium A-D Loperamide hydrochloride tablet's 2mg expired ,d+[DATE]. Latanoprost ophthalmic solution 0.0005%125mcg/2.5ml was opened on [DATE], it read to discard after 24 days. These failures could affect residents, placing them at risk for altered effectiveness of the medication and worsening of the resident's symptoms, requiring medical intervention. The findings included: During an observation of Station 1 nurse medication cart A on [DATE] at 1:25 p.m., with RN A and the ADON revealed a blister packet of Lorazepam 0.5mg for discharged Resident #300. The controlled medication was still in the medication cart. During an interview on [DATE] at 1:26 p.m., RN A said the controlled medication should be taken out of the medication cart by the nurse and given to the DON upon discharge. RN A said the discharged resident's medication should not be left in the cart because the nurse might administer the medication to another resident, or it could cause drug diversion. RN A said she was in- serviced on medication administration and storage. RN A said the ADON, and the pharmacist monitored the nurse and ensured there were no discontinued medications in the cart. During an interview on [DATE] at 1:27 p.m., the ADON said the discharged resident's medication should be kept from the cart to prevent the nurses from administering the wrong medication. The ADON said she would be responsible for pulling the medication now since the facility did not have a DON. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Nursing and Rehabilitation	7499 Stanwick Dr Houston, TX 77087

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of station 1 medication aide cart B on [DATE] at 1:46 p.m. with MA N revealed 6 blister packets of medications: Lipitor 40 mg, sertraline HCL 25 mg, levetiracetam 75 mg, metoprolol tartrate 25mg, baclofen 10mg, and gabapentin 100mg was left in the cart and the resident was discharged from the facility on [DATE]. There was a fluticasone propionate nasal spray that was open and not dated. During an interview on [DATE] at 1:46 p.m., MA N said she placed the resident medication in the bottom drawer of the cart when the resident was sent to the hospital, and she did not know what the protocol was for medication storage when the resident was discharged from the facility. MA N said the nurse, the DON, and the pharmacist checked the medication cart and ensured the medication in the cart was for the residents in the facility. MA N said she had skills checks-off for medication administration and storage. MA N said she did not open the nasal spray, which should be dated to prevent the nurse from administering expired medication. During an interview on [DATE] at 2:12 p.m., the ADON said if a resident went to the hospital and stayed for 72 hours, the computer discharged the resident. The ADON said the medication was kept in the cart for 30 days, but she was not sure. She said she would check the facility policy and protocol and get back to the state surveyor. During an interview on [DATE] at 2:14 p.m., the ADON said the nasal spray should be labeled to prevent the nurse from administering expired medication to the resident. The ADON said if the medication were administered when it was expired, the medication would not be effective. The ADON said that she and the pharmacist would check behind the nurses and MA to make sure the medication was stored appropriately. During an observation and interview of station 2 nurse cart check with LVN R on [DATE] at 2:34 p.m., revealed stock medication: Imodium A-D Loperamide hydrochloride tablet's 2mg expired ,d+[DATE], latanoprost ophthalmic solution 0.0005% 125mcg/2.5ml was opened on [DATE] and it read to discard after 24 days. LVN R said she did not open it, and she did not administer the medication today because it was for bedtime. LVN R said the medication should not be administered after the expiration date because it would not be effective. LVN R said she was trained in medication administration and storage. LVN R said the ADON, and the pharmacist monitor the cart and make sure the medications were not expired or outdated. LVN R said the stock medication should be removed from the cart as soon as it expired and replaced with the current medication. During an interview on [DATE] at 2:40 p.m., the ADON said the nurse should date medication as soon as it was opened and discard it by the expiration date to prevent administering the expired medication, which would not be effective. The ADON said she would monitor the nurses. Record review of the facility undated storage of medication policy read in part . no discontinued outdated, or deteriorated medications are available for use in the facility . Record review the facility undated policy renewal of discontinued medication after discharge and return read in part . establish uniform guideline concerning the facility's procedures for discontinuing medications when a resident is discharged from the facility .

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47215 Based on observations, interviews, and record review the facility failed to to provide appropriate dental care for 1 (Residents #113) of 16 residents reviewed for dental. The facility failed to provide proper dental care and assure her denture concerns were addressed with Resident #113. These failures could place residents at risk of not receiving the care needed to maintain their highest, practicable, physical, social, and psychosocial level of well-being. Findings included: Resident #113 Record review of Resident #113's face sheet dated 08/14/24, revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included, essential hypertension (primary) (high blood pressure), fall on same level from slipping, tripping, and stumbling without subsequent striking against object, neuropathy diseases, fracture of first lumbar (Fractures), heart failure, heart disease with heart failure, chronic obstructive pulmonary disease, generalized muscle weakness, muscle wasting and atrophy, and other abnormalities of gait and mobility. Record review of Resident #113's annual comprehensive MDS assessment dated [DATE] indicated Resident #113 had a BIMS score of 13 out 15 indicating her cognition was intact. Record review of section L for Oral\Dental status revealed she was checked as having no problem on her oral cavity. Observation and interview on 08/12/24 at 09:31 AM, revealed resident #113 had no teeth in her oral cavity. In an interview she said she had dentures, and they don't fit. Resident #113 said they hurt when she wears them. She pointed to her dentures in two separate containers and stated, they make me sick and they hurt bad. She said no one at the facility had asked her about them and she managed to eat what she could. In an interview on 08/13/24 at 3:45PM, the MDS Coordinator said Resident #113 had no teeth in her oral cavity. She said Resident # 113 had dentures but did not wear them. In an interview with the facility Administrator on 08/14/24 at 1:50 PM, he said he expected all MDS assessments to accurately reflect resident's conditions. He said inaccurate assessment may delay services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 26867 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. The facility failed to ensure that the deep fryer grease was changed regularly and kept clean. The facility failed to ensure that the dishwashing area was free of stagnant water and the walls were clean. This failure placed residents at risk for foodborne illness. Findings included: Kitchen observation and interview on 08/12/24 at 08:14AM to 8:50 AM, revealed the deep fryer had dark looking grease with brownish looking substances on top of the grease. One of one oven range had grease build up around the oven range. In an interview with the Dietary Manager, she said the deep fryer grease was due to be changed and she would change the grease from the deep fryer and make sure that the oven would be cleaned. She said it was usually changed every Friday or Monday but had not been changed. Observation of the dishwasher on 08/12/24 at 8:50AM, revealed standing water between the rinse sink and the dishwasher. In an interview, Dietary Aide N said the water was from spraying dishes and the dish washing machine. An observation revealed black looking substances around the walls behind and around the dishwashing area. The Dietary Manager said this was her first time observing the stagnant water on the floor between the sink and that she would tell the Maintenance Director to look at it and she would have the walls cleaned. Observation and interview on 08/12/24 at 2:30PM, with the Facility's Administrator, revealed the stagnant water was between the sink and the dishwashing machine. Multiple unidentified flying insects under the sink and around the dishwashing machine. The facility Administrator said to clean the area and call the pest control company. He said the facility was sprayed about a week ago. Record review of facility's undated policy on 08/14/24 titled {The facility} , Section 9-Dietary -Food Service: Policy Cleaning read in part. Procedure: All equipment, food contact surfaces and utensils shall be cleaned: Surfaces must be cleaned with a sanitizing agent/solution .Chlorine, iodine, or quaternary ammonium compounds are approved sanitizing agents. All food surfaces will be cleaned at the end of each food preparation session. Grid panels in the fire suppression hood over the stove will be removed and run through the dish machine once a month. Rubber mats on the floor in the kitchen must be cleaned daily. The floor of the kitchen must be cleaned daily and after each spill or contamination. Refrigerator units must be cleaned monthly. Wall surfaces that become splattered during the food preparation process must be cleaned daily .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observations, interviews, and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 2 of 6 residents (Housekeeper C, and CNA L) observed for infection control. 1. The facility failed to ensure Housekeeper C followed proper infection control and PPE while pushing a dirty trash can on section 1 hallway. 2. The facility failed to ensure CNA L followed proper infection control and hand washing procedure during incontinent care for Resident #25. These failures could place residents at risk for infection. Findings included: Observation and interview on 08/12/24 at 1:46 p.m., Housekeeper C was pushing the trash barrel into the station one hallway, and she had gloves on. Housekeeper C said she was not supposed to wear gloves in the hallway because of the risk for cross-contamination. Housekeeper C said she had been in-serviced on PPE use and infection control. Housekeeper C said the Environmental Manager monitored her during rounding. During an interview on 08/14/24 at 8:50 p.m., the Administrator said Housekeeper C should not have worn gloves in the hallway because of the risk for cross-contamination. During an interview on 08/14/24 at 12:15 p.m., Staff M said Housekeeper C should not have worn gloves while she pushed the trash barrel in the hallway because it was an infection control issue because of cross-contamination and the spread of germs. Staff M said Housekeeper C was in- serviced on infection control and PPE use. Staff M said she monitored all housekeepers when she made random rounds. Record review of Resident #25's face sheet dated 08/23/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Resident #25 had diagnoses which included: atrial fibrillation (an irregular heartbeat), hypertension (when the pressure in your blood vessel is too high), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and need for assistance with personal care. Record review of Resident #25's quarterly MDS assessment dated [DATE] revealed a BIMS score of 11 of 15 which indicated moderate impaired cognition. Further review revealed the resident needed extensive assistance with ADL's which required at least one staff assistance. Record review of Resident #25's care plan initiated on 07/23/24 revealed resident had an ADL self-care performance deficit and was at risk for not having her needs met in a timely manner. Performance deficit related to impaired cognition and muscle weakness. Intervention: provide shower, shave, oral care, and nail care, per schedule and when needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 08/13/24 at 10:10 a.m., incontinent care provided by CNA D and CNA L revealed, CNA L used the same gloved hands, when she wiped Resident #25's peri area, and took wipes from the multi-wipe packet, 15 times. CNA L changed her gloves thrice during the care and did not wash or sanitize her hands before she donned another glove. During an interview on 08/13/24 at 1030 a.m., CNA D said he saw CNA L took wipes from the multi wipe packet many times with the same gloved hands she used to clean Resident #25's bowel movement, and she changed her gloves three times, and she did not sanitize or wash her hands before she donned another glove. CNA D said it was an infection control issue because CNA L would have transferred germs from her gloves to the wipe packet or other surfaces she touched. During an interview on 08/13/24 at 11:00 a.m., CNA L said she forgot to change her gloves before going from dirty to clean, and she did not wash or sanitize her hands before she donned clean gloves. CNA L said it was an infection control issue, and she could have contaminated the multi wipe packet. During a telephone interview on 08/13/24 at 11:35 a.m., the Interim DON said CNA L was supposed to pull wipes out of the wipe packet before she started to wipe Resident #25's peri area and buttocks. The Interim DON said if CNA L needed more wipes, she should have removed the gloves and sanitized her hands before she went back to the multi wipe packet. The Interim DON said it was because of the risk for cross-contamination. The Interim DON said CNA L should have washed or sanitized her hands before she donned new gloves. The Interim DON said the facility did not train or in-service agency aides before the aide would be assigned to the floor because they had a contract with the agency. They know the facility's needs, but she would check with the COO and get back to the surveyor. During an interview on 08/14/24 at 1:28 p.m., the ADON said CNA L should have pulled some wipes out of the container, and if she needed more, she should have changed her gloves before she pulled more wipes from the container. The ADON said if CNA L did not wash or sanitize her hands, it was an infection control issue because it was cross-contamination. The ADON said CNA L could have transferred germs from her used gloves to the multi-wipe packets, and she should have washed or sanitized her hands because the gloves could have had holes. She said CNA L was an agency aide, and the facility did not provide training or in-services before the aide started working. Still, if the agency aide were in the facility during in-service, the agency aide would attend the in-service. Record review of the facility undated policy on housekeeping read in part . provide a safe environment for resident . Record review of the facility undated policy on personal protective equipment - gloves read in part . to prevent the spread of infection . miscellaneous #5 . wash hands after removing gloves. (Note: gloves do not replace handwashing) . Record review of the facility undated policy on hand washing read in part . hand washing will be regarded by this facility as the single most important means of preventing the spread of infections . procedure #2h . after contact . body fluid excretion .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review the facility failed to ensure all mechanical, electrical, and patient care equipment was in safe operating condition for 1 of 6 residents (Resident #25) reviewed for safe operating patient care equipment. The facility failed to maintain Resident #25's electric bed remote in safe operating condition. This failure could put residents in the facility at risk of injury. The findings included: Record review of Resident #25's face sheet dated 08/23/24 revealed she was a[AGE] year-old female admitted to the facility on [DATE]. Resident #25 had diagnoses which included: atrial fibrillation (an irregular heartbeat), hypertension (when the pressure in your blood vessel is too high), dementia (impair ability to remember, think, or make decisions that interferes with doing everyday activities), and need for assistance with personal care Record review of Resident #25's quarterly MDS assessment dated [DATE] revealed a BIMS score of 11 of 15 indicated moderate impaired cognition. Further review revealed the resident needed extensive assistance with ADL one staff assist. Record review of Resident #25's care plan initiated on 07/23/24 revealed resident had ADL self-care performance deficit and at risk for not having her needs met in a timely manner. Performance deficit related to impaired cognition and muscle weakness. Intervention: provide shower, shave, oral care, and nail care, per schedule and when needed. During an observation on 08/12/24 at 10:40 a.m., revealed Resident #25's bed was in a high position. During an observation and interview on 08/12/24 at 1:30 p.m., RN A said the remote control for Resident #25's bed had not been working, and she was not sure if it was reported to the maintenance, and she could not remember reporting it. RN A said Resident #25's bed was in a high position because the remote control would not let the bed down, and if Resident #25 fell out of the bed, Resident#25 could sustain an injury. During an observation and interview on 08/13/24 at 10:10 a.m., revealed Resident # 25 bed was still in a high position. After CNA L and CNA D provided incontinent care for Resident #25, CNA L tried to lower Resident #25's bed, but the bed would not go down. CNA L said she could not lower the bed because the remote malfunctioned. Then CNA D took the bed remote from CNA L and manipulated the bed remote for about 5 minutes. CNA D was able to lower the bed, and he said the remote was not working properly because there was wiring shortage, and the remote needed to be fixed. CNA B said he did not tell the nurse or the maintenance because today was his second orientation day. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/13/24 at 11:00 a.m., CNA L said she worked with Resident #25 yesterday (08/12/24). CNA L said she could not lower Resident #25's bed because the remote control was not working correctly, and she did not tell the nurse or the maintenance because she was an agency aide and did not know who to report to about the bed remote. CNA L said she did not get any training on equipment safety from her agency and the facility. CNA L said if Resident #25 had fallen out of the bed because the bed was left on a high level, Resident #25 could hurt herself. CNA L said the charge nurse monitored the aides when she made rounds. During an interview on 08/14/24 at 8:10 a.m., the ADON said the remote to Resident #25's bed had an electrical shortage, which affected the remote's function and caused the bed not to go down. The ADON said that since the remote was not functioning, this could cause harm to Resident #25 if Resident #25 happened to fall out of the bed because the bed was left in a high position because the remote was not functioning. The ADON said she was not aware the bed remote for Resident #25 had an electrical issue until this week, Monday (08/12/24), and she did not notify maintenance. During an interview on 08/14/24 at 8:14 a.m., the Maintenance assistant said he would become aware that Resident #25's bed remote was not working when one of the nurses told him, and he would get the remote fixed. The Maintenance Assistant said they had an order book at the nursing station for repairs, and there was no repair request for Resident #25's bed remote. The Maintenance Assistant said he was not aware that the bed remote for Resident #25 was not working until yesterday at around 11:00 a.m. (08/13/24). The Maintenance Assistant said the maintenance Director made rounds and checked on the bed remote, but he did not know how often the maintenance director made rounds. The Maintenance Assistant said the Maintenance Director was off this week because he was sick. The Maintenance Assistant said Resident #25 could have fallen out of bed, and Resident #25 could have hurt herself if the bed was left high because the bed remote was not functioning. During an interview on 08/14/24 at 8:42 a.m., The Administrator said the staff that goes into Resident #25's room should have told the manager. The manager would put the order in the telling system, and the maintenance would fix Resident #25's call light. Then the Administrator said he would prefer the nurses to tell maintenance immediately so the maintenance would fix it immediately. The Administrator said if Resident #25 fell from a bed left in a high position, Resident #25 could hurt herself. Record review of the facility undated policy on preventative maintaince read in part . the facility will ensure that a comprehensive preventive maintenance program is in place for essential operating equipment. Preventive maintenance will be completed routinely. and accordingly, to protocol by the maintenance supervisor .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 26867 Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests. The facility failed to ensure the facility was free from pests/insects in multiple areas including one of one kitchen and one of one conference room. This failure could place residents at risk for insect borne illnesses, and cause residents to live in an uncomfortable environment free of pests. Findings included: Observation on 08/12/24 at 10:00am, revealed flies and other flying insects in one of one conference room. Observation and interview with the facility Administrator on 08/12/24 at 2:30PM, revealed the following- Under the kitchen sink revealed multiple flying insects. On the wall above the sink by the window was a live roach. Observation of the dishwasher was a live roach. The facility Administrator asked the dietary Manager to call the pest control company. The Dietary Manager said the company had sprayed the facility a few weeks ago. Observation on 08/13/24 at 12:40PM, revealed live spider crawling from the wall in the conference room. The Administrator was notified. He said he would call the pest control company. Observation and interview on 08/13/24 at 12:30PM revealed a live roach and flies in the conference room. During an interview with the facility Administrator, he said the building was old and the facility had a pest control contract with a local company. He said all staff are responsible to report any pest control problem as to call in the pest control company for treatment. During an interview on 08/13/2024 at 10:12 AM, Resident #113 stated that she had seen cockroaches in her room. She said she believed the facility was aware. During an interview on 08/13/2024 at 9:31 AM, an Anonymous pest control staff said ng the kitchen. He said the only way to get rid of the rodents was to keep the floors around the dishwashing machine dry. During an interview on 08/13/24 at 1:00pm, Housekeeper T said that she had seen roaches in the resident's rooms and around, but they would always call pest control. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	DA stated that the bug on the wall next to the sink was a cockroach. He stated that they were everywhere in the building. He stated that pest control only came once and wished they came more often. He stated that when he saw cockroaches, he usually just killed them. He stated that he had not seen the cockroaches on clean dishes. He stated that they were in the outlet in the hallway and between the wheels of the trash can. He stated that the bug on the wall was next to a clean tray cart and was also a cockroach. During an interview with AFSS on 08/06/2024 at 11:37 AM, he stated that he has worked at the facility for two to three weeks. He stated that he noticed cockroaches shortly after he started. He stated he had not seen cockroaches in food. On 08/06/2024 at 11:39 AM, during an interview with [NAME] A, she stated that she had seen some cockroaches in the kitchen. She stated that she was unsure why they were in the kitchen but had not seen any in the food. Record review of facility's pest control policy undated section 10 read in part: The facility will maintain an effective pest control program in order to provide an insect and vermin free food service department. Procedure: .Arrangements are made with a reputable company for regular spraying for insects which includes rodent control when required. Facility will maintain appropriate screens, close fitting doors, properly sealed water/sewer pipes, structurally maintained walls, baseboards, etc. to prevent entrance access of insects and rodents. Sanitation of facility will be maintained per other stated sanitation policies to prevent food sources, breeding places, etc. for insects or rodents. Deliveries of food and supplies will be monitored for prevention of insect and rodent access .