STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455621	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Grande Manor	1212 S Bridge Weslaco, TX 78596

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based on interview and record review, the facility failed to to ensure all residents had the right to formulate an advance directive for three (Residents #30, #3, and #57) of 24 reviewed for advanced directives, in that: 1. The facility failed to ensure Resident #30's OOH-DNR was completed correctly. The OOH-DNR form did not have the physician's signature in the appropriate place. 2. The facility failed to ensure Resident #3"s OOH-DNR was completed correctly. The OOH-DNR form did not hat the physician's signature in the appropriate place. 3. The facility failed to ensure Resident #57's OOH-DNR was completed correctly. The OOH-DNR form did not have the signature for witness 2 in section E. These failures could affect all residents who have implemented Advance Directives and established their choice not to be resuscitated at risk of receiving CPR against their wishes. The findings were: 1.Record review of Resident #30's Admission Record dated [DATE] revealed Resident #30 was an [AGE] year-old male admitted to facility on [DATE] with diagnoses of Alzheimer's disease glaucoma, hypertension, and a code status of DNR. Record review of Resident #30's Significant Change in Status MDS assessment dated [DATE] indicated Resident #30 was usually understood by others and usually able to understand others and had moderate cognitive impairment. Record review of Resident #30's care plan dated [DATE] indicated Resident #30 chose to have a DNR code status. Interventions included to inform staff of code status. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #30's DNR form dated [DATE] revealed the form was signed by the resident's FM and two witnesses on [DATE]. Resident 30's physician signed on the section for the Physician Statement and signed on section F which was Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative. The Physician failed to sign below where the statement All persons who have signed above must sign below, acknowledging that this document has been properly completed. 2. Record review of Resident #3's electronic face sheet dated [DATE] reflected he was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included: Unspecified fracture of lower end of left tibia (left shin bone), hyperlipidemia (high cholesterol), basal cell carcinoma of skin of face (type of skin cancer on the face), Alzheimer's, hypertension (high blood pressure), congestive heart failure (the heart cannot pump enough blood), dysphagia (difficulty swallowing), peripheral vascular disease (reduced circulation of blood to a body part, other than the brain or heart, due to a narrowed or blocked blood vessel). Resident #3's electronic face sheet reflected he had DNR status. Record review of Resident #3's significant change MDS assessment dated [DATE] reflected he scored a 00 on his BIMS which signified he was severely impaired. He required extensive assistance with his ADL's. Record review of Resident #3's comprehensive care plan, dated [DATE] reflected Focus: the resident/family have chosen to have DNR status, Goal: resident will be kept safe and comfortable but will not receive artificial resuscitation through next review, Interventions: DNR will be respected through next review date. Record review of Resident #3's physician order dated [DATE] reflected Code Status: DNR. Record review of Resident #3's DNR form dated [DATE] revealed the form was signed by the resident's FM and two witnesses on [DATE]. The physicians failed to sign section F which was Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative. The Physician failed to sign below where the statement All persons who have signed above must sign below, acknowledging that this document has been properly completed. 3. Record review of Resident #57's electronic face sheet dated [DATE] reflected he was admitted to the facility on [DATE]. His diagnoses included: Unspecified Dementia (a group of symptoms caused by disorders that affect the brain in which a person loses the ability to think, remember, learn, make decisions, and solve problems), muscle wasting and atrophy (decrease in size or wasting away of a body part, tissue or muscles), other lack of coordination, cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) due to embolism (obstruction of an artery) of other cerebral artery (any of the arteries supplying the cerebral cortex), bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), hyperlipidemia (an abnormally high concentration of fats or lipids in the blood), and chronic systolic congestive heart failure (a specific type of heart failure that occurs in the heart's left ventricle). Resident #57's electronic face sheet reflected he had DNR status. Record review of Resident #57's quarterly MDS assessment dated [DATE] reflected he scored a 02 on his BIMS which signified he was severely cognitively impaired. He required substantial assistance with his ADL's. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #57's comprehensive care plan revealed, Focus: Resident #57 chose Advance Directive as DNR. Date initiated: [DATE]. Goal: status will be maintained through next review date. Date initiated: [DATE] and Target date: [DATE], Interventions: Inform staff of code status. Document and report any decrease in change of condition to MD and responsible party. Date Initiated: [DATE] Revision on: [DATE]. Keep DNR status posted in medical record at all times. Date Initiated: [DATE], Revision on: [DATE]. Notify family/Doctor of any changes. Date Initiated: [DATE], Revision on: [DATE]. Record review of Resident #57's physician order dated [DATE] reflected DNR uploaded under MISC Advance Directive. Record review of Resident #57's OOH-DNR form dated [DATE] revealed the form was signed by one of two witnesses on [DATE] in Section E. The second witness failed to sign section E - Two Witnesses: We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician. The Physician, guardian and witnesses signed the All Persons section at the bottom of the page where the statement All persons who have signed above must sign below, acknowledging that this document has been properly completed. In an interview on [DATE] at 9:46 AM, LVN D said that she checked the DNR orders in PCC under miscellaneous. LVN D said if there was a code, she made sure the form was on PCC. She said without the form the resident was a full code. LVN D said a completed form should have the MD signature, Resident/RP signature, and witnesses' signatures. If any signature was missing on the form, the DNR was void and the resident would be a full code. She said the negative effect would be performing CPR on someone who didn't want it done. In an interview on [DATE] at 2:30 PM, LVN C said that she checked the DNR orders in PCC. LVN C said if there was a code, she would ask for help since she was PRN and not fully familiar with all the residents here. She said if there were no power, she knew that the Social Worker had a binder with hard copies. LVN C said since the DNR was a legal document, it must be witnessed. She said if anything was missing then the DNR would not be valid, but the Social Worker would ensure the form was completed for them. LVN C said the nurse that took the intake was responsible for placing the code status in PCC. She said if the DNR was not valid and the resident coded, they could be legally accountable for incorrect care they provide. In an interview on [DATE] at 2:07 PM, the DON said the DNR form was initiated by the SW. The DON said even if they come from the hospital the facility wanted their own DNR forms. The SW ensured the forms were filled out correctly. The DON said the SW does edit but does not know how thorough she was. Every time they have care plans, they also ask the resident or family if they still want the code status of a DNR. The DON said they followed the doctor's orders, and the doctor signed the telephone orders. The nurses will follow the doctor's order so they would not look for the DNR form in the miscellaneous tab. In an interview on [DATE] at 2:31 PM LVN G said he would check the computer first, then he would ask the ADON or the DON for the code status. LVN G said they have a DNR binder at the nurse's station so he would look in the binder. If the power goes out, they will look in the binder for a resident's code status. If a DNR form is missing a signature, he was trained that the form was not valid. If that occurred, he would call the DON and she would give him guidance on what to do next. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 2:45 PM RN I said the DNR is in PCC and there is an additional form uploaded in PCC. There is a binder at the nurse's station with the DNR forms. If the resident is coding, they will look for the miscellaneous tab in PCC to look at the form to check if it had all signatures and was signed by a doctor. If a resident did not have the DNR form signed by a doctor the resident would be considered full code. In an interview on [DATE] at 3:00 PM, the SW said the Admissions Director would ask the resident or family about DNR status. If the resident wanted to be a DNR, they would sign the form. The SW would send the form to the doctor's office for his signature. Once the doctor signed the form, the doctor would send the signed form to the facility. The Medical Records Clerk would make sure the form was signed correctly. The NP would also ensure the forms were signed by the doctor. The SW or Medical Records Clerk would upload the form onto PCC. The IDT would also review the code status with the resident or family during the care plan meeting. The facility would keep a binder at the nurse's station, but they were told by the corporate that the binder was not necessary because the facility was going paperless. In an interview on [DATE] at 4:35 PM, The Medical Records Clerk said she did not handle the DNR forms. The SW did the DNR process. The SW would have the forms completed and would obtain the physician's signature. The Medical Records Clerk said she only obtained the signatures for transportation and the physician's orders. The Medical Records Clerk would place the folders at the front desk once the forms are signed and the forms would be uploaded to PCC. Once uploaded to PCC the forms would be put in the shred box. In an interview on [DATE] at 4:40 PM, LVN/MDS J and said that the Social Worker is responsible for informing resident/family about the DNR in admissions packet, ensuring it is completed by family and MD, and uploading it into PCC under miscellaneous. He said that his job is just to ensure that it is care planned once it is uploaded. In an interview on [DATE] at 04:49 PM, the Administrator said the Social Services department was responsible for completing the DNR forms for the resident or family at admission. The SW was responsible to verify that the forms are signed correctly on the appropriate spaces. The Administrator said the SW reviewed the DNR forms regularly. Record review of the facility's policy subject titled, Advance Directives, revised [DATE], revealed Policy Statement Advanced directives will be respected in accordance with state law and facility policy. Policy Interpretation and Implementation 15. (e) Do Not Resuscitate- indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26141 Based on interview and record review, the facility failed to notify the resident's representative of a transfer or discharge and the reasons for the move in writing and in a language and manner they understand and failed to send a copy of the notice to the Office of the State Long-Term Care Ombudsman, for 1 Resident (Resident #97) of 24 residents reviewed for hospitalization s. The facility failed to send a written notice of a transfer to Resident #97's RP and to the Office of the State Long-Term Care Ombudsman as soon as practicable after Resident #97 was transferred to the hospital. These failures could place residents at risk of not having access to available advocacy services, discharge/transfer options, and appeal processes. Findings included: Record review of Resident #97's physician's orders revealed R#97 was admitted to the facility on [DATE] and readmitted on [DATE]. R#97's diagnoses included Alzheimer's disease (progressive disease that destroys memory and other important mental functions), encephalopathy (a group of conditions that cause brain dysfunction), pneumonia (an infection that inflames the air sacs in one or both lungs), Type 2 Diabetes Mellitus (a chronic condition that affects the way the body processes blood sugar). Record review of Resident #97's annual MDS assessment, dated 04/29/24, indicated Resident #97 had clear speech, was usually understood by others, was usually able to understand others, and had moderate cognitive impairment. Record review of Resident #97's Progress Notes, dated 04/23/24 revealed: Patient labs came back with critical potassium at 2.5, was sent out to micro hospital. Record review of R#97's clinical record revealed no documentation that the Ombudsman or R#97's RP were informed in writing that the resident was transferred to the hospital. In an interview on 05/16/24 at 10:50 AM, the local Ombudsman revealed the facility was not sending notices of discharges or transfers to her. In an interview on 05/17/24 at 4:35 PM RN I said when a resident is sent to the hospital the nurse would call the RP and provide information via telephone. RN, I said they do not give anything in writing to the RP. In an interview on 05/17/24 at 5:55 PM the DON said the facility does not provide anything in writing to the RP when they transfer a resident to the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/17/24 at 6:05 PM, the BOM said she does not provide a copy of the Bed Hold Policy when a resident is transferred to the hospital or anything in writing about why the resident was transferred. The nurses do that. In an interview on 05/17/24 at 6:35 p.m. with a FM of another resident, the FM said the facility did not provide anything in writing when her resident was sent to the hospital. Record review of the facility's revised policy on Transfer or Discharge Notice dated December 2016 revealed: Policy Interpretation and Implementation 2. Under the following circumstances, the notice will be given as soon as is practicable but before the transfer or discharge: f. An immediate transfer or discharge is required by the resident's urgent medical needs. 3.The resident and/or representative (sponsor) will be notified in writing of the following information: a. The reason for the transfer or discharge. b. The effective date of the transfer or discharge. c. The location to which the resident is being transferred or discharged . d. A statement of the resident's rights to appeal the transfer or discharge, including.' (1) the name, address, email, and telephone number of the entity which receives such requests. (2) information about how to obtain, complete and submit the appeal form; and (3) how to get assistance completing the appeal process. f. The name, address, and telephone number of the Office of the State Long-term Care Ombudsman. 4. A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26141 Based on interview and record review, the facility failed to provide to the resident and the RP a written a notice of bed-hold policy before, or at the time of transfer for 1 Resident (Resident #97) of four residents reviewed for transfers. The facility did not provide written information on the facility's bed-hold policies to Resident #97 or to his RP when resident was sent to the hospital. This failure could place residents at risk for not receiving a notice of the facility's bed hold policy before/upon transfer and not having the necessary information to decide on whether to incur bed hold payments and have the opportunity for the resident to return to the facility. The findings were: Record review of Resident #97's physician's orders revealed R#97 was admitted to the facility on [DATE] and readmitted on [DATE]. R#97's diagnoses included Alzheimer's disease (progressive disease that destroys memory and other important mental functions), encephalopathy (a group of conditions that cause brain dysfunction), pneumonia (an infection that inflames the air sacs in one or both lungs), Type 2 Diabetes Mellitus (a chronic condition that affects the way the body processes blood sugar). Record review of Resident #97's annual MDS assessment, dated 04/29/24, indicated Resident #97 had clear speech, was usually understood by others, was usually able to understand others, and had moderate cognitive impairment. Record review of Resident #97's Progress Notes, dated 04/23/24 revealed: Patient labs came back with critical potassium at 2.5, was sent out to micro hospital. Record review of R#97's clinical record revealed no documentation that Resident #97 or his RP were provided a copy of the bed-hold policy in writing when the resident was transferred to the hospital. In an interview on 05/17/24 at 4:35 PM RN I said when a resident was sent to the hospital the nurse would call the RP and provide information via telephone. RN I said they do not give anything in writing to the RP. In an interview on 05/17/24 at 5:55 PM the DON said they do not provide anything in writing to the RP when they transfer a resident to the hospital. The DON said nursing did not provide the bed hold form during transfer, the Business office does that. In an interview on 05/17/24 at 6:05 PM, the BOM said she does not provide a copy of the Bed Hold Policy when a resident was transferred to the hospital or anything in writing about why the resident was transferred. The nurses do that. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/17/24 at 6:34 PM, Surveyor attempted to contact Resident 97's RP but was unsuccessful. In an interview on 05/17/24 at 6:35 p.m. with a FM of another resident, the FM said the facility did not provide anything in writing when her resident was sent to the hospital. Record review of the facility's revised policy on Transfer or Discharge Notice dated December 2016 revealed: Policy Interpretation and Implementation 2. Under the following circumstances, the notice will be given as soon as is practicable but before the transfer or discharge: 3.The resident and/or representative (sponsor) will be notified in writing of the following information: a. The reason for the transfer or discharge. b. The effective date of the transfer discharge. c. The location to which the resident is being transferred or discharged . d. A statement of the resident's rights to appeal the transfer or discharge, including.' (1) the name, address, email, and telephone number of the entity which receives such requests. (2) information about how to obtain, complete and submit the appeal form; and (3) how to get assistance completing the appeal process. e. The facility bed-hold policy. f. The name, address, and telephone number of the Office of the State Long-term Care Ombudsman. 4. A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman. 47828

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical and nursing needs and describes the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #40), reviewed for care plans. The facility failed to ensure Resident #40's comprehensive care plan dated 04/17/2024 reflected she had an order for O2 at 2 Lpm via N/C continuously. These deficient practices could place residents in the facility at risk of not being provided with the necessary care or services and no having personalized plans developed to address their specific needs. The Findings included: 1. Record review of Resident #40's face sheet dated 05/15/2024 revealed the resident was an [AGE] year-old female with an admitted [DATE]. Resident #40's relevant diagnoses included: chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), transient ischemic attack (a short period of symptoms like those of a stroke), and hypertension. Record review of Resident #40's quarterly MDS assessment dated [DATE] revealed a BIMS score of 12, indicating Resident #40's cognition was moderately intact. Record review of Resident #40's oxygen order revealed O2 at 2L via N/C Continuously. Date ordered 03/07/2024 and end date was indefinite. An observation on 05/14/24 at 11:30 a.m., revealed the signage on Resident #40's door read Oxygen in Use. Resident #40 was lying in her bed with O2 via nasal cannula set at 2.5 Lpm. An interview on 05/14/2024 at 11:33 a.m., Resident #40 said she had been placed on oxygen sometime ago. She said she had felt better since being on oxygen. An observation/interview on 05/15/2024 at 3:37 p.m., ADON was not able to say if Resident #40 had any negative outcome for not having her O2 order care planned. An interview on 05/16/2024 at 10:00 a.m., the DON was not able to say if Resident #40 had any negative outcome for not having her O2 order care planned. Record review of facility's Care Plans, Comprehensive Person-Centered policy dated 03/2022 revealed no mention of Resident #40 had an order for oxygen. Policy Statement: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A comprehensive, person-centered plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 7. The comprehensive, person-centered care plan a. Includes measurable objectives and timeframes. b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being: c. Includes the resident's stated goals upon admission and desired outcomes. d. Builds on the resident's strengths; and e. Reflects currently recognized standards of practice for problem areas and conditions.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care was provided such care consistent with professional standards of practice for 2 of 6 residents (Resident #40, and Resident #3) reviewed for oxygen in that: 1. Resident #40's oxygen was administered at 2.5 Lpm instead of 2.0 Lpm via nasal cannula as ordered by physician. 2. Resident #3's oxygen was administered at 4 Lpm instead of 2 Lpm via nasal cannula as ordered by the physician. This failure could place residents who received oxygen at risk of developing respiratory complications and a decreased qualify of care. The findings included: 1. Record review of Resident #40's face sheet dated 05/15/2024 revealed the resident was an [AGE] year-old female with an admitted [DATE]. Resident #40's relevant diagnoses included: chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), transient ischemic attack (a short period of symptoms like those of a stroke), and hypertension. Record review of Resident #40's quarterly MDS assessment dated [DATE] revealed a BIMS score of 12, indicating Resident #40's cognition moderately impaired. Record review of Resident #40's oxygen order revealed O2 at 2L via N/C Continuously. Date ordered was 03/07/2024 and end date was indefinite. An observation on 05/14/24 at 11:30 a.m., revealed the signage on Resident #40's door read Oxygen in Use. Resident #40 was lying in her bed with O2 via nasal cannula set at 2.5 Lpm. An interview on 05/14/2024 at 11:33 a.m., Resident #40 said she had been on oxygen sometime ago. She said she felt better now that she was on oxygen. An observation/interview on 05/15/2024 at 3:30 PM LVN C was observed checking Resident #40's oxygenator and said it was set at 2.5 Lpm. She then checked Resident #40's order on PCC and said prior to 05/15/2024 her O2 order was for her to receive 2.0 Lpm continuously via nasal cannula. LVN C said effective 05/15/2024 Resident #40's oxygen order was to receive 2 Lpm PRN via nasal cannula. LVN C said there were no negative effects to Resident #40 if she received 2.5 Lpm instead of 2.0 Lpm of oxygen. (continued on next page)

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	455621	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Grande Manor	1212 S Bridge Weslaco, TX 78596

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation/interview on 05/15/2024 at 3:37 p.m., ADON was observed in Resident #40's room and checked her oxygenator and said it was set at 2.5 Lpm. Resident #40 was not receiving O2 at time of observation, but the oxygenator was on and set at 2.5 Lpm. ADON was then observed walking over to her office to check Resident #40's order on PCC and said prior to 05/15/2024 her O2 order was for her to receive 2.0 Lpm continuously via nasal cannula. ADON said effective 05/15/2024 Resident #40's oxygen order was to receive 2 Lpm PRN via nasal cannula. ADON said there were no negative effects to Resident #40 if she received 2.5 Lpm instead of 2.0 Lpm of oxygen as ordered. An interview on 05/16/2024 at 10:00 a.m., the DON said there was no negative outcome to Resident #40 who received 2.5 Lpm of oxygen instead of 2.0 Lpm as ordered by physician. 2. Record review of Resident #3's electronic face sheet dated 05/17/2024 reflected he was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included: Unspecified fracture of lower end of left tibia(left shin bone) , hyperlipidemia (high cholesterol), basal cell carcinoma of skin of face (type of skin cancer on the face), Alzheimer's, hypertension (high blood pressure), congestive heart failure(the heart cannot pump enough blood), hemiplegia (one sided muscle paralysis or weakness), dysphagia (difficulty swallowing), peripheral vascular disease (reduced circulation of blood to a body part, other than the brain or heart, due to a narrowed or blocked blood vessel). Record review of Resident #3's quarterly MDS assessment dated [DATE] reflected he scored a 00 on his BIMS which signified he was severely cognitively impaired. Record review of Resident #3's comprehensive person-centered care plan, date initiated 12/14/23 reflected Focus Resident #3 has altered respiratory status/difficulty breathing r/t congestive heart failure. Goal: The resident will have no s/sx of poor oxygen absorption through the review date. The resident will have no complications related to SOB through the review date. Intervention: . Oxygen settings: Continuous oxygen via nasal cannula at 2LPM every shift for SOB. Record review of Resident #3's Physician Order, dated 1/26/24, reflected there was an order for oxygen administration O2 via nasal cannula continuous at 2 L/Min every shift. During an observation on 05/15/24 at 09:20am, Resident # 3 was lying in her bed with O2 via nasal cannula. Resident #3 observed in no distress. Resident #3's oxygen was set at 4 L/min. During an observation on 05/15/24 at 01:26pm, Resident # 3 was lying in her bed with O2 via nasal cannula. Resident #3 observed in no distress. Resident #3's oxygen was set at 4 L/min. In an interview and observation on 05/15/24 at 1:30pm, LVN G, stated she is the nurse for Resident #3. She walked with the surveyor to Resident #3's room and verified the oxygen setting. LVN G stated the oxygen setting was at 4L/min. LVN G then logged onto her computer, reviewed Resident #3's oxygen setting physician order and stated it has 2L/min. LVN G stated she checked Resident #3's oxygen setting this morning around breakfast time and it was at 4L/min . She also checked Resident #3's O2 saturation and stated it was good. LVN G stated she checks the resident's oxygen setting every shift. She stated the negative outcome to keeping Resident #3's oxygen setting at 4L/min is that it would cause Resident #3 to have more respiratory issues. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/15/24 at 1:45pm the DON stated that the nurses are responsible for checking the O2 setting on the concentrator. She stated that the O2 setting should be checked every shift when they walk in to make sure it is as prescribed. The DON stated that she has managers that do room rounds and are instructed to check everything. She stated that some managers are not clinical staff so they might not be checking everything. She stated the manager that does room rounds in Resident #3's room is the CS . The DON stated that the nurses are provided training for oxygen administration upon hire. She is currently working with a respiratory therapist to come and do training on an annual basis. The DON stated the negative outcome to keeping Resident #3's oxygen setting at 4L/min would be that I want to make sure Resident #3 oxygen saturation is between 95-100%. In an interview on 05/15/24 at 1:59pm, CS stated that she does morning rounds every day in the D wing. This was the hall where Resident #3's room was located. She stated that she checks the rooms that the call lights are in place, restrooms are clean, and trash cans have bags. CS also asks the residents if they need anything. She stated she does not check the oxygen setting. CS stated she checks the oxygen concentrator that they are clean, makes sure it is working properly and not beeping. If the concentrator is beeping, then she will call the nurse. She stated she did her morning rounds today, 05/15/24. Record review of the facility's policy subject titled, Oxygen Administration, revised October 2010, revealed, The purpose of this procedure is to provide guidelines for safe oxygen administering. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physicians' orders . Record review of the facility's policy subject titled, Medication and Treatment Orders, reviewed, July 2016, revealed, Orders for medications and treatment will be consistent with principles of safe and effective order writing. 1. Medications shall be administered only upon the written order . 48278

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49301 Based on interviews and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 25 residents who receive insulin services. The facility failed to keep an updated calibration log documenting the control solution testing results for the facility's blood glucose meters. This failure could result in not determining if the glucometers were functioning properly and/or obtaining false glucometer readings. The findings included: Record review of the facility's Resident Matrix dated 5/13/24 revealed the facility had 25 residents who were insulin dependent. Record review of the facility's Blood Glucose Monitoring System User's Guide for Control Solution Testing revealed that the intended use for the control solution is as a quality control check to verify the accuracy of blood glucose test results. Use Control Solution: Before testing with the system for the first time. When you open a new bottle of test strips. Whenever you suspect the meter or test strips may not be functioning properly. If test results appear to be abnormally high or low or are not consistent with clinical symptoms. The test strip bottle has been left open or has been exposed to light, temperatures below 39 F (4 C) or above 86 F (30 C), or humidity levels above 80%. To check your technique. When the meter has been dropped or stored below 32 F (0 C) or above 122 F (50 C). Each time the batteries are changed. Record review of Glucometer logs from March 2024 to May 2024 for A and D wing. A wing glucometer logs missing: 3/18-3/31 and the month of April of 2024. D wing glucometer logs missing: 3/18-3/31 and 4/1-4/10 of 2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Glucometer logs from March 2024 to May 2024 for B and C wing. B wing glucometer logs missing months of March and April. C wing glucometer logs missing: 3/22-3/28, 4/1-4/2, 4/10-4/13, and 4/26-4/28 for 2024. Interview on 05/15/24 at 01:45 PM with LVN D and she said that the night shift completes glucometer calibrations and updates glucometer logs daily. LVN D also said that glucometer calibrations are also completed anytime a new bottle is opened. As per LVN D, if glucometers are not calibrated, the glucometers may not provide a true reading. Interview on 5/15/24 at 2:20 PM with LVN N and he said that usually the 10-to-6-night shift completes glucometer calibrations and logs. He said uncalibrated glucometers could give bad glucose readings. As per LVN N, he has not been aware of any glucometer readings that are out of the resident's normal parameters. Interview on 5/15/24 at 2:24 pm with the DON and she said that the night shift is responsible for glucometer calibration checks. She said they also complete glucometer calibrations when they open a new bottle. She said the negative effect could be inconsistencies in the functioning of the glucometer and the glucose readings. Record review of the facility's policy on Obtaining a Fingerstick Glucose Level revised October 2011 revealed: The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level. Preparation 4. Ensure that the equipment and devices are working properly by performing any calibrations or checks as instructed by the manufacturer.

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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** 48278 Based on observation, interviews, and record review, the facility failed to establish and maintain an infection prevention and control program, designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for 2 of 2 Residents (Resident #17, and Resident #11) that were reviewed for infection control and transmission-based precautions policies and practices, in that: The facility failed to ensure CNA K performed proper pericare (incontinent care) for Resident #17 and #11. The facility failed to ensure CNA K performed hand hygiene during incontinent care on Resident #17. The facility failed to ensure CNA L performed hand hygiene during incontinent care on Resident #11. These deficient practices could place residents in the facility at risk for infections due to improper incontinent care and lead to the spread of infection to residents, resident illness, and/or resident distress. Findings included: 1.Record review of Resident #17's electronic face sheet dated 05/17/2024 revealed the resident was an [AGE] year-old male admitted to the facility on [DATE] and original date 03/17/2022. His diagnoses included Displaced Fracture of Olecranon (elbow fracture), Alzheimer's, Hypothyroidism, Type 2 Diabetes Mellitus, Anxiety Disorder, Dementia, Essential Hypertension (high blood pressure), Peripheral Vascular Disease (reduced circulation of blood to a body part, other than the brain or heart), Muscle weakness, chronic kidney disease, stage 3. Record review of Resident #17's comprehensive MDS assessment, dated 05/02/2024 revealed a BIMS score of 01, indicating Resident #17 was severely cognitively impaired. Resident #17's urinary incontinence is always incontinent, and bowels is always incontinent. Record review of Resident #17's comprehensive person-centered care plan, dated on 03/20/2022 reflected Focus Resident #17 has bowel and bladder incontinence related to Dementia, Alzheimer's, Poor toileting habits. Intervention Resident #17 clean peri-area with each incontinence episode. Observation on 05/15/24 at 02:45pm, revealed CNA K performed incontinent care for Resident #17, and did not clean the penis, scrotum, and inner thighs. She used one wipe to clean underneath the scrotum from side to side, while Resident #17 was logged rolled to one side. CNA K then removed dirty gloves and put on clean gloves without sanitizing her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Record review of Resident #11's electronic face sheet dated 05/17/2024 revealed the resident was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Heart Failure, Need for Assistance with Personal Care, Muscle Weakness, Dementia, Dysphagia (difficulty swallowing), Essential Hypertension (high blood pressure), Malignant Melanoma of Skin Unspecified (a type of skin cancer), Rhabdomyolysis (the breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood), Major Depressive Disorder. Record review of Resident #11's quarterly MDS assessment, dated 02/14/2024 revealed a BIMS score of 06, indicating Resident #11 was severely cognitively impaired. Resident #11's urinary incontinence is always incontinent, and bowels is always incontinent. Record review of Resident #11's comprehensive person-centered care plan, dated on 10/20/2023 reflected Focus Resident #11 has bowel and bladder incontinence related to Dementia, Disease process, and impaired mobility. Intervention Resident #11 clean peri-area with each incontinence episode. Observation on 05/15/24 at 03:03pm, revealed CNA K used one wipe to clean left and right inner thighs on Resident #11. CNA K then removed dirty gloves and put on clean gloves without sanitizing her hands. CNA K did not rinse or dry the perineal area. CNA L also removed dirty gloves and put on clean gloves without sanitizing his hands. In an Interview on 05/15/24 at 03:15 PM with CNA K, stated she forgot to clean Residents #17's penis, scrotum, and inner thighs because she was nervous. She stated the front area should be cleaned first. She stated she did not have enough wipes to use, and this was why she only used one to clean both sides. CNA K stated she forgot to rinse and dry Resident #11's perineal area because she was nervous. CNA K stated she forgot to use hand sanitizer between glove changes on both residents. She stated the potential negative outcome was infection. She stated she has been trained on incontinent care. CNA K stated she has competency checks for incontinent care once a year. She does not remember when the last in-service for infection control was done. In an interview on 05/15/24 at 03:21pm with CNA L, stated he completely forgot to use hand sanitizer between glove change with Resident #11. CNA L stated the potential negative outcome of not sanitizing hands in between glove changes was infection. He stated that he had been trained on incontinent care. CNA L stated, wound care nurse does competency checks for incontinent care once a year. He stated in service for infection control was done about twice a month. In an interview on 05/15/24 at 3:31pm with LVN M, the wound care nurse, stated she does not do incontinent care skill check offs. In an interview on 05/15/24 at 04:45pm with the DON, she stated that the CNAs always have access to supplies to include wipes. She stated CNAs have competency checks for incontinent care done yearly and as needed. The DON stated that the CNAs should have sanitized their hands in between glove changes to prevent infection. The DON stated she could not remember when the last in-service for infection control was done. Surveyor requested a copy of the most recent in service. Copy was not provided. Record review of CNA K, Perineal Care Performance Skills Checklist dated 04/29/24 revealed she performed satisfactory with providing incontinent care to male and female residents in accordance with the facility's standard of practice. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CNA L, Perineal Care Performance Skills Checklist dated 04/29/24 revealed he performed satisfactory with providing incontinent care to male and female residents in accordance with the facility's standard of practice. Record review of the policy titled Perineal Care date revised February 2018 revealed the following: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Steps in the Procedure for a female resident: a. (2) Continue to cleanse the perineum moving from inside outward to the thighs. Rinse perineum thoroughly in same direction, using disposable wipes. (4) Gently dry perineum. Steps in the Procedure for a male resident: (e) Cleanse perineal area starting with urethra and working outward. (i) Continue to clean the perineal area including the penis, scrotum and inner thighs.

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F 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough backup water supply for essential areas of the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26141 Based on observation and interview the facility failed to establish procedures to ensure that water was available to essential areas when there is loss of normal water supply. The facility failed to ensure the emergency water supply was readily available and stored in a safe and sanitary manner. The facility's emergency water supply was stored two blocks from the facility in a warehouse. This failure could place residents at risk of serious risk for complications from water that might be contaminated due to poor sanitary conditions. In an interview on 05/14/24 at 3:00 PM, The DM said the emergency water supply was across the street in the laundry department. The kitchen has a 7-day supply of food and once hurricane season starts she would order extra supplies of foam plates, cups, utensils and would order extra food supplies. On 05/16/24 at 9:21 AM, Surveyor conducted an observation of the laundry department located 0.2 miles from the facility. The water supply was in a warehouse type building. The laundry was at the front of the building. The emergency water supply was in a room at the back of the building. There were approximately 100 5-[NAME] jugs on pallets. Surveyor was unable to count all the jugs because there were too many boxes on top of the jugs along the back wall on the west side. Surveyor also observe an opened package of blue plastic lids on top of one of the boxes. There were 36 water jugs on pallets alongside the wall by the door and 4 jugs off the pallet. The rest of the jugs were toward the back wall of the building. There was dust on the 5-gallon jugs. Surveyor observed five jugs did not have caps, two jugs had what looked like a white paper napkin around the opening of the jug and a rubber band around the paper. Surveyor observed three jugs with dusty transparent plastic around the opening of the jugs and the cap over the plastic. The back wall had two vent openings to the outside and no air conditioning. In an interview on 05/17/24 at 10:23 AM, the Maintenance Supervisor said he checks the emergency water supply every two months. The Maintenance Supervisor said the building does not have air conditioning, but the weather has not been too hot, it's been around 85 degrees and the water bottles are not in direct sunlight. The Maintenance Supervisor said he did not know that some of the jugs did not have caps. The Maintenance Supervisor said he had new caps and would put them on. The Maintenance Supervisor said he would move the water supply to a room in the back of the facility that is air conditioned. In an interview on 05/17/24 at 11:48 AM, the Dietary Manager said the Maintenance Supervisor was responsible for the emergency water supply. The DM said they rotate the water jugs often. The Maintenance Supervisor would bring them to the kitchen for use and the Rehab department also uses the water. The Dietary Manager said she didn't know what the Rehab department uses the water for. The Dietary Manager said if they get notice of a hurricane or a notice that the water will be shut off, she and the staff will start filling the large pots and pans with water. (continued on next page)

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F 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/17/24 at 1:36 PM, the SLP said they do not use the facility's emergency water supply, they have their own bottles of water. The therapy department kept the jugs of 5 gallons on site. They used it for the hydrocollator (The hydrocollator, first introduced in 1947 by the Chattanooga Pharmaceutical Company, consists of a thermostatically controlled water bath for placing bentonite-filled cloth heating pads. When the pads are removed from the bath, they are placed in covers and placed on the patient). They do not use the water for drinking. In an interview on 05/17/24 at 4:49 PM, the Administrator said the Maintenance director was responsible for the emergency water supply. The Administrator said he did not know some of the water jugs did not have lids. Record review of the facility's policy for emergency water supply dated 2019 revealed: Preparing/Using Water Containers 1. Use food grade water storage containers made specifically for water storage. 2. Clean and sanitize containers prior to use. 6. Store in a cool dark place. Source: Federal Emergency Management Agency. Ready.gov Web site. Water. Updated 4/9/14. http://www.ready.gov/water. Accessed March 4, 2019.