STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455646	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Manor Nursing & Rehabilitation Center	1007 S Washington Ave Marshall, TX 75670

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observations, interviews, and record review the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 19 residents (Resident #76) reviewed for reasonable accommodations. The facility failed to ensure Resident #76 had a comfortable mattress. This failure could place residents at risk of a diminished quality of life due to an environment that is uncomfortable. Findings included: Record review of Resident #76's face sheet dated 5/7/25 indicated Resident #76 was a [AGE] year-old male admitted to the facility on [DATE]. Resident #76 had diagnoses including cerebral infarction (occurs when blood flow to the brain is blocked, leading to tissue damage or death), pain, insomnia (is a sleep disorder characterized by difficulty falling asleep, staying asleep, or waking up too early, causing daytime impairments), type 2 diabetes (is a chronic condition that happens when you have persistently high blood sugar levels), and hemiplegia (is a condition characterized by paralysis affecting one side of the body) and hemiparesis (is one-sided muscle weakness). Resident #76's face sheet indicated. Record review of Resident #76's quarterly MDS assessment dated [DATE] indicated Resident #76 was understood and had the ability to understand others. Resident #76's BIMS score was 13 which indicated intact cognition. Resident #76 required setup assistance for ADLs. Resident #76 was at risk for developing pressure ulcers/injuries. Record review of Resident #76's care plan dated 9/10/24 indicated Resident #76 was at risk for alternations in skin integrity due to impaired mobility and potential for skin associated skin damage due to occasional incontinence of bowel and bladder. Interventions included provide all preventative skin care and interventions as directed. Record review of a maintenance request dated 5/5/25 at 1:30 p.m. indicated, .RN D . [Resident #76's room] . description of problem .wants a new mattress . if corrected please explain what you did to correct .replaced mattress .completed by Maintenance J .5/5/25 . (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/5/25 at 10:31 a.m., Resident #76 was lying in the bed. Resident #76 said his only complaint was he had asked for a new mattress at the beginning of last week and still had not gotten one. He said the mattress was not comfortable and it was thin. He said he could not remember who the person was he told about wanting a new mattress. The state surveyor was unable to fully visualize Resident #76's mattress due to the resident being in the bed. Resident #76's mattress appeared slightly lower towards the middle of the mattress. During an observation and interview on 5/6/26 at 3:35 p.m., LVN K said Resident #76 had complained a few times about his mattress. She said Resident #76 had recently lost weight and may have a hole in the mattress from when he was heavier. She said she had not put a work order in for Resident #76's mattress. She said someone else may have done it. LVN K looked in the maintenance request book at the nursing station. Resident #76 had a maintenance request dated and completed on 5/5/25. During an interview on 5/7/25 at 10:17 a.m., RN D said on 5/5/25 was the first time Resident #76 had mentioned his mattress was uncomfortable. She said she put the mattress change request in the maintenance book on 5/5/25 and it was changed the same day. She said it was the resident's right to be comfortable and it affected the resident's dignity to have a good mattress. She said the residents could become unhappy, lose sleep, and become dissatisfied if they had to sleep on an uncomfortable mattress. During an interview on 5/7/25 at 10:20 a.m., CNA F said Resident #76 had never mentioned his mattress being uncomfortable to her. She said Resident #76 laid in his bed a lot. She said if a resident complained about their mattress, she would put it in the maintenance book. She said then maintenance would swap the mattress out for the resident. She said lying on an uncomfortable mattress could cause the resident's back to hurt or develop bed sores. During an interview on 5/7/25 at 3:01 p.m., Maintenance J said Resident #76's mattress was changed on 5/5/25. He said if staff needed something from maintenance, it was placed in the maintenance request book. He said sometimes staff told him things verbally. He said on 5/5/25 was the first time he was aware Resident #76 wanted a new mattress. He said Resident #76 told him the mattress hurt. He said Resident #76's mattress did have an indentation in it. During an interview on 5/7/25 at 3:05 p.m., the DON said anyone could put a maintenance request in the maintenance book. She said primarily the nurses put the request in the book. She said she expected staff to place the work order in the maintenance book the same day it was found or reported. She said most of the time, maintenance was able to fix the issue the same day or the next day. She said it was important for a resident to have a comfortable mattress to rest well and prevent skin breakdown. She said an uncomfortable mattress could affect the resident's behavior, appetite, and skin integrity. She said she did not know if maintenance performed mattress inspections. During an interview on 5/7/25 at 3:34 p.m., LVN K said she may have verbally told maintenance about Resident #76's request for a new mattress. She said she also may have put a maintenance request in the book, and it was previously pulled. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/25 at 3:40 p.m., the Administrator said staff verbally told maintenance about work requests if they were available or placed it in the maintenance book. He said any staff could report a maintenance issue. He said a resident was at risk for sleep deprivation if they had an uncomfortable mattress. He said the facility did not do scheduled mattress inspections. He said the CNAs, residents, or family members reported issues with mattresses. Record review of a facility's Quality of Life- Accommodation of Needs revised 8/2009 indicated, . Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being . The resident's individual needs and preferences shall be accommodated to the extent possible .

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observations, interviews, and record review, the facility failed to ensure residents received care, consistent with professional standards of practice, to prevent pressure ulcers based on the comprehensive assessment for 1 of 5 Residents (Resident #9) whose records were reviewed for skin integrity. The facility failed to ensure Resident #9's pressure-relieving mattress (is designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) was on the correct settings. This failure could place residents at risk for developing pressure ulcers and could contribute to developing avoidable pressure ulcers. Findings included: Record review of Resident #9's face sheet dated 05/07/25 indicated a 97-years-old female initially admitted to the facility on [DATE]. Resident #9 had diagnoses including pressure ulcer of sacral region stage 2 (stage 2 pressure injuries are opened. The skin breaks open, wear away, or forms an ulcer, which is usually tender ad painful), contracture of muscle, multiple sites, hemiplegia and hemiparesis following a cerebral infarction affecting the right side(weakness of the right side following a stroke), contracture of muscle, left ankle and foot, contracture, right foot, contracture, left foot, muscle weakness (decreased strength in the muscles) and muscle wasting and atrophy, not elsewhere classified (multiple sites multiple muscle groups throughout the body are experiencing a loss of muscle mass and strength). Record review of Resident #9's quarterly MDS assessment dated [DATE] indicated Resident #9 was usually understood and usually understood others. Resident #9 had a BIMS score of 3 which indicated severe cognitive impairment. Resident #9 required maximal assistance to roll left and right. Resident #9 was dependent to sit to lying, lying to sitting on side of the bed, and chair-to-chair transfer. Resident #9 weighed 136 pounds. Resident #9 was at risk of pressure ulcer/injuries. Resident #9 received pressure ulcer/injury care as skin and ulcer/injury treatment, pressure reducing device for bed, and application of dressing to feet. Record review of Resident #9's care plan dated 01/02/24 indicated a pressure ulcer: actual stage 2 sacrum pressure ulcer, related to decreased mobility, nutritional risk, and friction/shear. Interventions included pressure relieving mattress, pressure-relieving cushion, repositioning every 2 hours, treatments per MD orders, assess wound weekly as per schedule and as needed, incontinent care as needed, notify MD/RP of any changes in status, update MD/RP weekly on wound progress, seen by wound specialist in house weekly, nutritional supplement prostat, vitamins/ minerals multi vitamin, zinc and vitamin C, and treatment collagen. Record review of Resident #9's care plan dated 04/28/25 indicated a pressure ulcer: pressure ulcer, related to decreased sensation, decreased mobility, and incontinence. Interventions included reposition every 2 hours, collagen and dry dressing treatments every Monday, Wednesday, and Friday, assess wound weekly, incontinent care as needed, and notify MD/RP of any changes in status. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility's wound report dated 03/26/25-05/01/25 indicated .Resident #9 .facility acquired on 04/28/25 .stage 2 sacrum .improved .0.3x0.4x0.1 centimeters .assessment date 04/30/25 . Record review of Resident #9's physicians order dated 04/28/25 indicated sacrum: cleanse with normal saline or wound cleanser, pat dry, apply collagen to wound bed, then cover with dry dressing, as needed related to pressure ulcer of sacral region, stage 2. Record review of Resident #9's physicians order dated 04/28/25 indicated sacrum: cleanse with normal or wound cleanser, pat dry, apply collagen to wound bed, then cover with dry dressing, every day shift every Mon, Wed and Friday related to pressure ulcer of sacral region, stage 2 . Record review of Resident #9's weight record dated 05/06/25 indicated: *01/06/25 141 pounds *02/06/25 134.8 pounds *03/06/25 136.8 pounds *04/03/25 134.8 pounds During an observation on 05/05/25 at 9:21 a.m., Resident #9 was lying in bed resting. Resident #9 said she had no complaints about the facility. Resident #9's pressure relieving mattress weight setting was 360 pounds. During an observation on 05/05/25 at 3:13 p.m., Resident #9 was lying in her bed asleep. Resident #9's pressure relieving mattress weight setting was 360 pounds. During an observation on 05/06/24 at 9:31 a.m., Resident #9 was lying in her bed resting. Resident #9's pressure relieving mattress weight setting was 360 pounds. During an interview on 05/06/25 at 2:36 p.m., LVN Q said she did not know Resident #9 had a certain setting her bed needed to be set on. She said maintenance was responsible for the bed setting as far as she knew or maybe the treatment people. She said if the bed was not on the right setting that could cause a problem with the resident, such as skin breakdown. During an interview on 05/07/25 at 1:46 p.m., the Treatment Nurse said the charge nurse was responsible for the setting on the beds with the low air loss mattress beds. He said Resident #9 bed should be set according to her weight. He said a negative effect of the wrong setting of the low air loss mattress would be the flow would not circulate correctly if the setting was not set correct. He said too firm would have too much pressure and too soft would cave in on Resident #9. He said with the bed not set to the correct weight it would minimize Resident #9's healing potential. During an interview on 05/07/25 at 2:01 p.m., LVN ADON P said the nurse were responsible for ensuring that the low air loss mattress was on the correct setting. She said the mattress should be set according to the resident's weight. She said if there has too much pressure or too low pressure it could affect the resident and the mattress would be ineffective for the resident. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/07/25 at 2:33 p.m., the DON said the pressure relieving mattress should be set based on resident weight. She the nurses were responsible for making sure the beds were on the correct settings. She said if a mattress was too firm, it could cause skin breakdown or worsen the skin breakdown. During an interview on 05/07/25 at 2:46 p.m., the ADM said the nurses were responsible for ensuring the setting was set correctly for the pressure relieving mattress. He said the settings were normally based on the weight of the resident. He said with bed not on the correct setting could lead to a decline in Resident #9's skin integrity. Record review of a facility's Pressure Ulcer/Injury Risk Assessment policy revised 09/2013, indicated . The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing pressure ulcers/injuries.the care plan must be modified as the resident's condition changes, or if current interventions are deemed inadequate. Record review of a facility's Support Surface Guidelines policy dated 09/2013, indicated . The purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown.redistributing support surfaces are to promote comfort for all bed- or chairbound residents, prevent skin breakdown, promote circulation, and provide pressure relief or reduction. any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as foam, gel, static air, alternating air, or air-loss or gel when lying in bed . Record review of a facility's Pressure Ulcer Injury Overview policy revised 07/2017, indicated . The purpose of this procedure is to provide information regarding clinical identification of pressure ulcers/injuries and associated risk factors, which is derived from the definitions in S483.25(b)(1) Pressure ulcers . Record review of a facility's Prevention of Pressure Ulcer policy revised 07/2017, indicated . The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors.select appropriate support surfaces based the resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observations, interviews, and record review, the facility failed to provide residents with limited range of motion appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion for 2 of 5 residents reviewed for range of motion. (Resident #38 and Resident #65) 1. The facility failed to provide restorative therapy for limited range of motion for Resident #38 as recommended by occupation therapy on 04/22/25. 2. The facility failed to ensure Resident #65 wore a left upper extremity splint (is a medical device that stabilizes a part of your body and holds it in place) per the facility's range of motion/contracture (is a permanent shortening or stiffening of a muscle, tendon, or joint, leading to a loss of mobility and range of motion) log on 5/5/25, 5/6/25, and 5/7/25. These failures could place residents who had contractures at risk of not attaining/or maintaining their highest level of physical, mental, and psychosocial well-being. Findings included: 1. Record review of a face sheet dated 05/07/25 revealed Resident #38 was a [AGE] year-old male that admitted to the facility on [DATE] with diagnoses including diabetes, benign neoplasm of pituitary gland (a non-cancerous tumor of the pituitary gland), and presence of artificial hip joint. Record review of an Order Summary Report for Resident #38 revealed a physician's order for PT/OT to evaluate and treat with a start date of 03/29/25. Record review of an admission MDS dated [DATE] revealed Resident #38 was understood and understood others. Resident #38 had a BIMS score of 12 which indicated moderate cognitive impairment. The MDS indicated Resident #38 had limited range of motion to the upper extremities on one side and limited range of motion on both sides of the lower extremities. The MDS indicated Resident #38 required set up to partial/moderate assistance with ADL's. Record review of a care plan dated 04/15/25 revealed Resident #38 had the potential to have falls related to poor balance and posture. There was an intervention for PT/OT to screen and evaluate the resident as needed. The care plan revealed Resident #38 had the potential for pain due to chronic pain related to arthritic changes along with a history of bilateral total hip replacements with multiple revisions. Record review of an Occupation Therapy, OT Discharge Summary revealed Resident #38 received occupational therapy services from 03/31/25 to 04/22/25. The discharge summary revealed the discharge reason was, Maximum Potential Achieved. Resident #38 was referred to the restorative nursing program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Restorative Training Form revealed Resident #38 was discharged for m OT services on 04/22/25. The form recommended bilateral upper extremity exercise across all joints/planes as tolerated with focus on upper body and lower body dressing task. The form recommended lower extremity exercises of one pound ankle weights across all joints/planes as tolerated with focus on functional transfers. Record review of the documentation for the Restorative Nursing Program from 04/22/25 - 05/06/25 revealed no documentation for Resident #38. During an interview on 05/07/25 at 9:03 a.m., the Director of the Rehabilitation Department said Resident #38 was discharged from therapy on 04/22/2025 because he had reached his max potential. She said he had often refused services and at times only allowed staff to provide limited services. She said he was referred to the restorative program upon his discharge from occupational therapy. She said she was not sure how long that process took for him to be added to the restorative program. She said the DON oversaw the restorative program . During an interview on 05/07/25 at 9:44 a.m., Resident #38 said he just graduated from therapy. He said he did not have any contractures. He said his only issue was pain in his hips. He said he had surgeries on both hips, and he felt like he needed more surgeries on them. He said since he was discharged from therapy the aides were not doing exercises with him. He said he had not refused to participate in exercises. He said his hip pain and limited range of motion in his hips had not gotten any worse since admission. During an interview on 05/07/25 at 9:54 a.m., the DON said she could not find Restorative Training Form recommending Resident #38 to receive restorative services. She said she was unaware he had been referred to the restorative program. She said sometimes therapy put the forms in her box and sometimes slid it under her door. She said she preferred it be slid under her door and discussed at the morning meeting. She said it would only take 5 minutes to initiate restorative services for the resident. She said two weeks without restorative services could cause an increase in weakness, develop contractures, and increase the resident's risk of falling. During an interview on 05/07/25 at 10:12 a.m., the Director of the Rehabilitation Department said when a resident was discharged from therapy they were then immediately discharged to the restorative program. She said they complete the Restorative Training Form and place it in the DON's box so the resident could be added to the Restorative Program. She said she did not know what had happened to the Restorative Training Form for Resident #38. She said it was placed in the DON's box. She said she was not sure how not having restorative services for 2 weeks could negatively affect a resident. During an interview on 05/07/25 at 11:22 a.m., Restorative Aide A said, usually the DON, or the therapy department would tell her the restorative form was on the table in the restorative office for her to add a resident to the restorative program. She said she never got a form for Resident #38. She said she just found out on 05/07/25 that he was supposed to be on the restorative program. She said he would start the program on 05/07/25. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/07/25 at 1:30 p.m., the Administrator said therapy would make a recommendation for restorative therapy to the nursing department. He said therapy would also ask nursing if anyone has had any decline. He said the nursing staff were responsible for admitting a resident to the restorative program. He said the recommendation would go directly to the DON and she would admit the resident to the restorative program. He said he would have expected the process admit Resident #38 to have begun as soon as nursing received the recommendation from the therapy department. He said a resident not receiving recommended restorative therapy, there was always the possibility of decline. 2. Record review of Resident #65's face sheet dated 5/6/25 indicated Resident #65 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #65 had diagnoses including cerebral infarction (occurs when blood flow to the brain is blocked, leading to tissue damage or death), hemiplegia (is a condition characterized by paralysis affecting one side of the body) and hemiparesis (is one-sided muscle weakness) following cerebral infarction affecting left non-dominant side, pain, and rheumatoid arthritis (is a form of arthritis that causes pain, swelling, and stiffness in your joints). Record review of Resident #65's quarterly MDS assessment dated [DATE] indicated Resident #65 was understood and had the ability to understand others. Resident #65 had a BIMS score of 14 which indicated intact cognition. Resident #65 had functional limitation in range of motion on one side, on the upper and lower extremities. Resident #65 required setup for eating, partial assistance for oral hygiene, and maximal assistance for toileting and personal hygiene, upper and lower body dressing, and putting on/taking off footwear. Record review of Resident #65's care plan dated 8/24/23, reviewed 4/10/25 indicated Resident #65 required weight bearing support from staff during ADL care due to impaired mobility, very poor vision, hemiplegia, and chronic pain. Intervention included to provide range of motion to extremities daily during routine ADL care as tolerated and as will allow. Record review of Resident #65's Nursing Restorative Plan of Care dated 04/2025 indicated, .date restorative plan written .3/6/25 .approaches/interventions with frequency .perform right lower extremity therapy exercise with 3-pound ankle weights .perform postural control/positioning .DON .4/1/25 . The plan of care did not reflect left upper extremity splint placement. Record review of the facility's ROM/Contracture log dated 2025 indicated, .Resident #65 .contracture location or type .LLE/LUE ROM/TONE .device provided .LUE SPLINT .RNP .Yes . During an interview and observation on 5/5/25 at 10:40 a.m., Resident #65 was lying in bed watching television. Resident #65 said she had contractures in her arm and leg. She said she was currently not on therapy service. She said she should have a hand brace, but it was in her drawer somewhere. She said no one had offered to put the hand brace on. During an observation on 5/6/25 at 9:20 a.m., Resident #65 was lying in bed. Resident #65 did not have splint on her left upper extremity. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/6/25 at 11:00 a.m., the DON said she oversaw the RNP and two employees, RA A and RA H, and implemented the program. She said RA H was responsible for A/B wing and RA A was responsible for C/D wing. She said the RAs primarily did range of motion and CNAs and LVNs applied splints and hand rolls. She said the RAs only did the braces if there was a detailed restorative plan for it. She said the RAs normally visited the residents on the RNP daily, but they were also back up drivers. She said the RAs documented on a flowsheet when they provided treatment. During an observation on 5/6/25 at 11:15 a.m., Resident #65 was sitting up in a Broda chair (a wheelchair with ergonomic tilt and recline functions, designed to reduce pressure points, enhance comfort, and improve posture). Resident #65 did not have a splint on her left upper extremity. During an observation on 5/6/25 at 3:30 p.m., Resident #65 was sitting up in a Broda chair. Resident #65 did not have a splint on her left upper extremity. During an observation on 5/6/25 at 5:00 p.m., Resident #65 was sitting up in a Broda chair. Resident #65 did not have a splint on her left upper extremity. During an observation on 5/7/25 at 8:15 a.m., Resident #65 was lying in bed. Resident #65 did not have a splint on her left upper extremity. During an interview on 5/7/25 at 9:28 p.m., COTA E, with the DOR present, said Resident #65 was currently not on rehab therapy services. She said Resident #65 had been on OT 12/19/24-1/16/25 and PT 2/6/25-3/5/25. She said Resident #65 had been discharged to the restorative program. She said Resident #65 had limited range of motion to her left hand and leg. The DOR said therapy wrote the nursing restorative plan of care and gave it to the RNP. COTA E said Resident #65 should have a hand splint to her left hand. COTA E and the DOR said when Resident #65 was on therapy services, she never refused to wear the hand splint. The DOR said the hand splint was not from rehab therapy, but an outside physician ordered the splint. COTA E said she had shown ADON B how to correctly put Resident #65's hand splint on. The DOR said she did not know who was responsible for putting on Resident #65's hand splint since she was on RNP. COTA E said Resident #65's hand splint was important to decrease the risk of developing a contracture. During an interview on 5/7/25 at 10:38 a.m., RN G said she had been working at the facility since January 2025. She said she worked Monday thru Friday, 7am-3pm shift. She said Resident #65 had limited range of motion in her leg. She said she had never been shown or placed a hand splint on Resident #65. She said she knew Resident #65 was on the RNP. She said if the nurses were responsible for applying a resident's hand splint, it would be on the TAR. She said a hand splint was important for a resident with limited range of motion or contracture to prevent pain or discomfort. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/25 at 11:30 a.m., Restorative Aide H said she was responsible for the A hall. She said Resident #65 was one of her residents. She said she tried to see the residents every day for restorative therapy. She said she worked on Resident #65's right side of her body. She said she had placed a hand splint on Resident #65 before, but she did not keep it on. She said she did not know who was responsible for applying Resident #65's hand splint or how long it was supposed to be on. She said Resident #65 had the same range of motion since she started the RNP. She said Resident #65 liked to keep her hand closed. She said she did not put Resident #65's hand splint on at all last week or this week. She said Resident #65's hand splint was important to keep her hand open and from drawing up. She said the hand splint could help Resident #65 eventually use her hand and keep her fingers straight. During an interview on 5/7/25 at 2:40 p.m., ADON B said Resident #65 was not supposed to wear a hand splint. She said the only hand splint she knew about was one the family ordered a couple of months ago. She said Resident #65 had worn a hand splint one time for 30 minutes and asked her to remove it. She said Resident #65 never tried the hand splint again. She said a COTA had never shown her how to place a hand splint on Resident #65. She said she did not receive a copy of the resident's nursing restorative plan of care. She said if there was an order for Resident #65's hand splint then it would be on the TAR. She said if Resident #65's hand splint had been on the TAR, the nurses would have been responsible for applying it. She said the RAs were responsible for applying Resident #65's hand splint since she was on the RNP. She said Resident #65's hand splint was important to prevent further contractures. During an interview on 5/7/25 at 3:05 p.m., the DON said rehab therapy would communicate with the nursing staff to get an order for the duration and skin care of the splint. She said the PTs and/or OTs could write an order for the splint. She said if the hand splint was on Resident #65's nursing restorative program then the RAs were responsible for applying it. She said Resident #65's splint was important to decrease the risk of further contracture and maintain mobility. She said she was responsible for ensuring the RNP was implemented by the RAs. She said she oversaw the RNP by monitoring the staff during restorative therapy and reviewing the plan of care at the end of the month. During an interview on 5/7/25 at 3:40 p.m., the Administrator said he was told the family ordered Resident #65's hand splint. He said the facility was not aware Resident #65's hand splint needed to be applied. He said ADON B said the hand splint the family ordered did not fit Resident #65. He said the RAs were responsible for providing the restorative therapy. He said the DON was responsible for overseeing the restorative therapy program. He said splints prevented a decline of a resident's range of motion. Record review of a Rehabilitative Nursing Care facility policy last revised in July 2013 indicated, . Rehabilitative nursing care is provided for each resident admitted .The facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence .Rehabilitative nursing care is performed daily for those residents who require such service . Maintaining good body alignment and proper positioning .Assisting residents with their routine range of motion exercises . 44933

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interviews, and record review, the facility failed to ensure a resident with urinary incontinence, based on the resident's comprehensive assessment, received appropriate treatment and services to prevent urinary tract infections (UTI) for 1 of 4 residents (Residents #81) reviewed for urinary catheters. The facility failed to ensure Resident #81's indwelling urinary catheter (tube inserted into the bladder to drain urine) was secured by an anchor device (used to secure an indwelling urinary catheter). The facility failed to ensure CNA O performed proper catheter care to Resident #81. These failures could place residents at risk for indwelling urinary catheter dislodgement, urethral (empties urine from the bladder and out of the body) damage, pain, and urinary tract infections. Findings included: Record review of Resident #81's face sheet dated 05/07/25 indicated a 94-years-old male initially admitted to the facility on [DATE]. Resident #81 had diagnoses including: heart failure, unspecified (a chronic condition in which the heart doesn't pump blood as well as it should), sepsis, unspecified organism (a life-threatening condition where the body's response to infection leads to widespread inflammation and tissue damage, but the specific infectious agent is not identified), and acute kidney failure, unspecified (a condition in which the kidneys suddenly can't filter waste from the blood). Record review of Resident #81's Order Summary Report dated 5/07/25 indicated an order to ensure foley catheter care every shift with a start date of 4/16/25. Record review of Resident #81's Order Summary Report dated 5/07/25 indicated an order to ensure foley catheter leg strap every shift with a start date of 4/16/25. Record review of the comprehensive MDS dated [DATE] indicated Resident #81 had clear speech, understood others, and was understood by others. The MDS indicated he had a BIMS score of 12 indicating moderate cognitive impairment. Resident #81 required moderate assistance from staff for oral hygiene, toileting hygiene, and personal hygiene. The MDS indicated Resident #81 had an indwelling catheter (urinary catheter) and was always incontinent of bowel. Record review of the care plan dated 5/01/25 indicated Resident #81 had a foley catheter due to obstructive uropathy. He could not void without the foley catheter, due to obstructive uropathy. Interventions included: assess any complaints of dysuria, pubic or abdominal pain, assess pain level as needed, provide foley catheter care as per facility policy and procedure, use a foley catheter Velcro strap around the thigh to secure the tubing. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Competency Assessment, Foley Cath Care Checkoff dated 5/02/24 indicated CNA O was proficient in catheter care. Record review of a Competency Assessment, Peri care/Incontinent Care Evaluation dated 5/02/24 indicated CNA O was proficient in incontinent care. Record review of a Competency Assessment, Foley Cath Care Checkoff dated 2/15/25 indicated CNA N was proficient in catheter care. Record review of a Competency Assessment, Peri care/Incontinent Care Evaluation dated 2/15/25 indicated CNA N was proficient in incontinent care. During an observation on 05/06/25 at 2:00 P.M., CNA O performed incontinent care and catheter care assisted by CNA N. Resident #81's catheter leg securement device was not secured to the resident's leg. CNA O performed incontinent care starting from Resident #81's buttocks. She wiped both buttocks and applied a clean brief without changing her gloves or sanitizing her hands. After performing incontinent care to Resident #81's buttocks she started catheter care. She changed her gloves to before starting catheter care, but she did not wash or sanitize her hands. After CNA O performed catheter care she did not change the dirty brief and she did not change the dirty gloves before pulling up the Resident #81's pants. During an interview on 05/06/25 at 2:12 P.M., CNA N she said CNA O needed to slow down and listen. She said Resident #81's catheter was just hanging, because it was not secured. She said CNA O always worked fast. She said CNA O started with the back of Resident #81 and she was supposed to start with the catheter care first; before she did the behind. She said CNA O changed Resident #81's brief and did not change her gloves or sanitize her hands. She said then CNA O started the catheter care after cleaning the rectum. She said CNA O changed her gloves but did not wash or sanitize before starting catheter care. She said CNA O performed catheter care and did not remove the dirty brief after catheter care was performed. CNA N said CNA O did not remove her dirty gloves before pulling up Resident #81's pants. She said he could get an infection or urinary tract infection (infection in any part of the urinary system) from improper catheter care, improper incontinent care, and improper hand hygiene. She said Resident #81's catheter care did not look good, and he looked like he had redness and a discharge to his catheter site. During an interview on 05/06/25 at 2:29 P.M., CNA O said she knew the catheter was on the wrong side when she performed catheter care, she said it should have been on the right side of Resident #81 instead of the left side. She said she had notified LVN ADON Q that the resident's catheter securement device needed to be replaced. She said she should had started the catheter care first on Resident #81; from the front then worked her way to the back. She said she should have changed her gloves and sanitized her hands before she applied Resident #81's clean brief. She said she had anxiety and gets nervous with people watching her. She said a negative effective of improper catheter care, incontinent care, and improper hand hygiene was e. coli (a rod-shaped bacterium that's commonly found in the intestines) can get into the catheter and it can cause skin breakdown. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/06/25 at 2:36 P.M., LVN Q said she would expect the CNA's to start from the front to back with catheter care. She said she would expect them to start with the head of the penis then from the head of the penis down the tubing with a male resident, that had catheter care. She said then from side one side to the other side wiping down, then to the back side of the resident. She said to clean the back side of the resident last, because there was a harmful bacterium in the rectum that should not be brought to the front to the catheter. She said all residents with catheters should have a tubing securement device. She said a negative effect of improper catheter care, improper incontinent care, and improper hand hygiene was infection. During an interview on 05/07/25 at 2:01 P.M., LVN ADON P said she would expect the CNA's to clean from front to back and make sure the resident was free from any bile and ensure that the catheter was secured. She said gloves should be changed properly during the process of incontinent care and catheter care. She said she would have performed catheter care and change gloves and sanitized or washed hands before pulling up Resident #81's pants. She said CNA O notified her that Resident #81's catheter securement device was not securing the catheter and she had replaced it. She said improper incontinent care, catheter care, and hand hygiene could cause infection and cross contamination. During interview on 05/07/25 at 2:33 P.M., the DON said she expect the CNA's to start from front to back and at the penis away from the resident's body with catheter care for a male. She said then after cleaning the front wash or sanitize your hands, then move to the back, then apply clean gloves. She said she would expect the CNA's to change the brief if they got it dirty while cleaning another part of the body. She said all residents with catheters should have a securement device in place. She said improper incontinent care, catheter care, and hand hygiene made the resident at risk for infection and skin breakdown. During an interview on 05/07/25 at 2:46 P.M., the ADM said the CNA's were trained and they know what they were supposed to do and he expected them to do what they were trained to do. He said all residents with catheters should have a securement device in place. He said improper incontinent care, improper catheter care, and improper hand hygiene has a potential for infection. Record review of a facility's Urinary Continence and Incontinence-Assessment and Management policy revised 09/2010, indicated .3. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible.4. Indwelling urinary catheters will be used sparingly, for appropriate indicators only . Record review of a facility's Catheter Care, Urinary policy dated 09/2014, indicated . The purpose of this to prevent catheter-associated urinary tract infections . 1. Use standard precautions when handling or manipulating the drainage system .2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag.a. do not clean the periurethral area with antiseptics to prevent catheter-associated UTIs while the catheter is in place. Routine hygiene (e.g., cleansing of the meatal surface during daily bathing or showering) is appropriate . b. be sure the catheter tubing and drainage bag are kept off the floor . c. empty the drainage bag regularly using a separate, clean collection container for each resident. Avoid splashing and prevent contact of the drainage spigot with the nonsterile container . d. empty the collection bag at least every eight (8) hours

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929 Based on interviews and record review, the facility failed to act upon the recommendations of the pharmacist report of irregularities and to ensure the attending physician documented in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it in response to the pharmacist report for 2 of 5 residents (Resident #42 and Resident #89) reviewed for (MRR) Medication Regimen Review. 1. The facility failed to ensure a proper rationale was given for not following the pharmacy consultant's recommendation to discontinue Resident #42's Seroquel (an antipsychotic medication that treats several kinds of mental health conditions including schizophrenia and bipolar disorder) medication. 2. The facility failed to ensure Resident #89's Medication Regimen Review dated 4/28/25, had a detailed rationale for not implementing the pharmacist's recommendations. These failures could place residents at risk from maintaining their highest practicable level of physical, mental, and psychosocial well-being, and could place them at risk for adverse consequences related to medication therapy. Findings included: 1. Record review of Resident #42's face sheet, dated 05/07/25, indicated she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included vascular dementia (a type of dementia caused by reduced blood flow to the brain, damaging brain tissue, and impairing cognitive function), Parkinsonism (a clinical syndrome characterized by movement-related symptoms like tremors, slow movement, and rigidity), anxiety disorder (mental health conditions characterized by excessive fear and worry that significantly impair daily functioning), and delusional disorder (mental health condition characterized by one or more firmly held, false beliefs that persist for at least one month). Record review of Resident #42's significant change MDS assessment, dated 12/17/24, indicated she was rarely/never understood, and rarely/never was able to understand others. A BIMS assessment was not conducted because the resident was rarely/never understood. Record review of Resident #42's Order Summary Report, dated 05/07/25, indicated this order: *Seroquel oral tablet 25mg (Quetiapine Fumarate) Give 1 tablet by mouth two times a day related to Parkinsonism; Delusional Disorders. The start date was 03/26/25. Record review of Resident #42's care plan, indicated a focus dated 03/10/23, I am at risk for the development of complications related to receiving psychotropic medications. Interventions included: *Assess the reason I need the medication and reevaluate as needed. Assess for medication dose adjustment to achieve a minimum effective level of medication and notify my doctor as needed. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Conduct a drug utilization review per facility pharmacy consultant as needed. Record review of Resident #42's Consultant Pharmacist/Physician Communications, dated MRR Date 04/02/25 indicated: .This resident is taking a low dose of Seroquel . .I recommend DC unless therapeutic response outweighs risk/benefit. In such case, please document clear rationale and justification in chart . The Physician/Prescriber Response was marked as DISAGREE, and no rationale was given. The form was signed by RN L and dated 04/09/25. During an interview on 05/07/25 at 02:36 PM, ADON B said she expected the RN that signed the consultant pharmacist communication to write a verbal order or document some sort of rationale for the doctor disagreeing with the recommendation. She said the potential risk was the resident could be on an unnecessary medication. During an interview on 05/07/25 at 02:44 PM, the DON said she expected the nurse that signed the consultant pharmacist communication to write a verbal order or have the doctor sign it. She said the risk was the resident could be on unnecessary medication. During an interview on 05/07/25 at 02:54 PM, the Administrator said he expected the nurse to clarify if it was a verbal order or have the doctor sign the consultant pharmacist recommendation. He said the risk was resident could be on an unnecessary medication or there could be some confusion on what the order was. 2. Record review of Resident #89's face sheet dated 5/6/25 indicated resident #89 was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #89 had diagnoses including vascular dementia (is a type of dementia caused by reduced blood flow to the brain, damaging brain tissue, and affecting cognitive function), Parkinson's disease (is a progressive neurological disorder that primarily affects movement, causing symptoms like tremors, stiffness, and slowness of movement), generalized anxiety disorder (is a mental health condition characterized by persistent and excessive worry about various aspects of life, often in a way that is difficult to control), pain, hypertension (high blood pressure), difficulty in walking, and fall on same level. Record review of Resident #89's consolidated physician order dated 5/6/25 indicated: *Ativan Oral Tablet (Lorazepam) (is used to treat anxiety disorders) 0.5mg, give 1 tablet by mouth every 24 hours as needed for anxiety related to generalized anxiety disorder for 14 days. Start date 4/25/25. *Cyclobenzaprine HCL Oral Tablet (is used to help relax certain muscles in your body) 7.5mg, give 1 tablet by mouth every 12 hours as needed for muscle spasms related to muscle spasms. Start date 11/20/24. *Diphenhydramine HCL Oral Tablet (is an antihistamine and sedative) 25mg, give 1 tablet by mouth every 6 hours as needed for itching/allergies. Start date 11/20/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Flomax Oral Capsule 0.4.mg (Tamsulosin HCL) (helps relax the muscles in the prostate and the opening of the bladder), give 1 capsule by mouth one time a day related to retention of urine. Start date 11/20/24. *Metoprolol Tartrate Oral Tablet (is a medication that lowers your blood pressure and heart rate) 25mg, give 1 tablet by mouth one time a day related to essential (primary) hypertension. Start date 11/21/24. *Norco Oral Tablet 5-325 mg (Hydrocodone-Acetaminophen) (is a combination medicine taken to help treat pain), give 1 tablet by mouth every 6 hours as needed for pain related to pain. Start date 11/20/24. *Remeron Oral Tablet 30mg (Mitrazapine) (is commonly used to treat depression), give 1 tablet by mouth one time a day at hour of sleep related to depressive episodes. Start date 12/26/24. Record review of Resident #89's significant change in status MDS assessment dated [DATE] indicated Resident #89 was understood and had the ability to understand others. Resident #89 had minimal difficulty hearing, clear speech, and impaired vision with corrective lenses. Resident #89's BIMS score was 15 which indicated intact cognition. Resident #89 had falls since admission/entry or reentry or the prior assessment. Resident #89 had 2 falls with no injury and 1 with minor injury. Resident #89 had received anti-anxiety, antidepressant, and opioids during the last 7 days. Record review of Resident #89's care plan dated 11/15/24, reviewed 4/21/25 indicated Resident #89 had falls second to Parkinson's disease with tremors, poor balance, and posture. Resident #89 received multiple medications, history of hypotension and syncope with poor safety awareness and poor impulse control. Interventions included medication review as needed to assess for side effects and adverse drug reactions and sitter provided to assist with visual checks. Record review of Resident #89's Interim Medication Regimen Review dated 4/28/25 indicated, .Rec. Category: Interim Review - Fall Risk .Consultant Pharmacist .Interim Review requested due to recent falls and increased confusion . [Resident #89] is currently has orders for three medications listed on Beers Criteria (is a list of medications that older adults should potentially avoid or use with caution due to the risk of harm outweighing the benefits), and all three can contribute to increased fall risk and confusion. I consider these three the greatest contributors to falls and confusion (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Cyclobenzaprine 7.5mg Q12H PRN .Diphenhydramine 25mg Q6H PRN .Lorazepam 0.5mg BID and 0.5mg PRN once daily .I recommend DC cyclobenzaprine, diphenhydramine, and PRN dose of lorazepam .I also recommend plan to GDR routine lorazepam with plan to DC .Hydrocodone-Acetaminophen and Mirtazapine can also contribute .Both can cause sedation and confusion, and both can contribute to an increased fall risk . I recommend ensuring resident is taking lowest necessary dose of Norco and ensure that all non-pharmacological interventions are attempted and documented . I further recommend a plan to GDR mirtazapine to 15mg within the next month or two with a further plan to DC if tolerated . Finally, tamsulosin, metoprolol, and mirtazapine can all contribute to an increased risk of orthostatic hypotension . I recommend monitoring resident for orthostatic hypotension and counsel resident to sit up and rise from a seated position slowly to reduce risk of orthostatic hypotension (is a drop in blood pressure that occurs when a person stands up after sitting or lying down) . Recommendation Summary .DC Cyclobenzaprine .DC Diphenhydramine .DC PRN Ativan .Next month GDR Ativan to 0.25mg BID .Confirm Norco dosing is lowest effective dose .In July, GDR Mirtazapine to 15mg QHS .Monitor Resident for orthostatic hypotension .'Has a sitter now' .NP M .5/5/25 . During an interview on 5/7/25 at 3:05 p.m., the DON said the ADONs and the DON reviewed the MRRs and contacted the NP/MDs. She said hall B did not have an ADON, so she was responsible for hall B's MRRs. She said she had reviewed Resident #89's MRR from 4/28/25. She said when the NP or the MD reviewed the MRRs and disagreed with the recommendation, the facility expected a reason for not following the recommendations. She said, has a sitter now was not an appropriate response for Resident #89's MRR. She said she did not know NP M had written that response to Resident #89's MRR on 5/5/25. She said Resident #89 had a fall 4/20/25 and the facility provided a sitter as an intervention. She said Resident #89 would have a sitter until she was back to her baseline. She said Resident #89 was experiencing confusion possibly from a UTI (is an infection that affects a part of the urinary tract). She said Resident #89 was receiving treatment for the UTI. She said she reviewed the MRRs a few days after they were completed by the pharmacist and when she knew the NP/MD had rounded at the facility. She said it was important for the MRRs to have rationale or reasons for disagreeing with the recommendations to explain why, know how to better take care of the resident, and know when to notify the NP/MD when something was not working. She said it placed the resident at risk for not receiving the interventions they needed. During an interview on 5/7/25 at 3:40 p.m., the Administrator said the DON reviewed the all the resident's MRRs then gave them to the halls ADONs. He said the facility expected the MRRs to have rationales and staff should follow up. He said he did not know if NP M's response to Resident #89's MRR was an appropriate response to the recommendations. He said he would defer to NP M's response. He said the DON was responsible for overseeing the resident's MRRs. During an interview on 5/8/25 at 4:20 p.m., NP M said she had reviewed Resident #89's MRR a couple days ago. She said she could not recall what Resident #89's MRR recommendations were. She said she spoke with the staff to see what the biggest problems were and reviewed the resident's chart before responding to the pharmacist recommendations. She said Resident #89 had several falls but was also non complaint. She said Resident #89's sitter was a new intervention. She said she felt the new intervention needed to be tried then reevaluated. She said she did not know how long the facility planned to have a sitter with Resident #89. Record review of the facility's policy, Tapering Medications and Gradual Dose Reduction, last revised April 2007, indicated: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.1. After medications are ordered for a resident, the staff and practitioner shall seek an appropriate dose and duration for each medication that also minimizes the risk of adverse consequences . 2. All medications shall be considered for possible tapering. Tapering that is applicable to antipsychotic medications shall be referred to as gradual dose reduction . 3. Residents who use antipsychotic drugs shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs . 5. The Physician will review periodically whether current medications are still necessary in their current doses; for example, whether an individual's conditions or risk factors are sufficiently prominent or ensuring that they require medication therapy to continue in the current dose, or whether those conditions and risks could potentially be equally well managed or controlled without certain medications, or with a lower dose . 9. When a medication is tapered or stopped, the staff and practitioner shall document the rationale for any decisions to restart a medication or reverse a dose reduction; for example, because of a return of clinically significant symptoms . 10. Residents who use antipsychotic drugs shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue the use of such drugs. Pertinent behavioral interventions will also be at-tempted. (Behavioral interventions refer to non-pharmacological attempts to influence an individual's behavior, including environmental alterations and staff approaches to care) . 11. Within the first year after a resident is admitted on an antipsychotic medication or after the resident has been started on an antipsychotic medication, the staff and practitioner shall attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, the facility shall attempt a GDR at least annually, unless clinically contraindicated . 12. For any individual who is receiving an antipsychotic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if: a. The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and b. The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior . 13. For any individual who is receiving an antipsychotic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia (for example, schizophrenia, bipolar mania, or depression with psychotic features), the GDR may be considered contraindicated, if: a. The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder; or (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder . 14. Attempted tapering of sedatives and hypnotics shall be considered as a way to demonstrate whether the resident is benefiting from a medication or might benefit from a lower or less frequent dose. Tapering shall be done consistent with the following: a. For as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for duration of use, the physician shall attempt to taper the medication at least quarterly unless clinically contraindicated. Clinically contraindicated means: (1) The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder; or (2) The resident's target symptoms returned or worsened after the most recent attempt at tapering the dose within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder . Record review of https://agsjournals.onlinelibrary.[NAME].com/doi/epdf/10.1111/jgs.18372 was accessed on 5/12/25 and indicated, .the Beers Criteria was developed .with the purpose of identifying medications for which potential harm outweighed the expected benefit and that should be avoided in nursing home residents . Table 2 .potentially inappropriate medication use in older adults .Diphenhydramine (oral) .risk for confusion . drugs is associated with an increased risk of falls .Lorazepam .older adults increases sensitivity .increase the risk of cognitive impairment, delirium, falls, fracture .Cyclobenzaprine .adverse effects, sedation and increased risk of fractures . 44933

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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. 46929 Based on observation, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements. The facility failed to ensure the CNA Class Instructor did not walk into the kitchen without a hairnet during lunch service on 05/06/25. This failure could place residents at risk of foodborne illness and food contamination. Findings included: During an observation and interview on 05/06/25 at 11:56AM the CNA Class Instructor walked into the kitchen. She was not wearing a hairnet. The kitchen staff had the food out on the steam table and were plating the food for lunch. When questioned if she was wearing a hairnet she said, I'm just giving this sticky note to her. She pointed to one of the cooks on the serving line. She then handed the note to a dietary staff on the serving line next to the steam table and then walked out of the kitchen. During an interview on 05/07/25 at 01:35 PM, the Dietary Manager said she expected all staff that enter the kitchen to wear a hairnet. She said the risk was that a hair could get in the food and potentially cause a foodborne illness. During an interview on 05/07/25 at 02:54 PM, the Administrator said he expected the staff to wear a hairnet while in the kitchen. He said a hair could fall in the food and potentially cause foodborne illness. Record review of the facility's policy, Food Preparation and Service, last revised July 2014, indicated: .Food service employees shall prepare and serve food in a manner that complies with safe food handling practices . .Food Service/Distribution . .7. Dietary staff shall wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food . .13. Only Dietary staff are allowed in the kitchen. If for any reason other departments must enter the kitchen staff must wear hair restraints (hair net, hat, beard restraint, etc.) .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observations, 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 19 residents (Resident # 81 and Resident #89) and 1 of 1 Laundry room reviewed for infection control practices. 1.The facility failed to ensure CNA O changed her gloves or sanitized her hands after performing incontinent care and applying a clean brief for Resident #81. She touched a clean brief with her dirty gloves, and she touched the resident's pants with dirty gloves. 2.The facility failed to ensure Resident #89 was placed on contact isolation (implemented to prevent the spread of germs that are transmitted through direct or indirect contact with a person or objects they have touched) after her urinalysis with culture and sensitivity (UA examines urine for physical and chemical characteristics, while C&S identifies any bacterial infection and determines its sensitivity to antibiotics), dated 4/22/25, resulted with Vancomycin Resistant Enterococcus (VRE) (is a super bug, bacterial infection where the bacteria are resistant to the antibiotic vancomycin). 3.The facility failed to ensure laundry in the facility's laundry room was not stored on the floor or touching the floor on 5/7/25. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: 1.Record review of Resident #81's face sheet dated 05/07/25 indicated a 94-years-old male initially admitted to the facility on [DATE]. Resident #81 had diagnoses including: heart failure, unspecified (a chronic condition in which the heart doesn't pump blood as well as it should), sepsis, unspecified organism (a life-threatening condition where the body's response to infection leads to widespread inflammation and tissue damage, but the specific infectious agent is not identified), and acute kidney failure, unspecified (a condition in which the kidneys suddenly can't filter waste from the blood). Record review of Resident #81's Order Summary Report dated 5/07/25 indicated an order to ensure foley catheter care every shift with a start date of 4/16/25. Record review of the comprehensive MDS dated [DATE] indicated Resident #81 had clear speech, understood others, and was understood by others. The MDS indicated he had a BIMS score of 12 indicating moderate cognitive impairment. Resident #81 required moderate assistance from staff for oral hygiene, toileting hygiene, and personal hygiene. The MDS indicated Resident #81 had an indwelling catheter (urinary catheter) and was always incontinent of bowel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the care plan dated 5/01/25 indicated Resident #81 had a foley catheter due to obstructive uropathy. He could not void without the foley catheter, due to obstructive uropathy. Interventions included: assess any complaints of dysuria, pubic or abdominal pain, assess pain level as needed, provide foley catheter care as per facility policy and procedure, use a foley catheter Velcro strap around the thigh to secure the tubing. Record review of a Competency Assessment, Foley Cath Care Checkoff dated 5/02/24 indicated CNA O was proficient in catheter care. Record review of a Competency Assessment, Peri care/Incontinent Care Evaluation dated 5/02/24 indicated CNA O was proficient in incontinent care. Record review of a Competency Assessment, Foley Cath Care Checkoff dated 2/15/25 indicated CNA N was proficient in catheter care. Record review of a Competency Assessment, Peri care/Incontinent Care Evaluation dated 2/15/25 indicated CNA N was proficient in incontinent care. During an observation on 05/06/25 at 2:00 P.M., CNA O performed incontinent care and catheter care assisted by CNA N. CNA O performed incontinent care starting from Resident #81's buttocks. She wiped both buttocks and applied a clean brief without changing her gloves or sanitizing her hands. After performing incontinent care to Resident #81's buttocks she started catheter care. She changed her gloves to before starting catheter care, but she did not wash or sanitize her hands. After CNA O performed catheter care she did not change the dirty brief and she did not change the dirty gloves before pulling up the Resident #81's pants. During an interview on 05/06/25 at 2:12 P.M., CNA N she said CNA O needed to slow down and listen.She said CNA O always worked fast. She said CNA O started with the back of Resident #81 and she was supposed to start with the catheter care first; before she did the behind. She said CNA O changed Resident #81's brief and did not change her gloves or sanitize her hands. She said then CNA O started the catheter care after cleaning the rectum. She said CNA O changed her gloves but did not wash or sanitize before starting catheter care. She said CNA O performed catheter care and did not remove the dirty brief after catheter care was performed. CNA N said CNA O did not remove her dirty gloves before pulling up Resident #81's pants. She said he could get an infection or urinary tract infection (infection in any part of the urinary system) from improper catheter care, improper incontinent care, and improper hand hygiene. She said Resident #81's catheter care did not look good, and he looked like he had redness and a discharge to his catheter site. During an interview on 05/06/25 at 2:29 P.M., CNA O said she knew the catheter was on the wrong side when she performed catheter care, she said it should have been on the right side of Resident #81 instead of the left side. She said she should had started the catheter care first on Resident #81; from the front then worked her way to the back. She said she should have changed her gloves and sanitized her hands before she applied Resident #81's clean brief. She said she had anxiety and gets nervous with people watching her. She said a negative effective of improper catheter care, incontinent care, and improper hand hygiene was e. coli (a rod-shaped bacterium that's commonly found in the intestines) can get into the catheter and it can cause skin breakdown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/06/25 at 2:36 P.M., LVN Q said she would expect the CNA's to start from the front to back with catheter care. She said she would expect them to start with the head of the penis then from the head of the penis down the tubing with a male resident, that had catheter care. She said then from side one side to the other side wiping down, then to the back side of the resident. She said to clean the back side of the resident last, because there was a harmful bacterium in the rectum that should not be brought to the front to the catheter. She said a negative effect of improper catheter care, improper incontinent care, and improper hand hygiene was infection. During an interview on 05/07/25 at 2:01 P.M., LVN ADON P said she would expect the CNA's to clean from front to back and make sure the resident was free from any bile and ensure that the catheter was secured. She said gloves should be changed properly during the process of incontinent care and catheter care. She said she would have performed catheter care and change gloves and sanitized or washed hands before pulling up Resident #81's pants. She said improper incontinent care, catheter care, and hand hygiene could cause infection and cross contamination. During interview on 05/07/25 at 2:33 P.M., the DON said she expect the CNA's to start from front to back and at the penis away from the resident's body with catheter care for a male. She said then after cleaning the front wash or sanitize your hands, then move to the back, then apply clean gloves. She said she would expect the CNA's to change the brief if they got it dirty while cleaning another part of the body. She said improper incontinent care, catheter care, and hand hygiene made the resident at risk for infection and skin breakdown. During an interview on 05/07/25 at 2:46 P.M., the ADM said the CNA's were trained and they know what they were supposed to do and he expected them to do what they were trained to do. He said improper incontinent care, improper catheter care, and improper hand hygiene has a potential for infection. 2. Record review of Resident #89's face sheet dated 5/6/25 indicated resident #89 was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #89 had diagnoses including vascular dementia (is a type of dementia caused by reduced blood flow to the brain, damaging brain tissue and affecting cognitive function), Parkinson's disease (is a progressive neurological disorder that primarily affects movement, causing symptoms like tremors, stiffness, and slowness of movement), and urinary tract infection (is an infection that affects a part of the urinary tract). Record review of Resident #89's significant change in status MDS assessment dated [DATE] indicated Resident #89 was understood and had the ability to understand others. Resident #89's BIMS score was 15 which indicated intact cognition. Resident #89 required moderate assistance for toileting hygiene. Resident #89 had occasional urinary incontinence. Record review of Resident #89's care plan dated 11/25/24, reviewed 4/21/25 indicated Resident #89 had the potential for hydration and fluid maintenance problem. Intervention included obtain labs as directed and ensure the MD notification of lab results. Record Review of Resident #89's hard copy, physician's order dated 4/21/25-5/5/25 did not reflect a contact isolation order. Record review of Resident #89's consolidated physician orders dated 5/6/25 did not reflect a contact isolation order. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #89's Urinalysis with culture and sensitivity dated 4/22/25 indicated, .moderate enterococcus faecium, pseudomonas aeruginosa .the detected enterococcus is Vancomycin Resistant .NP M .4/24/25 . Record review of the facility's Infection Control log dated April 2025 indicated, . [Resident #89] .UTI . Enterococcus .Standard Precaution . During an interview on 5/6/25 at 11:00 a.m., the DON said she did not know Resident #89's UA from 4/22/25 had VRE. She said she had reviewed the results and spoke with NP M about antibiotic treatment. She said residents with VRE were placed on contact isolation the duration of the antibiotic treatment. She said Resident #89 was not placed on contact isolation for the UA results from 4/22/25. She said not placing a resident with VRE on contact isolation could spread the organism to other residents. She said as the ICP, she was responsible for reading the UA and C&S results and initiating isolation precautions. During an interview on 5/7/25 at 2:13 p.m., RN D said residents with VRE in the urine were normally placed on contact isolation. She said NP M had visited the facility on 4/24/25. She said NP M had reviewed and signed Resident #89's, 4/22/25 UA results. She said NP M did not order any new orders. She said residents with VRE were placed on contact isolation to decrease the risk of spreading VRE. She said Resident #89 was placed on contact isolation on 5/6/25 and another UA was ordered. During an interview on 5/7/25 at 3:40 p.m., the Administrator said the DON, who was the ICP, was responsible for reviewing UA results and making sure the residents were placed on the appropriate type of isolation. He said the residents were placed on isolation to prevent the spread of the organism. He said it became an infection control issue when residents were not placed on isolation. During an interview on 5/8/25 at 4:20 p.m., NP M said she could not recall if she noticed Resident #89's C&S results, from 4/22/24, reported VRE in her urine. She said the facility had policies and procedures they should follow when a resident had a resistant organism growing. She said most facilities placed their residents on contact isolation for VRE in the urine. She said the resident was placed on contact isolation for the duration of the antibiotics. She said when a resident with VRE was not placed on isolation, it could spread around the nursing home. 3. During an observation on 5/7/25 at 9:36 a.m., the clean side of the facility's laundry room, had the following items: *One small, white bag with resident labeled socks on the floor. *One small box of socks on the floor. *Three large clear bags of clothing on the floor. *One long sleeve of a shirt touched the floor. The long sleeve shirt was on top of a pile of clothes in a metal hamper on wheels. HSK Supervisor C placed the long sleeve shirt back in the pile of clothing. *One mechanical lift pad hung on a hook, with one of the loops touching the ground. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Two items of clothing fell on the floor from a metal hamper on wheels. HSK Supervisor C placed both items back in the pile of clothing. *Two house coat sleeves touched the floor. The house coats were draped over a metal hamper near the dryer. During an interview on 5/7/25 at 9:50 a.m., the HSK Supervisor said the laundry staff working today was not interviewable. She said the laundry staff did not speak English. She said the bags and boxes of clothing should not be on the floor. She said resident's clothing should not touch floor. She said the clothing in the bags and metal hampers were getting sorted. She said some of the clothing was going to be kept for residents who needed clothes at the facility. She said most of the clothes, in the bags and hampers were going to be donated to a local donation station. She said she had not taken the clothes to the local donation station because she wanted to make sure a resident or family member did not come back to claim anything. She said it was cross contamination for clothes to touch the floor or be on the floor then possibly given to the residents. She said the residents could get an infection from the contaminated clothes or lift pad. She said she was responsible for ensuring staff stored clothing correctly. She said she did rounds in the laundry room about every 2 hours to oversee the staff. During an interview on 5/7/25 at 3:05 p.m., the DON said clothing and lift pads should not touch the floor. She said it was an infection control issue. She said it placed the residents at risk for being exposed to germs. She said the residents could become sick and be exposed to dirt or grime. She said HSK Supervisor C should ensure resident's laundry was stored correctly. She said HSK Supervisor C should have a checking system in place and provided in-services to the laundry staff to ensure infection control was being maintained. During an interview on 5/7/25 at 3:40 p.m., the Administrator said it was an infection control issue for clothing to touch the floor. He said the laundry staff should be ensuring clothing and items in the laundry area were not on the ground or touching the ground. He said HSK Supervisor C should be overseeing the laundry staff. He said the residents would not be clean if they wore clothes that touched the floor. Record review of a facility's Urinary Continence and Incontinence-Assessment and Management policy revised 09/2010, indicated .3. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. Record review of a facility's Catheter Care, Urinary policy dated 09/2014, indicated . The purpose of this to prevent catheter-associated urinary tract infections . 1. Use standard precautions when handling or manipulating the drainage system .2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag.a. do not clean the periurethral area with antiseptics to prevent catheter-associated UTIs while the catheter is in place. Routine hygiene (e.g., cleansing of the meatal surface during daily bathing or showering) is appropriate . b. be sure the catheter tubing and drainage bag are kept off the floor . c. empty the drainage bag regularly using a separate, clean collection container for each resident. Avoid splashing and prevent contact of the drainage spigot with the nonsterile container . d. empty the collection bag at least every eight (8) hours (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility's Departmental (Environmental Services)- Laundry and Linen policy revised 1/2014 indicated, .The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen . Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts . Record review of a facility's Standard Precautions revised 12/2007 indicated, . Wear gloves when in direct contact with a resident who is infected or colonized with organisms that are transmitted by direct contact (VRE, MRSA, VISA-VRSA, etc.) . Wear a gown (clean, non-sterile) to protect skin and prevent soiling of clothing during procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions or cause soiling of clothing . Record review of https://www.ncbi.nlm.nih.gov/books/NBK513233/ was accessed on 5/12/25 and indicated, . Enterococcus is frequently cited as one of the three most likely etiologies of both uncomplicated and complicated UTI, especially healthcare-associated UTIs . Of these, the vast majority is E. faecalis, though the majority of vancomycin-resistant isolates are E. faecium .Enterococcus can persist on hands for as long as 60 minutes after inoculation and as long as four months on inanimate surfaces . Basic infection control prevention practices such as hand hygiene can help . This includes washing hands with soap and water or using alcohol-based hand rubs before and after patient encounters . Contact precautions such as wearing gowns and gloves also decrease transmission . There are reports that VRE can be transmitted by direct patient contact, touching of contaminated surfaces/equipment or through hand transfer after contact with the affected patient . 44933

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455646	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Manor Nursing & Rehabilitation Center	1007 S Washington Ave Marshall, TX 75670

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interviews, and record review, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy and providing written rationale, by the provider, when an antibiotic was used despite criteria, to determine the appropriate the use of an antibiotic for 1 of 5 residents reviewed antibiotic use. (Resident #31) The facility failed to ensure Resident #31 did not receive Cephalexin (is a cephalosporin antibiotic used to treat a variety of bacterial infections) for prophylactic antibiotic use. The facility failed to ensure Resident #31's Cephalexin, ordered prophylactically, was discontinued after he was started on Cefdinir (is a cephalosporin antibiotic used to treat a variety of bacterial infections) for an active UTI. These failures could place residents receiving antibiotics at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased antibiotic-resistant infections. Findings included: Record review of Resident #31's face sheet dated 5/5/25 indicated Resident #31 was an [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. Resident #31 had diagnoses including urinary tract infection (is an infection in any part of the urinary system, including the bladder, urethra, kidneys, or ureters), neuromuscular dysfunction of bladder (the nerves that carry messages back and forth between the bladder and the spinal cord and brain don't work the way they should), and retention of urine (is when your bladder doesn't empty completely or at all). Record review of Resident #31's significant change in status MDS assessment dated [DATE] indicated Resident #31 was understood and had the ability to understand others. Resident #31 had a BIMS score of 10 which indicated moderate cognitive impairment. Resident #31 required substantial/maximal assistance for toileting hygiene. Resident #31 had an indwelling catheter (is a thin, hollow tube inserted through the urethra into the urinary bladder to collect and drain urine) and frequent bowel incontinence. Resident #31 had received an antibiotic during the last 7 days. Record review of Resident #31's care plan dated 2/12/25 indicated Resident #31 had recurrent urinary tract infections. Intervention included assess causative factors that may have led to the development of the UTI. If identified, help develop additional approaches and interventions to prevent the reoccurrence. Record review of Resident #31's consolidated physician order dated 5/5/25 indicated Cephalexin Oral Capsule 250mg, give 1 capsule by mouth one time a day related to encounter for prophylactic measures. Start date 3/13/25. Record review of Resident #31's Telephone Orders dated 5/5/25 indicated Cefdinir 300mg 1 capsule by mouth two times a day for 10 days related to UTI. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #31's culture and sensitivity (is a laboratory procedure used to identify bacteria or fungi causing an infection and determine which antibiotics (or antifungals) are effective in treating it) results dated 5/2/25 indicated low pathogen detection of pseudomonas aeruginosa (is a germ that can cause infections). Pseudomonas aeruginosa may develop resistance during prolonged therapy with all antimicrobial agents. During an interview on 5/7/25 at 2:13 p.m., RN D said Resident #31 was currently on an antibiotic for a pseudomonas UTI. She said Resident #31 had a history of UTIs. She said Resident #31 used to have an indwelling catheter. She said Resident #31 had seen a urologist (is a medical doctor who specializes in the diagnosis and treatment of diseases and conditions of the urinary tract and the reproductive system) who discontinued the indwelling catheter in March 2025. She said Resident #31 refused to see the urologist after that appointment. She said she felt after Resident #31's last UTI, he would benefit from a prophylactic antibiotic. She said she spoke with NP M about a prophylactic antibiotic for Resident #31 and convinced her to order Cephalexin. She said Resident #31 started having behaviors earlier in the week and urinalysis with culture and sensitivity was collected and sent on 5/2/25. She said she spoke with NP M about Resident #31's, 5/2/25 lab results and she ordered Cefdinir. She said NP M did not order Resident #31's Cephalexin to be discontinued. She said the day after (5/6/25) she received the order for Resident #31's Cefdinir, she thought about him being on two antibiotics. She said she probably should have informed NP M of Resident #31 being on two antibiotics. She said the DON was over the antibiotic stewardship program. During an interview on 5/7/25 at 3:05 p.m., the DON said she was the ICP. She said the facility's antibiotic stewardship program did not recommend the use of prophylactic antibiotics. She said she was not aware Resident #31 was on Cephalexin as a prophylactic antibiotic. She said Resident #31 Cephalexin should have been discontinued when he was prescribed Cefdinir on 5/5/25. She said a resident could experience C.diff (is a bacterial infection that can cause serious digestive problems, particularly diarrhea and colitis) and GI issues being on two antibiotics. She said a resident being on a prophylactic antibiotic placed them at risk for a MDRO (is an infection caused by a germ (usually bacteria) that has become resistant to multiple antibiotics). She said as the DON and ICP, she provided in-services to staff on discouraging the use of prophylactic antibiotics. She said she monitored antibiotic use by reviewing the infection sheets the nursing staff completed that informed her who had an infection and what antibiotic was ordered. During an interview on 5/7/25 at 3:40 p.m., the Administrator said he could not speak on the use of prophylactic antibiotics use. He said the DON, who was the ICP, oversaw the antibiotic stewardship program. He said he expected the ordered antibiotic to treat the organism growing. He said proper antibiotic treatment affected the overall care and well-being of the residents. During an interview on 5/7/25 at 4:20 p.m., NP M said she was not a fan of prophylactic antibiotics. She said Resident #31 had a complicated medical history. She said Resident #31 had previously been seen by a urologist then refused to return. She said she had ordered a new urologist consult on 5/1/25. She said she did not recall Resident #31 being on Cephalexin for prophylactic antibiotic use. She said she wished the staff had reminded her Resident #31 was on Cephalexin when Cefdinir was ordered. She said prophylactic antibiotics did not work and risked the resident becoming resistant to antibiotics. She said a resident should only be prescribed two types of antibiotics when treating different type of organisms or infections. She said if a resident was on two types of antibiotics, their lab work needed to be monitored. She said a resident being on two types of antibiotics placed them at risk for yeast infection and C.diff, and could affect their kidneys. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility's Antibiotic Stewardship policy revised 12/2016 indicated, . Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program . The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents . Record review of a facility's Antibiotic Stewardship policy revised 12/2016 indicated, . 3. Appropriate indications for use of antibiotics include: a. Criteria met for clinical definition of active infection or suspected sepsis; and b. Pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending) .