STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455651	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downtown Health and Rehabilitation Center	424 S Adams St Fort Worth, TX 76104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to care for residents in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for two of four residents (Resident #59 and 88) reviewed for resident rights. CNA C failed to ensure the dignity of Residents #59 and #88 was respected during the breakfast meal when CNA C yelled in front of the residents at Laundry Aide D while they were being fed. This failure could place residents who need assistance with eating at risk for weight loss and a decreased quality of life. Findings included: Review of Resident #88's face sheet, dated 12/18/24, revealed the resident was a [AGE] year-old female admitted on [DATE], with the diagnoses of cognitive communication deficit, dysphagia (difficulty swallowing), and legal blindness. Review of Resident #88's quarterly MDS assessment, dated 11/15/24, revealed the resident was rarely/never understood. Resident #88 was dependent on staff on eating. Review of Resident #88's care plan, dated 12/16/24, revealed the resident had a communication problem due to impaired hearing, impaired vision, and impaired cognition. Interventions included: Speak directly into ear when communicating with [Resident#88] .reduce environmental noise .Resident #88 also had maladaptive behaviors at times due to impaired cognition, new environment/disorientation, confusion, frustration, difficult communicating, and sensory impairments (blind/deaf). Interventions included: Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed . Review of Resident #59's face sheet, dated 12/18/24, revealed the resident was a [AGE] year-old female admitted on [DATE], with the diagnoses of major depressive disorder, cognitive communication deficit, and abnormal weight loss. Review of Resident #59's quarterly MDS, dated [DATE], revealed a BIMS score of 00, which indicated the resident could not complete the interview or was rarely understood. Resident #59 was dependent on staff for eating. (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: 455651	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER: Downtown Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 424 S Adams St Fort Worth, TX 76104	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #59's care plan, dated 12/14/24, revealed Resident #59 exhibited maladaptive behavior at times due to impaired cognition and frustration. Interventions included: Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Resident #59 had a potential for a psychosocial well-being problem due to anxiety. Interventions included: Allow the resident time to answer questions and to verbalize feelings, perceptions, and fears. Observation on 12/18/24 from 07:36 AM to 07:50 AM CNA C was observed feeding two residents at the same time before yelling across the dining room towards Laundry Aide D for two straws. Laundry Aide D then walked over to where CNA C was feeding Resident #59 and Resident #88 and stood over Resident #88 as she and CNA C chatted to each other on social matters. Interview on 12/19/24 at 8:52 AM with CNA C revealed its proper to sit down and feed the resident, not stand over them, so that you can monitor them. She stated she did sometimes feed multiple residents at once and prefers to feed the residents she normally feeds. CNA C stated she yelled across the dining room again because laundry Aide D didn't answer. CNA C stated she was letting Laundry Aide D know she needed another pair of pants for the resident, which was why she was yelling. She stated it would not be polite to yell in front of someone. CNA C stated residents have the right to dignity and right to refuse showers, meals, medications, and the right to wear clothing. She stated residents could feel it wasn't polite if a resident's dignity was not respected. Interview on 12/19/24 at 09:32 AM with Laundry Aide D revealed residents had the right to feel respected. She stated she was having a conversation about a party with CNA C. She stated residents would feel like they were not being respected. She stated residents did not understand her and CNA C's conversation. Laundry Aide D stated residents have a right to a dignified dining experience and they have a right to be respected. Interview on 12/19/24 at 3:39 PM with the AIT revealed it was a resident's right issue when residents were not respected during lunch meals. She stated the best practice was to feed one resident at a time. Review of facilities policy titled Residents Rights dated November 2021 reflected . The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility . Review of facility policy titled Feeding, Assistive/Complete with revision date 02/12/07 reflected read in part . The resident will achieve maximal participation in daily self-feeding .the resident will receive optimal nutritional intake with partial or complete assistance .Resident will be free from aspiration .Provide a pleasant environment

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48122 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Resident #115) reviewed for accidents and supervision. The facility failed to ensure Resident #115 received adequate supervision when he went out into the courtyard to smoke during non-smoking times. This failure placed residents who required supervision at risk of injury or accidents. Findings included: Review of Resident #115's face sheet, dated 12/18/24, revealed the resident was a [AGE] year-old male admitted on [DATE] with diagnoses of staphylococcus arthritis, right knee, methicillin resistant staphylococcus aureus infection as the cause of disease (MRSA - a type of bacteria that many antibiotics don't work on), and hypertension (high-blood pressure). Review of Resident #115's initial MDS Assessment, dated 12/08/24, revealed the resident had a BIMS score of 15, which indicated the resident was cognitively intact. Resident #115 was independent in eating, oral hygiene, toilet hygiene, upper and lower body dressing, putting on/taking off footwear, personal hygiene. Resident #115 required set-up or clean-up assistance for showering/bathing. Resident #115 was coded with an active multi-drug-resistant organism (MDRO) infection. Review of Resident #115's care plan, dated 12/06/2024 and last revised, 12/17/2024, revealed Resident #115 smoked. The goal indicated the resident would be able to smoke without causing injury. Interventions included: .ensure that the resident and/or responsible is made aware of the facility's smoking policy, no smoking materials or igniters will be stored in the resident rooms, and the resident will be always supervised by a visitor or facility staff member. Review of Resident #115's smoking assessment, dated 12/02/24, at admission, revealed Resident #115 required direct supervision while smoking, all smoking materials would be kept at the nurse's station, and the evaluation would be discussed with the resident. Review of the facility's smoking times, undated and received from the Corporate RN on 12/18/2024, revealed nursing staff were responsible for supervising smoking breaks at 9:30 AM and 8:00 PM. Laundry staff were responsible for supervising the 11:30 AM smoking break. Housekeeping staff were responsible for supervising the 1:30 PM smoking break. The 3:30 PM smoking break was supervised by activities staff. Evening floor tech was responsible for supervising the 6:00 PM smoking break. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/17/24 at 1:55 PM of the smoking area patio revealed Resident #115 had an almost completely smoked cigarette that was lit. Resident #115 was smoking and no staff/volunteer was at the patio. Five other residents were observed sitting at the patio area, conversing. The five residents were observed with no smoking materials on them, nor were they smoking. There were seven heavy base ashtrays spread about the patio, one locked and closed fire-proof metal container for cigarette disposal, and no trash observed in the surrounding area. Two protective smoking aprons, used by residents who were assessed to be at risk for burns from dropping cigarettes or ashes while smoking, were on hooks near doorway out of any weather, and a fire extinguisher and fire blanket box near doorway in easily accessible location. Resident #115 was observed clothed without burn marks on his clothes or body. Observation on 12/17/24 at 2:09 PM revealed Resident #115 lit a second cigarette by himself and began to smoke it. Staff continued not to be present. Observation on 12/17/24 at 2:19 PM revealed Resident #115 continued to remain unsupervised while smoking. Surveyor intervened and informed staff of Resident #115 smoking unsupervised. Two of the 200 hall nurses were observed going outside to escort Resident #115 back inside before educating the resident on the smoking policy. Interview on 12/17/24 at 2:46 PM with Resident #115 revealed he had been at the facility for about two weeks. Resident #115 stated he got to smoke on occasion. He stated he waited for when a staff member was free to take him out to smoke and was told that as of 12/17/2024 he was able to leave his room at any time as long as his wounds were covered (resident could previously only go out with a staff member with no other residents around due to being on isolation for MDRO). After staff were made aware of his smoking unsupervised on 12/17/2024, he would have to go back to waiting for when staff were free to be able to smoke. He stated he tries to be mindful of their time and would wait for as long as he could before asking. Resident #115 stated he kept his own cigarettes and lighter and stated he didn't know facility was to have them. He stated he tried not to bother staff but needed a break from his room after being cooped up for so long. He stated staff wouldn't let him vape in room. He stated he did still have a lighter but did not remember if he was asked for or handed over smoking items when admitted . Resident #115 stated he did not remember which staff members supervised his smoking breaks over the last two weeks or their names. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/18/24 at 10:16 AM with ADON B revealed the process for a smoking evaluation was when the admission charge nurse would ask if a resident was a smoker. The admission nurse observed the first smoke break, observing the resident smoking. The admission nurse would then review policy and smoke times with the resident, let them know not to keep any smoking materials on them, education on ashtrays and that the first cigarette would have to be finished before a second cigarette could be smoked. ADON B stated if assessed to require an apron, the resident would have to wear the apron, and staff would ensure an appropriate number of aprons were kept available on the smoking patio. The admitting nurse would be responsible for taking the smoking materials from the resident at admission. The nurse would label the smoking materials with the resident's name and put into the smoking box. Staff were to monitor during scheduled smoking times, and periodically throughout the day staff were to go through the courtyard to make sure no one smoked unsupervised. ADON B stated if a resident was found with smoking materials or smoking unsupervised, staff would ask for the smoking items. If the resident refused, staff were to get the DON or Administrator to inform them of the policy along with repercussions of violating the policy. The DON or Administrator would reeducate the resident on smoking policy and review the signed admission policy including the smoking policy that had been agreed to. The ADON stated the facility usually gave a 30-day notice and if caught a second time they would be discharged . She stated the resident would usually hand over all items after that conversation. She stated when guests visit residents or residents leave the facility and come back, staff would ask to look in bags residents had, however, staff would not search if the resident refused to allow staff to check. ADON B stated if a family member brought in smoking materials for the resident, staff would remind them that they would need to be brought to the nurses to hold. She stated if a resident was known to try to keep smoking items, staff would remind periodically that they would need to turn in items for safety reasons. ADON B stated smoking assessments are reviewed and revised quarterly or with a change of condition. She stated the last smoking in-service was conducted about a month ago for all staff. Interview on 12/18/24 at 10:44 AM with Housekeeper F revealed staff, usually the social worker or admission coordinator, would go over smoking policy, times, and inform that smoking items would need to be kept in a locked blue box at the nurse's station. The resident would then be evaluated for apron-use. He stated residents would be informed a staff member had to be outside to monitor for residents to smoke. Afterwards a staff member would clean up when residents were done smoking. Housekeeper F stated the nurses were responsible for taking up the smoking materials from residents at admission or obtain them from friends/family. He stated staff were scheduled to monitor residents smoking. If a resident was found with smoking materials on their person, he would inform the nurse and the nurse would reeducate the resident. Housekeeper F stated he was last in-serviced on the smoking policy and procedures probably sometime in June 2024. Interview on 12/18/24 at 10:53 AM with CNA C revealed nurses evaluate residents who smoke to see if it would be safe for them to smoke on their own or would need an apron. She stated nurses would see what safety precautions were needed. CNA C stated all staff were responsible for taking up smoking-related items. She stated if residents refuse to turn over their smoking related items, staff were to report it to the nurse and unit managers immediately. CNA C stated different departments were responsible for different smoking times: 9:30 AM - CNAs 11:30 AM - Housekeeping (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:30 PM - Laundry CNA C stated after the residents finished smoking, monitoring staff emptied the ashtrays and ensured all butts were removed. She stated staff were to make sure the smoke box was filled. She stated if a resident was violating smoking policy, staff would ask residents to put out cigarettes, give up any smoking items, report to the nurse, unit managers, and the Administrator. She stated smoking assessments were revised when a change of condition occurred. CNA C stated the unit manager reminded CNAs daily during the start of shift regarding smoking policies and processes. Interview on 12/18/24 at 11:07 AM with the Corporate RN revealed residents at admission would be asked by the admitting nurse if they are a smoker and the safe smoking assessment populated to be completed. She stated all staff were responsible for taking smoking materials if a resident was found with them. The Corporate RN stated if a resident did not turn over the smoking materials, staff were to immediately inform the Administrator to address the situation. She stated smoking monitoring was divided by departments per smoke break. A designated staff member would be in charge of passing out cigarettes and monitoring residents during the smoking break. She stated the designated staff member would then clean up all the cigarette butts and empty out the ashtrays after residents finished smoking. The Corporate RN stated the resident and family were educated on the smoking policy and if the policy was violated, the facility would give a warning and reeducate the resident and family that smoking items need to be given to nurse. She stated violations were grounds for discharge. She stated if the resident continued to violate, then a 30-day discharge notice would be issued. She stated if a resident leaves the facility on a day pass and buys more smoking related items, the resident was informed to turn into the nurse to have the items safely locked up. Residents were reeducated on the facility policy and process periodically by staff when monitoring smoke breaks to remind residents of rules that need to be followed. The Corporate RN stated the last in-service was conducted within the last two months. She stated Resident #115 was care planned, assessed for smoking, and his smoking materials should have been in the locked boxes at the nurse's station. She stated she was unsure how he had smoking items in his room or on his person but felt confident staff had some of his smoking materials at the nurse's station. The Corporate RN stated it was possible when the family visited, they had brought Resident #115 more smoking items that they did not turn it over to the facility. She stated their fire panel monitoring company was in the process of installing magnetic locks with keypads on doors to the smoking patio. She stated staff would have to enter a code to let residents out onto the patio and to come back inside a push button would be near the door to release the lock to come back in from the patio; this was so staff would be more aware when residents go outside and when to be checking more frequently. She stated they would have residents sign the smoking policy at smoke breaks and ongoing for new admissions. Interview on 12/19/2024 at 10:15 AM with Activities G revealed that the 300-hall locked smoking box had items for 7 residents, however no items were for Resident #115.Activities G stated he was the one responsible for ensuring the locked smoking boxes had adequate supplies available for the residents who provided their own smoking items or who had provided funds to the facility to purchase smoking supplies for them; excess items were kept in a secondary secured location. Activities G stated he did not recall having any smoking supplies for Resident #115 and was not sure where the Resident was obtaining smoking items from or why the staff who had provided monitoring during 1:1 smoke breaks had not requested the smoking items for appropriate storage. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/19/2024 at 10:33 with Activities G revealed that he had spoken with Resident #115 about proper storage of smoking supplies and the resident stated he gave his smoking items to a family member when she visited the evening prior and no longer had any smoking items in his possession. Interview on 12/19/24 at 11:10 AM with ADON A revealed if the resident stated that yes, they smoked, during admission assessments, then the admission nurse should go watch the resident smoke and ensure they were safe to complete the assessment. The admission nurse should then ask for smoking related supplies and hand them over to the activities director to put in the locked blue boxes that were kept at the 200 hall nurses' station or ask family members to provide smoking supplies or funds for the facility to purchase. ADON A stated that she was not the admitting nurse and spoke with Resident #115 about additional assessments that needed to be done. She stated she did not ask for his smoking items because he did not say he had them and she was not aware he had been smoking since his admission. ADON A stated that normally it should be asked if a resident is a smoker during admission assessments and to select yes for the additional assessment to populate. Review of the facility's Smoking Policy, revised 4/26/2022, revealed: The facility is responsible for enforcement of smoking policies which must include at least the following provisions: 1. Smoking tobacco, matches, lighters, or other ignition sources for smoking are not permitted to be kept or stored in a resident's room 2. A safe smoking assessment will be done regularly for each resident who smokes. Smoking by residents classified as unsafe will be prohibited except when the resident will be directly supervised by facility personnel or visitors who are aware of the resident's limitations with smoking. The resident must be within direct view of the smoking supervisor, in reasonably proximity of the supervisor, and the supervisor must be able to quickly respond in the event of an emergency. Additionally, the supervisor, whether staff or visitor must be aware of these responsibilities. 3. If the facility identifies that the resident needs assistance/supervision and/or additional protective devices for smoking, the facility includes this information in the resident's care plan, and reviews and revises the plan periodically as needed . 6. Smoking is not allowed in any resident rooms . 8. Employees, medical staff, contract employees and visitors may not use any form of tobacco products inside the facility. This includes, but is not limited to, cigarettes, cigars, pipes, water pipes, bidis, kreteks, electronic cigarettes, smokeless tobacco, snuff, and chewing tobacco . 10. The resident will be informed of the smoking policy upon admission and in conjunction with care plan meetings thereafter . 14. Smoking policies must be formulated for site specific situations by each facility. The policies must comply with all applicable codes and regulations including the items contained within this policy. The facility is responsible for informing residents, staff, visitors, and other applicable parties of smoking policies through distribution and/or posting. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	15. The facility will post a copy of the smoking policy in an easily accessible area for the information of residents, visitors, and employees .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for two (Resident #34 and Resident #74) of five residents reviewed for pharmaceutical services. LVN E failed to hold medication Furosemide 40 MG with parameter to hold at SBP less than110 when Resident #34's BP was 95/84. LVN E failed to check vancomycin blood level (trough) results for Resident #74 before administering vancomycin antibiotic. These failures placed residents at risk for not receiving the intended therapeutic benefit of their medications or receiving them as prescribed, per physician orders. Findings included: Review of Resident #34's face sheet, dated 12/18/24, revealed the resident was an [AGE] year-old female readmitted on [DATE] with the diagnoses of type 2 diabetes, sepsis, and hypertension. Review of Resident #34's physician orders, dated12/18/24, revealed the resident received the following medications: - Furosemide Tablet 40 MG - Give 1 tablet via G-Tube two times a day related to essential (primary) hypertension .hold for SBP <110 and HR <60 Review of Resident #34's MAR for December 2024, revealed Furosemide Tablet 40 MG - Give 1 tablet via G-Tube two times a day related to essential (primary) hypertension .hold for SBP <110 and HR <60 administered by LVN E. BP reading 95/84, pulse 92. Review of Resident #74's face sheet, dated/ 12/19/24, revealed the resident was a [AGE] year-old male readmitted on [DATE] with diagnoses of paraplegia (paralysis), major depressive disorder, and essential hypertension (high-blood pressure) Review of Resident #74's physician orders, dated11/26/24, revealed the resident received the following orders: - Twice weekly lab monitoring trough levels on Mondays and Thursdays. Vanco trough level 15-20. Weekly labs need to be faxed at [number provided]. - Vancomycin HCl Intravenous Solution 1250 MG/250ML (Vancomycin HCl) Use 250 ml intravenously every 8 hours for Osteomyelitis until 01/04/2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #74's MAR for December 2024, revealed Vancomycin HCl Intravenous Solution 1250 MG/250ML (Vancomycin HCl) Use 250 ml intravenously every 8 hours for Osteomyelitis until 01/04/2025. Review of Resident #74's random trough collected on 12/18/24 at 02:59 AM resulted on 12/18/24 at 08:18 AM. Result 2.2 vancomycin random level. Observation on 12/18/24 from 6:25 AM to 06:43 AM of medication pass with LVN E revealed the following: LVN E checked BP and pulse for Resident #34. Reading was BP 95/84, HR 92. LVN E administered Furosemide Tablet 40 mg to Resident #34 without checking the parameters in the electronic record prior to administering. Observation on 12/18/24 from 08:30 AM to 08:53 AM with LVN E revealed the following: LVN E administered Vancomycin to Resident #74 without checking the vancomycin trough results in the electronic record prior to administering. Resident #74 asked for the trough results in which LVN E stated she had not seen the results yet. LVN E then went to the computer after starting the vancomycin medication administration and retrieved the random trough results told Resident #74 the new results of 2.2. Interview on 12/18/24 at 7:24 AM with LVN E revealed she should have held the Lasix (Furosemide Tablet 40 mg) before administering. She stated it was not showing the parameters on the electronic record, but had she pressed the more button (to expand the order), she would have seen the parameter. She stated she was supposed to look at the medication card and match what was on the computer. She stated the risk of not checking BP parameters was there could be a drop in BP. She stated if the resident's BP was not in range, she would notify the physician. In an interview with LVN E on 12/19/24 at 10:04 AM she stated she had been instructed by the facility to not hold any medications pending random trough monitoring. She stated that was the reason she did not check the results before administering Resident #74's vancomycin. She stated in her nursing experience it was good nursing practice to hold a medication until results were in before administering medication. She stated the risk for not checking the lab results was not knowing what the current blood level of the medication could cause toxicity (too much in the blood). In an interview with ADON A on 12/19/24 at 11:08 AM, it was revealed that the infectious diseases clinic was difficult to get a hold of for Resident #74's trough results therefore the facility physician gave orders to check a random trough level for Resident #74. She stated it was not necessary to hold the vancomycin while waiting for the trough level results because it was not accurate due to Resident #74 refusing his medication for the past two days. She stated it was important to know the trough level so that the resident did not get too much medication and become septic or too little and not the therapeutic range. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the corporate DON on 12/19/24 at 12:28 PM, she stated the expectation was that the results to labs were read prior to medication administration. She stated the expectation was that all parameters in place were followed for medication administration. She stated the physician was notified for Resident #34's Lasix (furosemide) and he had changed it to be held if BP was less than 90. She stated the risk to following parameters was adverse reactions. She stated the facility had already started to provide in-service the nursing staff regarding medication administration. Review of facility policy titled Medications, Intravenous Infusion revision date 02/14/07 reflected, . The resident will be free from injury following intravenous infusion of medication .become familiar with the drug action, dose, side effects, compatibilities, time and rate of infusion, expected results .Explain the procedure to the resident including expected results .Medication errors and adverse drug reactions are immediately reported to the residents physician. In addition, the Director of nurses and/or designer should be notified of any medication errors. Any medication errors will require a medication error report that indicates the error and actions to prevent reoccurrence . Review of facility policy titled Physician Orders dated 2015 reflected, . Nurse will review the order and if needed contact the prescriber for any clarifications

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional standard for 1 of 2 medication rooms (Med Room A) reviewed for storage of drugs. ADON A failed to ensure medications were secured and not left out in the open outside Med Room A. This could affect residents by placing them at risk of medication not meeting therapeutic levels, misuse and diversion. Findings included: Review of Resident #12's face sheet, dated 12/19/24, revealed the resident was a [AGE] year-old male readmitted on [DATE] with the diagnoses of epilepsy (seizure disorder), schizophrenia (a serious mental health condition that affects a person's thoughts, feelings and behaviors), and essential hypertension (high-blood pressure). Review of Resident #51's face sheet, dated 12/19/24, revealed the resident was a [AGE] year-old male admitted on [DATE] with the diagnoses of type 2 diabetes, heart failure, and personal history of transient ischemic attack (TIA, and cerebral infarction (stroke). Review of Resident #26's face sheet, dated 12/19/24, revealed the resident was a [AGE] year-old female admitted on [DATE] with diagnoses of transient cerebral ischemic attack (stroke), seizures, and anxiety disorder. Observation on 12/17/24 at 10:33 AM revealed ADON A left the following medication outside Med Room A on top of a cart; 4 boxes of breathing treatment medication, inhaler albuterol inhalation medication, Afrin nose spray medication, and Geri Tussin DM cough medication 473 mL bottle. Resident #12 was observed walking by the medications twice and Resident #26 was observed pushing Resident #51 past the medications. The door to Med Room A was closed and locked. ADON A was inside the med room. In an interview with ADON A on 12/17/24 at 10:47 AM, she stated Med Room A had a window and she could see the cart with the medications. She stated that she did not see Residents #12, #26, and #51 pass by the cart because of the med room window view. ADON A stated she should have taken the cart inside Med Room A and not left it outside where residents had access to the medications. She stated the risk to the resident was that they could take the medications and hurt themselves. She stated it was her responsibility to secure medications when they were in her possession. Interview on 12/19/24 at 3:39 PM with the AIT revealed she expected medications to be secured and stored based on facility. She stated if the ADON did not follow policy, it was the DON's responsibility to ensure the ADON was following policy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy titled labelling of Container, revision date April 2007, reflected policy statement All medications maintained in the facility shall be properly labelled in accordance with current state and federal regulations. Policy interpretation and implementations .read in part 1. Medications labels must be legible at all times. 3. Labels for individual drug containers shall include all necessary information such as a) Residents name, f) Date medication was dispensed, h) Expiration date .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43843 Based on observation, interview and record review the facility failed to store, prepare, and accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food and nutrition services. 1. The facility failed to ensure stored food was properly labeled (marked or identified with the contents in the bag), dated (date the item was received into the facility) . These failures could place all residents at risk of cross contamination and food-borne illness. Findings include: Observation on 12/17/2024 at 8:47 AM, during initial kitchen rounds of 1 of 1 walk-in freezer revealed: 1. An unopened bag of 8 pack of pre-made frozen pancakes, a unopen bag of broccoli were not labeled (marked or identified with the contents in the bag) and not dated (date the item was received into the facility) and not in the original box. 2. Open cardboard box contained individual 4 fl oz magic cup ice cream containers the top of the box had ice crystal conduction collected on top. Interview on 12/19/2025 at 9:42 AM with Dietary Manager revealed the expectation is staff are to close the boxes properly and label identify the name of the item inside, item used date use by date, or date the item was open. The risk was cross contamination and food borne illness. Record review of the Food Storage and Supplies policy , Manual dated 2012, reflected open packages of food are stored in closed containers with covers or in sealed bags, and dated as to when opened. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the U.S. Public Health Service Food Code, dated 2022, reflected: 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (C) A refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD ingredient or a portion of a refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest prepared or first-prepared ingredient. (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507 48520 Based on interview and record review, the facility failed to provide specialized rehabilitative services such as but not limited to physical therapy, speech therapy-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as required in the resident's comprehensive plan of care for 2 of 2 residents (Resident #1 and Resident #111) reviewed for specialized rehabilitative services. The facility failed to screen Resident #1 and Resident #111 for physical therapy. This failure could place residents who required rehabilitative services at risk of a decline or decrease in their physical capabilities. Findings included: Review of Resident # 1's face sheet, dated 12/19/2024, revealed a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, personal history of transient ischemic attack (stroke), heart failure and chronic obstructive pulmonary disease. Review of Resident #1's care plan, dated 11/13/2024, revealed Resident #1 has an ADL Self Care Performance Deficit with interventions that included PT/OT evaluation and treatment as per MD orders. Review of Resident #1's order summary report dated 12/19/2024 revealed no orders for physical therapy. Review of Resident # 111's face sheet, dated 12/19/24, revealed the resident was a [AGE] year-old female admitted on [DATE] with the diagnoses of diastolic heart failure (still left heart ventricle), muscle weakness, and personal history of transient ischemic attack (stroke). Review of resident # 111's physician orders revealed no mention of physical therapy ordered, only occupational therapy, which was ordered 10/07/24 for three days a week for 30 days. Interview on 12/17/24 at 10:02 AM with Resident # 111 revealed the resident had lived in the facility for three months but she has not had any therapy. She stated she wanted to walk. Resident #111 stated OT only did therapy on her hands and not her legs. Interview on 12/19/24 at 11:44 AM with the DOR revealed he had been at the facility for two weeks . He stated the goal with new admissions was to be screened for therapy within 48 hours, in which they would screen for PT, OT, and ST. He stated if residents were found to be in decline or weak, they would be screened as positive for therapy services. The DOR stated Residents #1 and #111 were not screened for PT. He stated quarterly, residents were reassessed to see where they were in therapy and at what level, which would be relayed to the physician to sign for new orders for therapy. He stated the risk of residents not being screened for therapy for residents who may need services could be a risk of contractures, decreased bed mobility, and increased need for assistants. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/19/24 at 12:26 PM with the Corporate RN revealed when it comes to screening for therapy, it would depend on facility to facility as well as the resident. She stated she would double-check the facility procedures. She stated Resident #1 and Resident #111 may have been overlooked in between DORs, as the new one just started. She stated ideally residents should be screened around admission. She stated the resident may not need therapy, but the facility would typically screen anyway to identify any deficits or to confirm there are no issues that would require therapy. The Corporate RN stated it also depended on payor source as well. She stated she was not sure how often therapy screened. She stated usually if a change in condition was identified or a fall, the facility would screen. She stated staff would talk in morning meetings, including the DOR and clinical staff, to identify residents who may have had falls from day to day and over the weekend. Therapist would then screen the residents identified and come up with a plan. The Corporate RN stated the PRN PT would just do baseline screening and establish plan of care/treatment care; PTAs would follow treatment plans established by PT. She stated there may not always be a PT, but they would come when an evaluation was needed. The Corporate RN stated they do have staffed PTA and COTAs that would do the treatments . Care meetings were conducted weekly, which would allow the facility time to identify concerns. She stated usually therapy would constantly look to screen as many residents as they could. The Corporate RN stated she would have to get therapy to see if there was a certain timeframe for screening. She stated the risk of not getting screened for PT if there was a change of condition or at admission was the resident may not be as independent, require more care, and may not get services that they need. She stated if the resident fell , she would expect staff to screen the resident for physical therapy services. Review of Resident # 111's medical record revealed no screening for physical therapy. In an interview on 12/19/24 at 2:06 PM, the Corporate RN stated she could not find a specific policy on screening for therapy and stated the admission policy included the IDT meeting in which therapy would have identified the resident for physical therapy screening. Interview on 12/19/24 at 3:15 PM with the AIT revealed the expectation of therapy was for all residents to be screened for services. She stated the DOR was new and they were positive the residents would be picked up for services needed once the DOR had more time. The risk to the residents not being screened was their function could decline. The AIT stated the facility had morning meetings and therapy would stay behind for incident reports. She stated standard morning meetings happen so that residents were not missed. She stated the DOR would be responsible for ensuring all residents were screened for therapy. The AIT stated the expectation she had for therapy was to follow facility policy. She stated once the facility obtains a new DON, they would conduct more in-services. At this time, the facility was short-staffed and they were rushing through their work. Review of the facility's Admission/Readmission policy, dated 2003, revealed, .initiate an interdisciplinary plan of care for the resident and place a copy on the clinical record .

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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** 43843 48520 Based on observation, interview, and record review, the facility failed to 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 4 of 30 residents reviewed for infection control (Resident 34, #59, #88, and #369) 1. The facility failed to follow EBP (Enhanced Barrier Precautions) procedures for Resident #34 when LVN Failed to wear PPE while administering medications to Resident #34. 2. The facility failed to follow contact isolation precautions (this is a precaution used to prevent the spread of germs that are spread by touching a person or their belonging) when ADON A and the wound care physician failed to don (to put on) PPE while providing wound care for Resident #369. 3. CNA C failed to sanitize her hands in between feeding Resident #59 and Resident #88. These failures affected residents by placing them at an increased and unnecessary risk of exposure to communicable diseases and infections. Findings included: 1.Review of Resident #34's face sheet, dated 12/19/24, revealed the resident was an [AGE] year-old female readmitted on [DATE] with the diagnoses of type 2 diabetes, sepsis (a serious condition in which the body responds improperly to an infection), and hypertension. Review of Resident #34's quarterly MDS Assessment, dated 11/07/24, revealed Resident #34 had a feeding tube. Review of Resident #34's care plan, dated 10/08/24, revealed the resident was on enhanced barrier precautions with a goal of there would be no transmission of infection from one or another resident. Interventions included: Gloves and gowns should be donned if any of the following activities were to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity. Perform hand sanitation before entering the room and prior to leaving the room. Postings at the resident's room entrance indicating the resident is on enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 12/18/24 at 6:43 AM during medication pass with LVN E with Resident #34 revealed the resident was on EBP isolation for g-tube. LVN E was observed not wearing a gown when administering medication to Resident #34. LVN E checked Resident #34's vitals, cleaned the medication tray, crushed medications into individual cups, and washed her hands. LVNE _donned gloves and mixed water with medications. LVN E stated she liked to clean Resident #34's mouth before she left and washed the resident's mouth with a syringe. She washed the syringe after use and then completed hand hygiene. LVNE stated Resident #34 had a UTI, but she was on post-antibiotic treatment and was not on EBP (the sign outside the resident's door indicated the resident was on EBP). LVNE was not aware a g-tube was considered an indwelling medical device which would require EBP. She stated the facility had not removed the sign for EBP after antibiotics were completed. LVN E stated she had only been at the facility for three months and was not trained on EBP, only for wounds and foley catheter. She stated now she understood anyone with a g-tube or anything invasive would require PPE. 2.Review of Resident #369's face sheet, dated 12/19/24, revealed the resident was a [AGE] year-old male readmitted on [DATE] with the diagnoses of methicillin resistant staphylococcus aureus infection as the cause of diseases (MRSA - a type of bacteria that many antibiotics don't work on), diabetes mellitus (Type 2 diabetes), and non-pressure chronic ulcer. Review of Resident #369's quarterly MDS Assessment, dated 11/26/24, revealed the resident had an active diagnosis of multi-drug-resistant organism infection (MDRO). Resident #369 has a pressure ulcer and is at risk for developing pressure ulcers. Review of Resident #369's physician orders dated 12/12/24 reflected resident was on Contact isolation every shift for ESBL/MRSA Review of Resident #369's care plan, dated 12/02/24, revealed no mention of the use of contact precautions, enhanced barrier precautions, or MDRO status. Observation on 12/17/24 at 9:00 AM of Resident #369 revealed the wound care physician and ADON A were seen not wearing PPE while providing wound care. Resident #369 was observed with a sign outside his door, indicating he was on contact and EBP precaution. Interview on 12/17/24 at 9:47 AM with Resident #369 revealed he had wounds and a PICC line that was used for antibiotics. Interview on 12/17/24 at 10:04 AM with ADON B revealed staff were supposed to put on a gown when going into Resident #369's room due to contact isolation in urine and blood. She expected all staff to go in with PPE, as staff would be touching something. Interview on 12/17/24 at 10:06 AM with RN H revealed Resident #369 was on contact isolation which meant staff were to wear gloves and gowns. She stated she did not see the wound care physician and ADON A in Resident #369's room. She stated if she had she seen them, then she would have reminded them to wear PPE. She stated she all staff were expected to wear PPE to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with ADON A on 12/17/24 at 10:47 AM, it was revealed that the wound care doctor wanted to look at Resident #369's leg. She stated all he did was look at the left leg. She stated she was aware that Resident #369 was on contact isolation. She stated she had a mask on and wore gloves and the wound care physician had on gloves but they both did not have gowns on. ADON A stated they should have had a gown. She stated Isolation precaution are in place to keep the residents safe. She stated the risk of not following isolation precaution was Spreading infection. She stated it was her responsibility to remind the physicians, and she should have asked wound care physician to wear PPE but all he wanted to do was look at the leg She stated wound care physician was usually good about gowning up. She stated he did not touch the resident. She said she opened Resident #369's wound to look at it. ADON stated there was no specific reason why she did not wear PPE. An attempt to interview wound care physician on the phone, left message to return call on 12/18/24 at 2:15 PM. 3.Review of Resident #88's face sheet, dated 12/18/24, revealed the resident was a [AGE] year-old female admitted on [DATE], with the diagnoses of hypertension (high-blood pressure), heart failure, and acute kidney failure. Review of Resident #59's face sheet, dated 12/18/24, revealed the resident was a [AGE] year-old female admitted on [DATE], with the diagnoses of chronic pulmonary (lung) disease, cognitive communication deficit, and major depressive disorder. Observation on 12/18/24 from 07:36 AM to 07:50 AM CNA C was observed feeding two residents at the same time without performing hand hygiene. Interview on 12/19/24 at 8:52 AM with CNA C revealed she stated she did sometimes feed multiple residents at once but preferred to feed the residents she normally feeds. CNAC stated she didn't sanitize hands between feeding Resident #88 and Resident #59 . CNA C stated it was important to perform hand hygiene due to germs. She did not answer as to why she did not sanitize her hands in between feeding Resident #88 and Resident #59. Interview on 12/19/24 at 11:08 AM with corporate DON Revealed staff should only feed one resident at a time so that they could focus on each resident and ask another member of staff to feed the other resident. If feeding multiple residents at once, attention is divided. Residents could feel disrespected and could be a safety concern. Interview on 12/19/24 at 3:39 with the AIT revealed it was important to feed one resident at a time and sanitize in between feeding residents due to risk of infection spreading to other residents. She stated she also expected PPE guidelines to be followed due to infection risks. Review of facility policy titled Hand Washing dated 2012 reflected . We will ensure proper hand washing procedures are utilized. Employees are to frequently perform hand washing . Review of facility policy titled Feeding, Assistive/Complete with revision date 02/12/07 reflected read in part . 4. wash hands .,6. Provide a pleasant environment (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of policy Implementation of Standard and Transmission-Based Precautions dated 03/24, revealed, . EBP are indicated for residents with any of the following: 1. Infection or colonization with a CDC-targeted MDRO .Wounds and/or indwelling medical devices even if a resident is not known to be infected or colonized with a MDRO .post signage .high-contact resident care activities requiring gown and glove use . Review of the Infection Control policy, revised 10/23, reflected Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Policy Interpretation and Implementation: Administrative Practices to Promote Hand Hygiene: 1. Personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. (.) Indications for Hand Hygiene: 1. Hand hygiene is indicated: a. immediately before touching a resident; (.) c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; (.) 2. Use an alcohol-based hand rub containing at least 60% alcohol for most clinical situations.