STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455670	A. Building B. Wing	06/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Retirement and Healthcare Community	1900 W State Hwy 6 Waco, TX 76712

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to ensure residents were aware of where to locate the State Agency (SA) survey inspection results such as (surveys, certifications, and complaint/incident investigations) and post in a place readily accessible to residents, family members, and legal representatives of residents for 1 of 1 facility in that: The facility failed on 06/11/2025 to make a survey binder that was readily available and easily identified to all residents or the public that included survey results for viewing. This failure placed residents at risk of not being able to fully exercise their rights and at risk of not being aware of the facility's past deficiencies. Findings included: In an observation on 06/11/25 at 2:25PM of the facility's front door area, the receptionist desk, and the area near the administrative offices revealed there was no evidence of a survey results binder or notice of where to locate the binder. In a confidential interview on 06/11/2025 beginning at 2:00pm, eleven residents stated they did not know where or how to access survey results in the facility and multiple residents stated they would like to know what the previous survey and investigation results were. They all stated they had never seen a binder labeled with that information near the front door or receptionist desk. In an observation and interview on 06/11/25 at 2:32 PM with the ADM who when asked where the state survey results binder was located, the ADM stated it was in his office, and he brought it out to the state surveyors. He stated that he kept it in his office. The ADM stated that a negative outcome of residents and the public not being able to see the results of the facility's surveys and investigations would be that they were not able to see what kind of care the facility provided. In a follow up interview on 06/11/25 at 4:47PM with the ADM who stated that the survey binder was now sitting atop a shelf near the receptionist desk, and it did not have to be requested for resident or visitor observation. This was verified through surveyor observation on 06/11/25 at 5:15PM. Review of the facility's Survey Results, Examination of policy dated last revised April 2007, reflected : (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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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	A copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisits reports, etc., along with state approved plans of correction of noted deficiencies, is maintained in a 3-ring binder located in an area frequented by most residents, such as the main lobby or resident activity room.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to ensure that all alleged violations involving abuse, neglect are reported immediately, but not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the State Survey Agency in accordance with State law through established procedures for 1 of 9 residents (Resident #53) reviewed for abuse and neglect, in that: The facility did not report an incident concerning Resident #53 when on 06/09/25 Resident #53 told the SW he was planning to commit suicide and was found to have hoarded 21 pills of his medication administration to do so. This deficient practice could place residents at risk of not having incident and accidents reported or investigated. Findings included: Review of Resident #53's Face Sheet dated 06/12/25 reflected a [AGE] year old male admitted to the facility on [DATE] with diagnosis that included Schizophrenia (mental health condition that affects how people think, feel, behave and can result in hallucinations, delusions, disorganized thinking and behavior), cognitive communication deficit (condition that affects how individuals think, remember, and communicate), other specified depressive episodes (condition that can include persistent sadness or low mood, fatigue or loss of energy, irritability, and thoughts of death or suicide), unspecified dementia (group of symptoms affecting memory, thinking, and social abilities), and anxiety disorder (characterized by fear or worry that is both intense and excessive). The Face Sheet reflected Resident #53 was discharged on 06/09/25 to a psychiatric hospital. Review of Resident #53's Annual MDS assessment dated [DATE] reflected a BIMS score of 15 indicating cognition intact. Section D Mood reflected a resident mood interview that revealed over the last two weeks have you been bothered by any of the following problems? and showed little interest or pleasure in doing things was marked yes for symptom presence and 2-6 days (several days) for frequency. Feeling down, depressed, or hopeless was also marked as a symptom present and 2-6 days (several days) for frequency. Section I of the MDS assessment reflected Resident #53 was marked for having a diagnosis of Anxiety Disorder, Depression, and Schizophrenia. Section N of the MDS assessment reflected Resident #53 was taking an antipsychotic, antianxiety, and antidepressant. Review of resident #53's care plan last revised 06/11/25 reflected a focus on: I am currently receiving anti-anxiety medication related to anxiety disorder. I am currently receiving psychotropic medications related to Schizophrenia. Review of Resident #53's physician's orders reflected an order dated 05/22/25 Make sure resident takes his medications before leaving the room. Every shift monitoring of taking medication **Make sure resident swallows his medications before leaving his room. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #53's progress note revealed a progress note dated 06/09/25 entered by SW that stated, SW was sitting with resident when he stated he wasn't feeling well. SW asked resident to elaborate- he stated can I be honest with you? SW stated of course. Resident began telling this writer that he wanted to kill himself. He stated he has hoarded his medications in his locked bedside table and planned to take all at once and overdose. SW proceeded to inform ADM and DON about the situation. ADM and DON stated resident needed to be sent out and be on a 1:1 until he was sent out. SW gave resident two options to be sent to emergency room or psychiatric hospital. Resident agreed to go to psychiatric hospital to stabilize. SW called psychiatric hospital inpatient and received authorization for resident to admit to an inpatient stay. SW then collected all medications from bedroom and handed them over to DON. SW stayed 1:1 with resident, listening to music, coloring, until psychiatric hospital was ready to admit him. At 03:15 PM resident boarded onto facility van voluntarily with staff to transport to psychiatric hospital. IDT aware, PASRR aware. SW was with resident from 01:50 PM to 03:15 PM. Review of the facility reported incidents on 06/12/25 for the month of June 2025 revealed there was no self-report for the event concerning Resident #53 on 06/09/25 was reported internally or observed in TULIP to state agency. In an interview on 06/12/25 at 02:56 PM with the DON she stated she was just now working on an internal incident report for Resident #53 so that it could be kept on file and referred to when needed. She stated to her knowledge this was not an incident reported to HHSC. She stated she would consider this an emergency situation. The DON stated if Resident #53 would have gone through with his plan and consumed all the medication he had pocketed, it would be enough to cause a change in condition and the potential for harm. In an interview on 06/13/25 at 01:30 PM with the ADM he stated he was responsible for reporting incidents and that at the time of the incident he did not believe it needed to be reported to HHSC which is why he didn't report it. He stated Resident #53 had not consumed the medication and there was no harm at the time, so he did not believe it met the conditions to be a reportable incident. The ADM stated that based on the findings on 06/09/25 when Resident #53 wanted to commit suicide and was found to have 21 pills he believed it was important to send the resident out for evaluation and stated he made sure Resident #53 made a visit to either the ER or a psychiatric hospital due to the suicidal ideations which is why he was immediately sent out the same day. He stated a potential negative outcome of not reporting incidents is the potential for residents to not get the services they need. In an interview on 06/13/25 at 05:05 PM with the SW, she stated Resident #53 made the suicidal ideation report to her and showed her the pills he had been hoarding in order to fulfill his plan on 06/09/25. She stated the day after the incident on 06/10/25 she asked the ADM if this would be reported to HHS and was told he did not think it needed to be reported. Review of the undated Accidents and Incidents Investigation and Reporting policy reflected: All accidents or incidents involving residents, employees, visitors, vendors, etc. occurring on our premises shall be reviewed and investigated. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate an investigation of the accident or incident and notify the Administrator immediately for allegations of abuse, neglect, misappropriation, and exploitation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse Supervisor/Charge Nurse and/or the department director shall complete an Incident/Accident report. The Administrator and Director of Nursing shall review the Incident/Accident report form for each occurrence and follow-up with the appropriate interventions. A policy was requested from the ADM on 06/13/25 at 02:50 PM, he stated there was no other reporting policy that specified the reporting requirements for different incidents.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a comprehensive assessment within 14 calendar days after admission as required for 3 (Resident #19, Resident #63, and Resident #168) of 5 residents records reviewed for comprehensive assessment accuracy and timing. The facility failed on 6/11/2025 to complete Resident #19, Resident #63, and Resident #168's comprehensive MDS assessments within 14 days following their admissions to the facility. This deficient practice could result in newly admitted residents not receiving the proper care required to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Findings included: Review of Resident #19's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included stroke (when blood supply to part of the brain is suddenly reduced, leading to brain cell death and/or permanent damage), high blood pressure, diabetes mellitus (chronic disease where the body does not produce enough insulin), non-Alzheimer's dementia, hemiplegia (paralysis) affecting right nondominant side. Her BIMS score was a 15, indicating she was cognitively intact. The MDS sections A, B, C, D, E, GG, H, I, J, M, N, O, P, and Q were not completed until 06/01/2025 and the MDS was signed as completed on 06/02/2025. Review of Resident #19's comprehensive care plan dated 05/13/2025 reflected the care plan had not been completed and only indicated that she had a behavior problem of refusing care and bathing, and that she took anxiety medication. Review of Resident #63's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old-female who admitted to the facility on [DATE] with diagnoses that included cancer, high blood pressure, kidney failure, malnutrition, depression (sadness), white matter disease (damage to the white matter of the brain), and vitamin D deficiency. Her BIMS score was a 15, indicating she was cognitively intact. The MDS sections B, C, E, and Q were not signed as completed until 5/28/2025 and the MDS was signed as completed on 05/28/2025. Review of Resident #63's care plan was attempted on 06/10/25 however there was no comprehensive care plan started for Resident #63. Review of Resident #168's undated face sheet reflected Resident #168 was a [AGE] year-old-male with diagnoses including unspecified dementia, epilepsy (recurrent seizures), polyneuropathy (damage to multiple peripheral nerves causing pain, weakness, and sensory loss), spondylosis (degenerative changes in the spine), and osteoporosis (weak and brittle bones). Review of Resident #168's admission MDS assessment dated [DATE] reflected a [AGE] year-old male who admitted to the facility on [DATE]. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #168's comprehensive MDS assessment dated [DATE] reflected the only section that had been completed was Section F (Preferences for Customary Routine and Activities) and signed and completed by the facility's AD on 05/29/2025. In an interview on 06/12/25 at 10:28 AM with the DON who stated that when the MDS assessments were done, they triggered the care plans which needed to be completed. She stated the care plans were done as a group effort. She stated the social worker was responsible for opening the baseline care plan. She stated she may add some things to the baseline care plan later as needed but the social worker was ultimately responsible for those. She stated that all staff who were responsible for the MDS assessments, care plans, and baseline care plans were trained on completing them accurately and within the required time frame . She stated if an MDS assessment was not completed correctly, it may have caused the staff to not know how to properly care for the resident or the staff may not know the residents' preferences. She stated if the care plan was not completed correctly, it could have limited some of the communication for providing care to the residents. DON stated if a baseline care plan was not completed within the 48-hour period, there could be goals missed for the new resident and it could have potentially affected their care. In an interview on 06/12/25 at 12:18 PM with LVN D who stated that he began working remotely for the facility 2 weeks ago. He stated that for his first day or two he met with staff in the building. He stated that most of the assessments, (pain, depression, BIMS) are conducted by the facility staff. He stated that he takes all those assessments and puts the information into the MDS assessment. He stated that majority of the questions have been answered for him, but he did have to dig through some records (such as skin integrity), to find out what date it was done. He stated that he was not responsible for ensuring the timeliness of assessments, it was the VPR. In an interview on 06/12/25 at 12:41 PM with the VPR who stated that he had been in his position since the beginning of 2025 and that he had been submitting MDS assessments off and on for a couple months for the facility. He stated that he was responsible for submitting those within their required timeframes. He was aware of the late MDS's, and it was due to the MDS position at the facility not being filled. He stated that not submitting the assessments on time may lead to negative outcomes by not identifying the care residents needed. He stated he had 2 people working remotely to help assemble the MDS assessments. He stated they got constant communication from the ADON/DON/ADM to accurately assemble the MDS. He stated that the remote workers look at documents in the clinical profile to ensure accuracy, but that most of the needed assessments are conducted onsite by the facility staff and left for the MDS team to assemble and put in the assessment. Review of the facility's undated Electronic Transmission of the MDS policy reflected: All MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.) and discharge and reentry records will be completed and electronically encoded into our facility's MDS information system and transmitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current OBRA regulations governing the transmission of MDS data. MDS electronic submissions shall be conducted in accordance with current OBRA regulations governing the transmission of such data.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure the resident assessment accurately reflected the resident's status for 2 (Resident #119, and Resident #168) of 12 residents reviewed for accuracy of assessments. The facility failed on 6/11/2025 to ensure Resident's #119 and #168's comprehensive MDS assessments accurately reflected their healthcare status and needs. This deficient practice could have placed the resident at risk for inadequate care due to incomplete assessments. Findings included: Record review of Resident #119's face sheet dated 06/12/25 reflected Resident #119 was an [AGE] year-old female with an admission date of 05/20/25. Resident #119's diagnoses encephalopathy (a group of conditions that cause brain dysfunction. Brain dysfunction can appear as confusion, memory loss, personality changes and/or coma in the most severe form), congestive heart failure (a serious condition that occurs when the heart can't pump enough blood to meet the body's needs), hypothyroidism (a disorder of the endocrine system in which the thyroid gland does not produce enough thyroid hormones), and muscle weakness (commonly due to lack of exercise, ageing, muscle injury or pregnancy). Record review of Resident #119's admission MDS assessment dated [DATE] reflected Resident #119's MDS was not completed. Record review of Resident 119s assessment titled Brief Interview for Mental Status (BIMS) Evaluation reflected Resident had a BIMS score of 15 indicating Resident #119 was cognitively intact. Record review of Resident #119's care plan dated 05/29/25 and revised 05/31/25 reflected Focus: At risk of infection due to picking at her wounds with her nails. She has a burn area on her upper medial abdomen that she picks at frequently. Goal: Resident will not have any complications related to wound healing during the review period. Interventions included: Assess area frequently for signs or symptoms of worsening skin integrity. Record review of Resident #119's clinical physician orders dated 06/12/25 reflected an order for Wound Care : Right dorsal foot (top of the foot)- cleanse area with wound cleanser, pat dry, apply medi-honey (wound gel) to wound, cover with bordered gauze then wrap with kerlix every day shift. Review of Resident #168's undated face sheet reflected Resident #168 was a [AGE] year-old-male with diagnoses including unspecified dementia, epilepsy (recurrent seizures), polyneuropathy (damage to multiple peripheral nerves causing pain, weakness, and sensory loss), spondylosis (degenerative changes in the spine), and osteoporosis (weak and brittle bones). Review of Resident #168's admission MDS assessment dated [DATE] reflected a [AGE] year-old male who admitted to the facility on [DATE]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #168's comprehensive MDS assessment dated [DATE] reflected the only section that had been completed was Section F (Preferences for Customary Routine and Activities) and signed and completed by the facility's AD on 05/29/2025. In an interview on 06/12/25 at 12:18 PM with LVN D who stated that he began working remotely for the facility 2 weeks ago. He stated that for his first day or two he met with staff in the building. He stated that most of the assessments, (pain, depression, BIMS) are conducted by the facility staff. He stated that he takes all those assessments and puts the information into the MDS assessment. He stated that majority of the questions have been answered for him, but he did have to dig through some records (such as skin integrity), to find out what date it was done. LVN D stated that he was not responsible for ensuring the timeliness of assessments, it was the VPR. In an interview on 06/12/25 at 12:41 PM with the VPR who stated that he had been in his position since the beginning of 2025 and that he had been submitting MDS assessments off and on for a couple months for the facility. He stated that he was responsible for submitting those within their required timeframes. He was aware of the late MDS's, and it was due to the MDS position at the facility not being filled. He stated that not submitting the assessments on time may lead to negative outcomes by not identifying the care residents needed. He stated he had 2 people working remotely to help assemble the MDS assessments. He stated they got constant communication from the ADON/DON/ADM to accurately assemble the MDS. VPR stated that the remote workers look at documents in the clinical profile to ensure accuracy, but that most of the needed assessments are conducted onsite by the facility staff and left for the MDS team to assemble and put in the assessment. Review of the facility's undated Electronic Transmission of the MDS policy reflected: All MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.) and discharge and reentry records will be completed and electronically encoded into our facility's MDS information system and transmitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current OBRA regulations governing the transmission of MDS data. MDS electronic submissions shall be conducted in accordance with current OBRA regulations governing the transmission of such data.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to develop and implement a baseline care plan within 48 hours from admission for 1 of 5 resident (Resident #120) reviewed for care plans. The facility failed to ensure Resident #120 had a Baseline Care Plan that was due within 48 hours of admission to reflect the person-centered needs of Resident #120. This failure could place residents at risk of getting insufficient care and having personal needs not met and could result in diminished physical and psychosocial well-being. Findings include: Review of Resident #120's face sheet dated 06/12/25 reflected that he was a [AGE] year-old male admitted [DATE] with diagnoses of displaced fracture of anterior wall of right acetabulum(medial boundary of hip socket) (a serious injury often requiring surgery), muscle weakness (commonly due to lack of exercise, ageing, muscle injury or pregnancy), cognitive communication deficit (a communication problem caused by underlying cognitive impairments rather than a primary language or speech deficit), hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated), and emphysema (a long-term lung condition that causes shortness of breath). Review of Resident #120's 05/15/25 admission MDS reflected his BIMS score was 13, which indicated Resident #120 was cognitively intact. Review of Resident #120's assessments reflected a Baseline Care Plan dated on 05/21/25, initiated at admission. Review of the resident's records reflected that the Baseline Care Plan was due by 05/17/25, which was 4 days after Resident # 120's admission date. In an interview on 06/12/25 at 10:28 AM, the DON stated the SW was responsible for opening the baseline care plan and getting it going. She stated she may add some things to the baseline care plan later as needed but the social worker was ultimately responsible. She stated staff that were responsible for completing baseline care plans had been trained on completing the baseline care plans accurately and within the required time frame. She stated she was not aware that Resident #120's baseline care plan had not been completed within the 48 hour time frame. She stated if a baseline care plan was not completed within the 48 hour period, there could be goals missed for the new resident and it could have potentially affected their care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/12/25 at 12:24 PM, the SW stated she completed the baseline care plans in addition to the rest of the IDT. She stated the nurses should have opened the baseline care plans but she was the one that usually did. She stated she was aware that the baseline care plan should have been completed within 48 hours. She stated she was not aware the baseline care plan for Resident #120 was not completed within the 48 hour timeframe. She stated she had been out of the facility on vacation until 05/21/25 and she opened and completed the baseline care plan for Resident #120 on the day she returned. She stated Resident #120's baseline care plan should have been completed within 48 hours of his admission. She stated if a resident's baseline care plan was not completed within the required time frame, the facility would have been out of regulation and staff would not have known the resident's correct assessment results. She stated she did not think the baseline care plan not being completed within 48 hours would have affected the resident's care. In an interview on 06/12/25 at 01:37 PM, the ADM stated at this time it was the SW's responsibility to complete the baseline care plans within 48 hours, but it also was a group effort shared with the DON and nurses. He stated typically the MDS nurse would have been responsible for completing the baseline care plans, but they did not have a MDS nurse in that position at that time. He stated he asked the SW every morning in their stand up meeting if the 48 hour care plans were completed for the required residents and that was part of his stand up meeting checklist. He stated all staff that were responsible for completing the baseline care plans had been trained on completing the baseline care plans within the required time frame. He stated he was not aware that Resident #120's baseline care plan had not been completed within the 48 hour time frame. He stated if a baseline care plan was not completed within the 48 hour time frame, the staff could not reflect on the baseline care plan and the resident may not have gotten what they needed. Record Review of the facility policy titled, Care Plans - Baseline and dated December 2016, reflected: Policy Statement: A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and Implementation: 1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission .

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Ridgecrest Retirement and Healthcare Community	1900 W State Hwy 6 Waco, TX 76712

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to develop a comprehensive person-centered care plan furnishing services to attain, or maintain, the resident's highest practicable physical, mental, and psychosocial well-being for 2 (Resident #19, Resident #63, and Resident #119) of 6 residents reviewed for comprehensive care plans. The facility failed on 6/11/2025 to develop and implement a comprehensive care plan for Resident #19 and Resident #63. The facility failed to care plan Resident #119's wound on her right foot. These failures place residents at risk of not receiving appropriate care and treatment. Findings included: In an observation and interview on 06/10/25 at 3:02 PM with Resident #19 who was in her room revealed a communication board on her bedside table. When asked if the communication board helped the resident communicate her needs/wants with facility staff she said sometimes. It was observed that the resident had a difficult time getting the words out that she was trying to say, she took long pauses, looked around, used finger motions such as to draw numbers, and ultimately used a pen and paper to write to communicate some things to the state surveyor. At one point she began to cry and exclaimed that she wished staff would stay longer to hear what she was trying to tell them, because they will leave while she is trying to find the right words. The resident stated that made her feel sad and angry when staff would walk out instead of taking the time to listen to her. She stated that no one had offered her rehab services, but she would like help with her speech and with the healing of her right leg after a fall that happened before she moved into the facility. Review of Resident #19's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included stroke (when blood supply to part of the brain is suddenly reduced, leading to brain cell death and/or permanent damage), high blood pressure, diabetes mellitus (chronic disease where the body does not produce enough insulin), non-Alzheimer's dementia, hemiplegia (paralysis) affecting right nondominant side. In Section V- Care Area Assessment (CAA) Summary, it was indicated that a care area and care planning decision was triggered for communication and ADL Functional/Rehabilitation Potential, and a CAA WS was completed on 6/1/2025. Resident 19's BIMS score was a 15, indicating she was cognitively intact. Review of Resident #19's comprehensive care plan dated 05/13/2025 reflected the care plan had not been completed and only indicated that she had a behavior problem of refusing care and bathing, and that she took anxiety medication. Review of Resident #63's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old-female who admitted to the facility on [DATE] with diagnoses that included cancer, high blood pressure, kidney failure, malnutrition, depression (sadness), white matter disease (damage to the white matter of the brain), and vitamin D deficiency. Her BIMS score was a 15, indicating she was cognitively intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #63's care plan was attempted on 06/10/25 however there was no comprehensive care plan started for Resident #63. Record review of Resident #119's face sheet dated 06/12/25 reflected Resident #119 was an [AGE] year-old female with an admission date of 05/20/25. Resident #119's diagnoses encephalopathy (a group of conditions that cause brain dysfunction. Brain dysfunction can appear as confusion, memory loss, personality changes and/or coma in the most severe form), congestive heart failure (a serious condition that occurs when the heart can't pump enough blood to meet the body's needs), hypothyroidism (a disorder of the endocrine system in which the thyroid gland does not produce enough thyroid hormones), and muscle weakness (commonly due to lack of exercise, ageing, muscle injury or pregnancy). Resident # 19's BIMS was a 15, indicating she was cognitively intact. Record review of resident's assessment titled Brief Interview For Mental Status (BIMS) Evaluation reflected Resident had a BIMS score of 15 indicating Resident #119 was cognitively intact. Record review of Resident #119's care plan initiated 05/22/25 reflected: Resident #119 was not care planned for having a wound present to the top of resident's right foot. Record review of Resident #119's care plan dated 05/29/25 and revised 05/31/25 reflected Focus: At risk of infection due to picking at her wounds with her nails. She has a burn area on her upper medial abdomen that she picks at frequently. Goal: Resident will not have any complications related to wound healing during the review period. Interventions included: Assess area frequently for signs or symptoms of worsening skin integrity. Record review of Resident #119's clinical physician orders dated 06/12/25 reflected an order for Wound Care: Right dorsal foot (top of foot)- cleanse area with wound cleanser, pat dry, apply medi-honey (wound gel) to wound, cover with bordered gauze then wrap with kerlix every day shift. In an interview on 06/10/2025 at 5:45 PM with the DON who stated that Resident #63 did not have a comprehensive care plan started. She stated that the facility's MDS RN had turned in their notice and did not finish it out, so care plans and MDS assessments were having to be done by herself and remote LVN's who work for the company. In an interview on 06/12/25 at 9:18 AM with CNA C she stated that she looked at new admission's care plans to know the backgrounds, behaviors, and needing to get a full picture of the residents she is to provide care for, and she will ask the RN if she has any questions. She stated if there was no care plan it made her job harder, but she would ask the RN about the resident. In an interview on 06/12/25 at 9:30 AM with LVN A who stated that she was not sure if Resident #19 admitted with the communication board or if it was given to her by the SLP. LVN A stated that she had not informed therapy about Resident #19 possibly benefiting from therapy because she thought the communication board was already a part of therapy services. She stated that if a residents' care plan was not complete, she would go assess the resident and then go to the SW to discuss what should be put in the care plan, she stated it hindered her job if there were no care plans in the system, and that the residents have a lot of memory deficits, so sometimes trying to get a fuller picture of who the resident was, could be difficult. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow-up interview on 06/12/25 at 10:28 AM with the DON who stated that when the MDS assessments were done, they triggered the care plans which needed to be completed. She stated the care plans were done as a group effort. She stated the social worker was responsible for opening the baseline care plan. She stated she may add some things to the baseline care plan later as needed but the social worker was ultimately responsible for those. She stated that all staff who were responsible for the MDS assessments, care plans, and baseline care plans were trained on completing them accurately and within the required time frame. She stated if an MDS assessment was not completed correctly, it may have caused the staff to not know how to properly care for the resident or the staff may not know the residents' preferences. She stated if the care plan was not completed correctly, it could have limited some of the communication for providing care to the residents. DON stated if a baseline care plan was not completed within the 48-hour period, there could be goals missed for the new resident and it could have potentially affected their care. Review of the facility's undated Care Plans, Comprehensive Person-Centered policy reflected: Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASRR recommendations; and (3) which professional services are responsible for each element of care; (4) Psychiatric diagnoses must include supporting documentation. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident was given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living for 1 of 6 residents (Resident #19) reviewed for ADL activities. The facility failed on 6/11/2025 to provide therapy services to maintain or improve Resident #19's communication ability by not evaluating her communication deficit for intervention or improvements. This failure could place residents at risk of ADL decline, frustration, and decreased socialization. Findings included: Review of Resident #19's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included stroke (when blood supply to part of the brain is suddenly reduced, leading to brain cell death and/or permanent damage), high blood pressure, diabetes mellitus (chronic disease where the body does not produce enough insulin), non-Alzheimer's dementia, hemiplegia (paralysis) affecting right nondominant side. In Section V- Care Area Assessment (CAA) Summary, it was indicated that a care area and care planning decision was triggered for communication and ADL Functional/Rehabilitation Potential, and a CAA WS was completed on 6/1/2025. Resident # 19's BIMS score was a 15, indicating she was cognitively intact. Review of Resident #19's comprehensive care plan dated 05/13/2025 reflected the care plan had not been completed and only indicated that she had a behavior problem of refusing care and bathing, and that she took anxiety medication. Review of Resident #19's CAA WS dated 6/1/2025 reflected the following: -Triggering conditions-Impaired ability to make self-understood through verbal and non-verbal expression of ideas/wants as indicated by: ability to express ideas and wants, consider both verbal and non-verbal expression, resident was indicated as sometimes understood. -Characteristics of the communication impairment (from clinical record): expressive communication, difficulty putting sentences together, problem describing objects and events. -Care Plan Considerations, if care planning for this problem, what is the overall objective? Maintain current level of functioning, minimize risks. Review of Resident #19's physician's orders, dated 04/30/2025, reflected the following standing (a written protocol that allows the healthcare team to perform specific clinical tasks without needing a physician's order) orders: PT, OT, ST may eval and treat as indicated. PT, OT, ST to eval & treat as indicated. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Rehab potential In an observation and interview on 06/10/25 at 3:02 PM with Resident #19 who was in her room revealed a communication board on her bedside table. When asked if the communication board helped the resident communicate her needs/wants with facility staff she said sometimes. It was observed that the resident had a difficult time getting the words out that she was trying to say, she took long pauses, looked around, used finger motions such as to draw numbers, and ultimately used a pen and paper to write to communicate some things to the state surveyor. At one point she began to cry and exclaimed that she wished staff would stay longer to hear what she was trying to tell them, because they will leave while she is trying to find the right words. The resident stated that made her feel sad and angry when staff would walk out instead of taking the time to listen to her. She stated that no one had offered her rehab services, but she would like help with her speech and with the healing of her right leg after a fall that happened before she moved into the facility. In an interview on 06/11/25 at 3:42 PM with the SLP who stated that she had not conducted any therapy screenings, evaluations, or assessments on Resident #19. She had only conducted the BIMS and depression questionnaire. She stated that she had not done a screening because the facility's process was to only screen a resident if therapy was notified by nursing that a resident had a decline or showed a need for therapy. She stated she had not been informed by any of the nursing staff that Resident #19 had a communication board and she stated she would verify if the resident admitted with the board. If a decline was to be reported by nursing staff the therapy department would do a screening to determine if a more in-depth evaluation was needed, then they would run a verification of benefits to see if the resident's payor source had benefits to cover therapy services, if there were no benefits the facility could ask for a facility authorization which is where the facility ultimately covers the cost of therapy services. In an interview on 06/11/25 at 5:07 PM with the DOR who stated she would check to see if Resident #19 admitted with the communication board. She stated that the process for screening a resident for therapy would be to screen all short-term (skilled) residents for therapy needs, but for LTC residents they typically do not evaluate unless they get a referral from nursing that there has been a decline. The residents quarterly MDS's would trigger an initial therapy evaluation if a decline had been documented. The DOR would then run a verification of benefits to see if a resident had benefits for therapy, but if they came back with no benefits available, the facility would request a facility authorization, which is where the facility could essentially pay for the services until the resident gets another payor source or the therapy is no longer needed. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 06/12/25 at 10:23 AM with Resident #19's FM who stated that Resident #19 had been paralyzed on her right side for about 13 years after having a stroke. The FM stated that Resident #19's mind works well, but her speech was difficult to understand especially when she got tired or agitated. The FM stated that Resident #19 had a fall back in February 2025, prior to that fall the resident was able to get around with the use of a walker, the broken leg made it to where she could not walk at all because the leg could no longer bear weight. The FM stated that the resident chose to let her leg heal naturally with assistance of a brace and that she wears it consistently, and she still attended doctor's visits about her leg. The FM stated that during the healing process, the resident was well confined to a wheelchair or her bed but was adjusting well. The FM stated they thought the resident could benefit from speech therapy, and that the socialization aspect would be great for the resident. The FM stated that approximately 3-4 years ago the resident took ST independently. The FM also stated that Resident #19's Medicaid was in limbo, because prior to admitting to the facility she was using community Medicaid, and they were switching her to NF Medicaid. In a follow-up interview on 06/12/25 at 10:47 AM with the SLP who stated that Resident #19 admitted with the communication board and that nursing should have told her the resident admitted with a communication board so the SLP would have been able to conduct a screening. She would have liked to screen her earlier in her stay to determine if she was appropriate for a further in-depth speech evaluation, and then ask the DOR if the resident qualified for therapy based on her payor source. She stated she has in the past educated nursing staff on how to use a communication board with previous residents who had them. She stated that she went to the resident and conducted an initial therapy screening on 6/12/25 and that from her screening the SLP determined the resident could benefit from a higher tech, augmentative alternative communication device. The resident could receive training on how to use the device and communicate her needs more efficiently and reduce her frustration. She stated that she could try to get a company out to the facility to teach the resident how to use the device. A negative impact could be further decline in function, limiting independence and daily tasks, not being able to express her pain, higher risk for hospital readmission, falls and injury, emotional distress, and social isolation. She stated it was also determined from the screening that Resident #19 could benefit from PT to address a contracture in her right leg to relieve pain. Furthermore, the SLP stated that Resident #19 could benefit from OT services but Resident #19 declined wanting to participate in OT. In an interview on 06/12/25 at 11:03 AM with the ADM who stated that nursing staff should have made therapy aware of the communication board that Resident #19 had, and then therapy should have started their verification processes and screenings. He stated that if therapy was given the proper communication from nursing and had done their screen and assessed that the resident could benefit from therapy services, and that resident does not have a payor source with therapy benefits, the ADM could sign an authorization form to begin services, until other payment arrangements could be made. He stated that if nursing didn't notice a decline in the resident, they may not have said anything to therapy. The ADM stated that it was possible therapy should have already looked at Resident #19. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/12/25 at 9:30 AM with LVN A who stated that she was not sure if Resident #19 admitted with the communication board or if it was given to her by the SLP. LVN A stated that she had not told therapy Resident #19 could benefit from therapy because she thought the communication board was already a part of therapy services. When asked how she knew what care to provide to Resident #19 based on an incomplete care plan, she stated she had to go assess the resident herself to get a better picture of who she was and what she needed. She stated that Resident #19 was cognitively intact, and could communicate, but when she tried to hold conversations, she took a long time to get her words out, and they (staff) would have to tend to other residents, and they should have told Resident #19 they would return after providing care to others and follow through with that promise. Review of the facility's undated Resident Rights policy reflected, Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. A dignified existence; b. Be treated with respect, kindness, and dignity

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 9 Residents (Resident #53) reviewed for quality of care. The facility failed to provide needed care or services by failing to communicate to staff Resident #53's need for supervision while taking medications as stated in his Psych NP note dated 04/22/25, remain in room and ask to open mouth to check to see he swallowed his medication. This resulted in Resident #53 being able to pocket 21 pills that he planned to use to commit suicide and caused him to be sent to a psychiatric hospital on [DATE]. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 06/12/25 at 07:09 PM and an IJ template was given. While the IJ was removed on 06/15/25 the facility remained out of compliance at a severity of no actual harm with a potential for more than minimal harm, that was not immediate jeopardy at a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice could place residents at risk for hospitalization and death. The findings included: Review of Resident #53's Face Sheet dated 06/12/25 reflected a [AGE] year old male admitted to the facility on [DATE] with diagnoses that included Schizophrenia (mental health condition that affects how people think, feel, behave and can result in hallucinations, delusions, disorganized thinking and behavior), cognitive communication deficit (condition that affects how individuals think, remember, and communicate), other specified depressive episodes (condition that can include persistent sadness or low mood, fatigue or loss of energy, irritability, and thoughts of death or suicide), unspecified dementia (group of symptoms affecting memory, thinking, and social abilities), and anxiety disorder (characterized by fear or worry that is both intense and excessive). The Face Sheet reflected Resident #53 was discharged on 06/09/25 to a psychiatric hospital. Review of Resident #53's Annual MDS assessment dated [DATE] reflected a BIMS score of 15 indicating his cognition intact. Section D Mood reflected a resident mood interview that revealed over the last two weeks have you been bothered by any of the following problems? and reflected little interest or pleasure in doing things was marked yes for symptom presence and 2-6 days (several days) for frequency. Feeling down, depressed, or hopeless was also marked as a symptom present and 2-6 days (several days) for frequency. Section I of the MDS assessment reflected Resident #53 was marked for having a diagnosis of Anxiety Disorder, Depression, and Schizophrenia. Section N of the MDS assessment reflected Resident #53 was taking an antipsychotic, antianxiety, and antidepressant. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of resident #53's care plan last revised 06/11/25 reflected a focus on risk for complications, injury, infection, and ineffective protection related to resisting care and refusal of medications with interventions that included refer to psychology/psychiatry as needed. A focus for I am receiving antidepressant medication with interventions that included, monitor/document/report adverse reactions to antidepressant therapy: suicidal thoughts. A focus was seen for , I am currently receiving anti-anxiety medication related to anxiety disorder with interventions that included, monitor/document/report any adverse reactions to anti-anxiety therapy: depression, impaired thinking and judgement, impulsive behavior and a focus for I am currently receiving psychotropic medications related to Schizophrenia with interventions that included administer psychotropic medications as ordered by physician, monitor/document/report adverse reactions to psychotropic medications: depression, suicidal ideations, social isolation and behavior symptoms not usual to the person. Review of Resident #53's Psych NP progress note dated 04/22/25 reflected, resident seen today for psychiatric visit for Schizophrenia, anxiety, dementia with behavioral disturbance .review report received from staff. Reports patient is pocketing his medication and not taking it, plan in place now, staff remain in room and ask patient to open his mouth to check and see he swallowed his medications. Review of Resident #53's physician's orders reflected an order dated 05/22/25 Make sure resident takes his medications before leaving the room. Every shift monitoring of taking medication **Make sure resident swallows his medications before leaving his room. Review of Resident #53's progress note revealed a progress note dated 06/09/25 entered by the SW that reflected, SW was sitting with resident when he stated he wasn't feeling well. SW asked resident to elaborate- he stated can I be honest with you? SW stated of course. Resident began telling this writer that he wanted to kill himself. He stated he has hoarded his medications in his locked bedside table and planned to take all at once and overdose. SW proceeded to inform ADM and DON about the situation. ADM and DON stated resident needed to be sent out and be on a 1:1 until he was sent out. SW gave resident two options to be sent to emergency room or psychiatric hospital. Resident agreed to go to psychiatric hospital to stabilize. SW called psychiatric hospital inpatient and received authorization for resident to admit to an inpatient stay. SW then collected all medications from bedroom and handed them over to DON. SW stayed 1:1 with resident, listening to music, coloring, until psychiatric hospital was ready to admit him. At 03:15 PM resident boarded onto facility van voluntarily with staff to transport to psychiatric hospital. IDT aware, PASRR aware. SW was with resident from 01:50 PM to 03:15 PM. Review of an email to the surveyor dated 06/12/25 at 01:30 PM from the DON identifying Resident #53's hoarded medications confiscated on 06/09/25, email reflected: After reviewing the picture and auditing his medications, I was able to determine that the cup of meds appeared to have: (8) Depakote (anticonvulsant), (2) gabapentin (anticonvulsant), (2) zenpep (pancreatic/digestive enzyme), (1) ½ tab [NAME] (opiate antagonist), (2) metoprolol (beta blocker), (4) fluoxetine (antidepressant), (1)Loratadine (antihistamine), (1)memantine (NMDA, N-methyl-D-aspartate receptor antagonist, used to treat symptoms of Alzheimer's disease). Review of the facility reported incidents for the month of June 2025 revealed there was no self-report to the state agency for the event concerning Resident #53 on 06/09/25. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility staff in-services for the month of June 2025 revealed there was no in-services for medication administration related to remaining with residents to ensure medication was swallowed. In an interview and observation on 06/12/25 at 02:56 PM with the DON, she stated Resident #53 was feeling different and there were reports of behavior/mood changes during a care conference that occurred on 05/21/25. She stated to her knowledge that was why the order was placed in the system on 05/22/25 to make sure staff were watching Resident #53 take his medications . She stated that to her knowledge they did not know Resident #53 was having behavior changes or required supervision with med administration prior to the 05/21/25 care conference. The DON was observed reviewing Resident #53's chart and stated the last uploaded Psych NP visit in the system was for the month of March 2025. In an interview and observation on 06/12/25 at 03:47 PM the MR/FD entered the DON's office and in an interview with both staff MR/FD stated the Psych NP notes from visits were provided one of two ways, by being left at the nurse's station or sent via fax. The MR/FD stated that if the notes arrived via fax machine, they came to the attention of the ADON, and she was to review the notes and update the resident's chart as needed. The MR/FD stated that the ADON would just know that if there was a Psych NP visit, notes should be on the fax by the next day. The MR/FD stated there was only one fax machine that was used by everyone and there was the potential for communication issues if pages slipped out, or the machine could skip a page and notes would go missing. At this time the MR/FD provided the surveyor with copies of the Psych NP notes for Resident #53's visits dated 04/22/25 and 05/19/25 that she stated were not yet scanned into Resident #53's medical record . The visit for 04/22/25 reflected, Reports patient is pocketing his medication and not taking it, plan in place now, staff remain in room and ask patient to open his mouth to check and see he swallowed his medications. At this time the DON stated she was not aware of the Psych NP visit notes for 04/22/25 or 05/19/25 and was not sure how they were missed because it was before she took the position of DON. The DON stated that if notes came in via fax, they were not able to verify who saw the notes since it's a fax used by the whole facility. The DON stated there's the potential for missed communication because pages of notes or orders could go missing or end up somewhere else without being reviewed by nursing. In an interview on 06/12/25 at 04:24 PM with the Psych NP, he stated that he first became aware of Resident #53 pocketing medication during his visit on 04/22/25 and was notified by the ADON. He stated he was told on that day that there was already a system in place to ensure staff were supervising Resident #53 and ensuring he swallowed his medication before leaving the room due to reports of pocketing medications. He stated he did not review the resident's EMR that day to confirm that the orders were in place and took the ADON at her word. The Psych NP stated that it was his expectation that there was an order in place and staff were implementing supervision of Resident #53's medication administration since 04/22/25 and he stated that he also followed up on it with ADON on 05/19/25 and was told it was still in place . The Psych NP stated that based on the 21 medications Resident #53 had hoarded there was concern for a negative outcome. He stated, Anyone on its own would not have been a concern but all together would have had the potential for a negative outcome. In an interview on 06/12/25 at 05:19 PM with the ADON, she stated she put the order in for supervision of Resident #53's medication administration as soon as she was made aware of the resident pocketing his medications. She stated she could not say why the order was not implemented in April 2025 and said, It was always known to monitor him. She stated the Psych NP notes were either faxed into the facility or left at the nurse's station. She stated the facility's way of communication was through orders so that everyone is on board and knows what to do. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	06/13/25 In an interview and record review 06/13/25 at 05:25 the ADM provided an email confirmation for review from the company IT team letting them know an eFax setup was completed. In an interview with the ADM he stated the eFax that was set up would allow all incoming faxes to be sent in an electronic format to the ADM, DON, and ADON so that they could ensure all provider notes and orders would be reviewed. The ADM and MR/FD stated that verbal confirmation was received from the Psych NP on 06/13/25 that all notes and orders would now be sent to the eFax that was set up. 06/15/25 Resident #53 remains in the Psychiatric hospital. The facility's Medical director was notified on 6/12/25 at 07:30 PM by the DON via phone of Immediate Jeopardy. Uploaded text verification reviewed by the surveyor. Record review revealed emotional distress assessments were completed on all 60 Residents on 6/13/25 documented within the progress notes of the electronic medical record. The progress note reflected: Note Text: Upon assessment this shift, resident states that she is not having any type of emotional distress. Denies any fear and that she feels safe. Surveyor verified this through record review of 5 resident chart audits. Record review of Resident #53's Care Plan was done and revealed it was updated which reflected: Medication Administration Date Initiated: 06/12/2025 Nursing - Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away to CNA possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment, or safety awareness. The DON began medication administration competency check offs on all licensed staff and medication aides. This will be completed before the employees scheduled shift. It will include the 5 rights of medication administration and will also include staying with the resident until medications are ingested. Surveyor verification was completed for 12 of 21 nurses and medication assistants. 100% Facility sweep for loose medications was completed on 06/12/2025 verified by the DON and ADM this was verified by surveyor through interview and written statement. An eFax system was set up by the facility on June 13, 2025, to ensure all faxes with pertinent information such as physician order and visit notes are sent and reviewed by the department heads. Verified with ADM email conformation on June 13,2025. IT team contract. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Training was given to the nursing staff by the ADM and DON 06/13/25-06/15/25. The staff verbalized that they had received instruction to ensure that all medications were taken. Do Not allow residents to self-administer medication. Do not leave medication at the resident's bedside. If a resident was seen not taking medication, pocketing medications, spitting out medications it must be reported to the charge nurse and DON immediately. Staff were instructed if they find medications in a cup or otherwise that have not been administered, they are to notify the charge nurse immediately. All residents were to be supervised while taking their medications and leaving medications at the bedside is never allowed. The nurses and MAs were to verify medication had been swallowed by oral assessment. Staff also verbalized they had been trained on abuse and neglect. They were able to give examples of abuse such as hitting a resident, neglecting to change resident clothes, and allowing residents to fall by not using proper equipment. Staff were able to identify the ADM as the abuse coordinator and stated all abuse is reported immediately to the abuse coordinator. Interviews reflected below. The DON's training was given by the VP of Clinical Services on 6/12/2025. The Training included policy and procedures for oral medication administrations and abuse investigating and reporting in-service record review completed for verification of the document. Interviews were completed with 3 LVNs, 1 RN, 9 CNAs, 2 MA, 1 housekeeper, 1 dietary staff and included 6-night shift and 9-day shift nursing staff. The interviews revealed the following: Interview on 6/15/25 5:45 AM with LVN BB night shift charge nurse revealed she did have an observation competency evaluation on medication pass, ensuring the right dose and resident's medication. She stated she was specifically told to ensure residents were swallowing their medications, ensure no medications were left in room, do not leave any medication cups in the room, do not allow residents to self-administer medications. She stated she had been trained on abuse and neglect to report to the ADM immediately. She gave an example of abuse as staff yelling at a resident or treating them badly. She stated she would protect the resident and report to the ADM immediately. Interview on 6/15/25 05:55 AM CNA CC stated she had been CNA here for 3 years-night shift. The aide stated she had been trained on abuse and neglect. She stated take all allegations seriously report immediately to the abuse coordinator. She stated the abuse coordinator was the ADM. She stated she had been instructed on to make sure if any medications were found in residents' rooms to report to the nurse. She stated medications were not supposed to be in residents' rooms. Interview on 6/15/25 06:15 AM with CNA DD-night shift, she said she was in-serviced regularly on abuse and neglect. She stated an example of abuse is yelling at a resident and she has never witnessed abuse in this facility. She stated if she suspected abuse, she would call and report it to the ADM who is the Abuse Coordinator. She stated medications were not supposed to be in residents' rooms. She stated if medications were found in the room she is supposed to report it to the charge nurse immediately. Interview on 6/15/25 06:24 AM with CNA EE-nightshift, she stated she had been trained on abuse and neglect, and if she were to see abuse protect the resident and report to the ADM. She stated if she were to see medications sitting around on bed side table in residents' she was instructed to remove medications and report to nurse immediately. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 6/15/25 06:30 AM with CNA FF -night shift, she stated if she were to see loose pills in a residents' room, she would remove the medications and take them to the charge nurse. She stated she had been trained on abuse, example yelling at a resident. She stated the ADM was the abuse coordinator. Day shift Interview on 6/15/25 06:42 AM with RN GG -day shift, he stated he had been instructed to make sure residents take all medication prior to leaving the room. He stated he was instructed to not allow residents to self-administer medications. He stated he had been observed performing a medication pass by the DON. He stated he had been trained on abuse and neglect by the ADM. He stated the ADM is the abuse coordinator. He stated an example of abuse was neglecting to change a resident. He stated if he were to see abuse, he would protect the resident and report it immediately. Interview on 6/15/25 06:55 AM with LVN HH -agency nurse, she stated she had been observed performing a medication pass by the DON. She stated she had been in-serviced on medication administration including review of resident rights, staying with residents to make sure they are not pocketing medications. She stated she was instructed do not leave room until all medications are taken. She stated she was instructed to perform and oral check to ensure residents swallowed their medications. She stated she had been in-serviced on abuse and neglect. She stated abuse and neglect should be reported immediately to ADM and DON. Interview on 6/15/25 07:05 AM with MA II - day shift, she stated she had been trained to ensure residents swallowed medications, and to talk to the resident and make sure their mouth is clear, she had been checked off on medication pass, and did complete a medication pass with the DON she stated she reviewed resident rights, medications storage, types of medications routes. She stated she had been trained on abuse, and said an example was yelling at a resident. She gave an example of abuse such as hitting a resident. She stated the ADM was the abuse coordinator. Interview on 6/15/25 07:15 AM MA JJ -day shift, she stated she had been trained to ensure residents swallowing medications, that she is to speak to residents and make sure their mouth is clear. She said she has been checked off on medication pass, did complete a medication pass with the DON she reviewed resident rights, medications storage, types of medications routes. She stated she had been trained on abuse, example yelling at a resident. She gave an example of abuse such as slapping a resident. She stated the ADM is the abuse coordinator. Interview on 6/15/25 07:25 CNA KK -day shift, she stated if she were to see loose pills in a resident's room, she would remove the medications and take them to the charge nurse. She stated she had been trained on abuse; an example was yelling at a resident. She gave an example of abuse such as leaving a resident in dirty clothing. She stated the ADM is the abuse coordinator. Interview on 6/15/25 07:35 AM CNA LL-day shift, she stated if she were to see loose pills in a resident's room, she would remove the medications and take them to the charge nurse. She stated medications were not to be in residents' rooms. She stated she had been trained on abuse, and an example would be yelling at a resident. She stated the ADM was the abuse coordinator. She stated an example of abuse would be pushing a resident. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 6/15/25 07:45 AM with CNA MM -day shift, she stated if she were to see loose pills in a resident's room, she would remove the medications and take them to the charge nurse. She stated medications were not to be in residents' rooms. She stated she had been trained on abuse and provided the example yelling at a resident. She stated the ADM was the abuse coordinator. She stated an example of abuse would be yelling at a resident. Interview on 6/15/25 07:55 AM with CNA NN - day shift - She stated if she were to see loose pills in a residents' room, she would remove the medications and take them to the charge nurse if there were any loose in the resident room. She stated medications were not to be in residents' rooms unattended. She stated she had been trained on abuse, example yelling at a resident. She stated the ADM is the abuse coordinator. She stated an example of abuse would be pushing a resident. Interview on 6/15/25 08:05AM with MA OO - She stated if she were to see loose pills in a residents' room, she would remove the medications and report them to the charge nurse immediately. She stated medications were not to be left behind in residents' rooms. She stated she had been trained on abuse. She stated the ADM is the abuse coordinator. She stated an example of abuse would be hitting a resident. Interview on 6/15/25 08:15 AM interview with HK PP, he stated if he were to see loose pills in a residents' room, he would remove the medications and report them to the charge nurse. He stated medications were not to be left in residents' rooms. He stated he had been trained on abuse, example yelling at a resident. He stated the ADM is the abuse coordinator. He stated an example of abuse would be not using appropriate transferring equipment for a resident causing a fall. Interview on 6/15/25 08:25 AM interview with DA QQ, she stated examples of abuse were threating a resident, not meeting their needs, pulling on a resident. She stated she would report abuse to the ADM, he is the abuse Coordinator. She stated if she were to see any pills on a tray or lying around, she would report to the charge nurse immediately. She stated residents were not allowed to have medications in their rooms. The failures detailed above resulted in an identification of an Immediate Jeopardy (IJ) on 06/12/2025 at 07:09 PM and an IJ template was given. While the IJ was removed on 06/15/25 the facility remained out of compliance at a severity of no actual harm with a potential for more than minimal harm, that was not immediate jeopardy at a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services which included procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of resident for 2 of 3 residents (Resident #60 and Resident #168), and 1 of 2 medication rooms (Medication room [ROOM NUMBER]) reviewed for pharmacy services. 1. The MA failed to check Resident #168's blood pressure prior to the administration of his Metoprolol (a medication used to lower blood pressure) on 06/11/2025 at 9:45am during medication pass observation. 2. The facility failed to ensure Resident #60's physician's ordered medication Hydralazine was available for administration. 3. The facility failed to ensure 1 of 2 medication rooms observed (Medication room [ROOM NUMBER]) was free from expired drugs. This failure could place residents at risk of low blood pressure, dizziness, risk of falling and hospitalizations. Findings include: 1.) Review of Resident #168's face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses Dementia (memory loss), epilepsy (seizures), polyneuropathy (nerve pain) and age-related osteoporosis (a thinning of the bone making it brittle). Review of Resident #168's consolidated physician's orders dated 06/11/2025 reflected an order for Metoprolol Tartrate 25mg 1 tablet by mouth in the morning hold medication is systolic blood pressure (top number) is less than 110 or diastolic blood pressure (bottom number) is less than 60 or heart rate less than 55 beats per minute. 2.) Review of Resident #168's June 2025 medication administration record reflected entries for Metoprolol Tartrate 25mg 1 tablet by mouth in the morning with instructions to hold medication is systolic blood pressure is less than 110 or diastolic blood pressure is less than 60 or heart rate less than 55 beats per minute. There were no documented blood pressure checks prior to the administration of medication from June 1, 2025, thru June 11, 2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 06/11/2025 at 9:45 AM, revealed the MA prepared 10 medications for Resident #168's medication for administration. The medications for administration included his physician's ordered Metoprolol Tartrate 25mg. The MA went into the room to administer medications when the surveyor stopped her to question if the blood pressure should have been checked. The MA stated there were no areas to document a blood pressure within the medication administration record, so she assumed she did not have to take a blood pressure prior to administration of medications. She stated the risk to the residents for not checking a blood pressure prior to administering medications that could affect the blood pressure could have been the resident's blood pressure could become very low causing dizziness or causing the resident to pass out. The MA then checked the resident's blood pressure and it was 139/81 with a pulse of 61. Resident #168 stated he was feeling fine, and the MA administered medications as ordered. 3.) Review of Resident #60's face sheet reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses diverticulitis of the intestines (inflammation of the intestine), unspecified mood disorder, anxiety, and high blood pressure. Review of Resident #60's admission MDS dated [DATE] reflected she was assessed to have a BIMS score of 15 indicating she was cognitively intact. Review of Resident #60's comprehensive care plan reflected a problem dated 04/01/2025 and revised on 06/02/2025 The resident had a mood problem related to bipolar disorder and psychosis disorder. Interventions included Administer medications as ordered. Monitor/document for side effects and effectiveness. Review of Resident #60's consolidated physician's orders dated 06/11/2025 reflected an order for hydralazine HCl 25mg by mouth two times daily for elevated anxiety. Review of Resident #60's June 2025 MAR reflected entries for hydralazine 25mg tablets twice daily. Review of the documentation on the MAR for the 06/11/2025 reflected a 9 was documented indicating from the facility's chart code other/ see nurses notes. Review of Resident # 60's nurses' notes reflected medication not available. Observation on 06/11/2025 at 10:00 AM, revealed the MA prepared 12 medications for Resident #60's medication for administration. The medications for administration did not include her physician's ordered hydralazine. In an interview on 06/11/2025 at 10:15 AM, the MA stated she was not sure why Resident #60 had not had her hydralazine available. She stated the medication was ordered yesterday (06/10/25). She stated the medication aides generally reordered medications when there was a 4-to-5-day supply available. She stated she notified the charge nurse the medication was unavailable. She stated the resident could have had discomfort from not receiving her medication for her anxiety. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Retirement and Healthcare Community	1900 W State Hwy 6 Waco, TX 76712

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/11/25 at 01:58 PM LVN A stated the MA had not notified her that Resident #60 was out of her hydralazine. She stated she would expect the MA to report to the charge nurse if a medication was not available. She stated she could have checked the emergency kit and pulled the medication from it if it were in there. She stated she was not sure if that specific medication was in the emergency medication kit. She stated if it were not in the kit she would have reported to DON and called the pharmacy to get it delivered stat. She stated Resident #60 could have had increased anxiety, itching, elevated blood pressure from not receiving her medications. In an interview on 06/11/25 at 1:58 PM LVN A stated the MA had reported to her that Resident #168 needed an order in the computer for documentation of parameters for blood pressure. She stated she did call the doctor and he had the nurse to check all blood pressure medication orders for parameters. She stated if a resident were to receive a medication that could lower the blood pressure without the blood pressure being checked prior to administration it could cause harm to the resident such as dizziness, have falls, and altered mental status. In an interview on 06/11/25 at 1:01 PM the DON stated it was her expectation is that if there was a discrepancy in medication directions the MA should have notified the nurse, and the order should have been corrected. There were several employees who were responsible for checking those orders and ensuring the orders were correct on admission. The blood pressure parameters were on the original order but was not entered in the computer by the admitting nurse. She stated the DON would be taking responsibility for checking orders for all new admissions from now on. She stated negative effects for administering blood pressure medications without proper monitoring of the blood pressure could have included a low heart rate, and ineffective medication. In an observation on 06/11/25 at 02:11 PM of station 2 stock medication storage room [ROOM NUMBER] there were two (2) bottles of melatonin (a sleep aide) 1mg 60 tablets that expired in March 2025 and 3 bottles of folic acid (an essential b vitamin) 800mcg 60 tabs that expired in January 2025. Located in the refrigerator were acetaminophen (a pain reliever) 650mg 5 suppositories that expired January 04, 2025. In an interview on 06/11/25 at 02:15 PM LVN A stated she really was not sure when the medications were checked for expiration dates in the medication supply room. She stated the nurses monitored for incoming insulin syringes dates and labels, only when they were received. She stated the medication aides were trained to keep the supply room clean and stocked. She stated negative effects for the residents for receiving expired and outdated medications could have been subtherapeutic effects of the medication or adverse reactions. In an interview on 06/12/25 at 01:01 PM the DON stated her expectation was the MAs notify the nurses immediately if a medication was not available. She stated the nurse could have called the doctor and had him call it into our local pharmacy for pick up to ensure the medication was available for Resident #60. She stated negative effects for not having medications available could have been low blood pressure, to high of a blood pressure, change in condition and anxiety. The DON stated medication aides and nurses should have checked med rooms daily for expired medications. She stated there was no designated person responsible for checking the medications in the stock medication room for expiration dates. She stated negative effects for administering expired drugs could have included or potentially caused ineffective medications, or illness. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility undated policy titled Pharmacy Services reflected: The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist. Policy Interpretation and Implementation: Pharmaceutical services consists of: Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration. Medications acquired or dispensed in this facility are FDA approved for use by the residents and meet the requirements established by the Federal Food, Drug and Cosmetic Act. Medications are received, labeled, stored, administered, and disposed of according to all applicable state and federal laws and consistent with standards of practice. Record review of facility undated policy titled Administering Oral Medications reflected: Verify that there is a physician's medication order for this procedure. Perform any pre-administration assessments.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 6.45%, based on 2 errors out of 31 opportunities, which involved 2 of 2 residents (Residents #60 and Resident #168) observed during medication administration for medication errors. The facility failed to ensure Resident #60's physician's ordered medication Hydralazine was available for administration on 06/11/2025 at 10:00 am during medication pass. The MA failed to check Resident #168's blood pressure prior to the administration of his Metoprolol (a medication used to lower blood pressure) on 06/11/2025 at 9:45am during medication pass observation. This failure could place residents at risk of low blood pressure, dizziness, risk of falling and hospitalizations. The findings included: 1.) Review of Resident #60's face sheet reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses diverticulitis of the intestines (inflammation of the intestine), unspecified mood disorder, anxiety, and high blood pressure. Review of Resident #60's admission MDS dated [DATE] reflected she was assessed to have a BIMS score of 15 indicating she was cognitively intact. Review of Resident #60's comprehensive care plan reflected a problem dated 04/01/2025 and revised on 06/02/2025 The resident had a mood problem related to bipolar disorder and psychosis disorder. Interventions included Administer medications as ordered. Monitor/document for side effects and effectiveness. Review of Resident #60's consolidated physician orders dated 06/11/2025 reflected an order for hydralazine HCl 25mg by mouth two times daily for elevated anxiety. Review of Resident #60's June 2025 MAR reflected entries for hydralazine 25mg tablets twice daily. Review of the documentation on the MAR for the 06/11/2025 reflected a 9 was documented indicating from the facility's chart code other/ see nurses notes. Review of nurses' notes reflected medication not available. Observation on 06/11/2025 at 10:00 AM, revealed the MA prepared 12 medications for Resident #60's medication for administration. The medications for administration did not include her physician ordered hydralazine. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/11/2025 at 10:15 AM, the MA stated she was not sure why resident #60 did not have her hydralazine available. She stated the medication was ordered yesterday. She stated the medication aides generally reorder medications when there was a 4-to-5-day supply available. She stated she notified the charge nurse the medication was unavailable. She stated the resident could have had discomfort from not receiving her medication for her anxiety. In an interview on 06/11/25 at 01:58 PM LVN A stated the MA had not notified her that Resident #60 was out of her hydralazine. She stated she would have expected the MA to report to the charge nurse if a medication was not available. She stated she could have checked the emergency kit and pulled the medication from it if it were in there. She stated she was not sure if that specific medication was in the emergency medication kit. She stated if it were not in the kit she would have reported to the DON and called the pharmacy to get it delivered stat. She stated Resident #60 could have had increased anxiety, itching, elevated blood pressure from not receiving her medications. 2.) Review of Resident #168's face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses Dementia (memory loss), epilepsy (seizures), polyneuropathy (nerve pain) and age-related osteoporosis (a thinning of the bone making it brittle). Review of Resident #168's consolidated physician orders dated 06/11/2025 reflected an order for Metoprolol Tartrate 25mg 1 tablet by mouth in the morning hold medication is systolic blood pressure is less than 110 or diastolic blood pressure is less than 60 or heart rate less than 55 beats per minute. Review of Resident #168's June 2025 medication administration record reflected entries for Metoprolol Tartrate 25mg 1 tablet by mouth in the morning with instructions to hold medication is systolic blood pressure is less than 110 or diastolic blood pressure is less than 60 or heart rate less than 55 beats per minute. There were no documented blood pressure checks prior to the administration of medication from June 1, 2025, thru June 11, 2025. In an Observation and interview on 06/11/2025 at 9:45 AM, revealed the MA prepared 10 medications for Resident #168's medication for administration. The medications for administration included her physician ordered Metoprolol Tartrate 25mg. The MA went into room to administer medications when this surveyor stopped her to question if blood pressure should have been checked. The MA stated there were no areas to document a blood pressure within the medication administration record, so she assumed she did not have to take a blood pressure prior to administration of medications. She stated the risk to the residents for not checking a blood pressure prior to administering medications that could affect the blood pressure could have been the residents blood pressure could become very low causing dizziness or causing the resident to pass out. The MA then checked residents blood pressure and it was 139/81 with a pulse of 61. Resident #168 stated he was feeling fine, and the MA administered medications as ordered. In an interview on 06/11/25 at 1:58 PM LVN A stated the MA had reported to her that Resident #168 needed an order in the computer for documentation of parameters for blood pressure. She stated she had called the doctor and he had the nurse to check all blood pressure medication orders for parameters. She stated if a resident were to receive a medication that could lower the blood pressure without the blood pressure being checked prior to administration it could have causeed harm to the resident such as dizziness, have falls, and altered mental status. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/12/25 at 01:01 PM, the DON stated her expectation was that the MA's notify the nurses immediately if a medication was not available. She stated the nurse could have called the doctor and had him call it into our local pharmacy for pick up to ensure the medication was available for Resident #60. She stated negative effects for not having medications available could have been low blood pressure, too high of a blood pressure, change in condition, or anxiety. The DON stated it was her expectation is that if there was a discrepancy in medication directions the MA should notify the nurse and the order should be corrected. There were several employees responsible for checking those orders and ensuring the orders are correct on admission. The blood pressure parameters were on the original order but was not entered in the computer by the admitting nurse. She stated DON would be taking responsibility for checking orders for all new admissions from now on. She stated negative effects for administering blood pressure medications without proper monitoring of the blood pressure could have included a low heart rate, and ineffective medication. Record review of facility undated policy titled Pharmacy Services reflected: The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist. Policy Interpretation and Implementation: Pharmaceutical services consists of: Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration. Record review of facility undated policy titled Administering Oral Medications reflected: Verify that there is a physician's medication order for this procedure. Perform any pre-administration assessments.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability of services of a lesser intensity, for one of six residents (Resident #19) reviewed for specialized rehabilitative services, in that: The facility failed on 6/11/2025 to ensure Resident #19 received a PT/OT/ST evaluation and treat as indicated upon admission as ordered in her admission clinical records dated 4/30/2025. This failure could place residents at risk of decline or decrease in their physical capabilities and emotional distress. Findings included: Review of Resident #19's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included stroke (when blood supply to part of the brain is suddenly reduced, leading to brain cell death and/or permanent damage), high blood pressure, diabetes mellitus (chronic disease where the body does not produce enough insulin), non-Alzheimer's dementia, hemiplegia (paralysis) affecting right nondominant side. In Section V- Care Area Assessment (CAA) Summary, it was indicated that a care area and care planning decision was triggered for communication and ADL Functional/Rehabilitation Potential, and a CAA WS was completed on 6/1/2025. Her BIMS score was a 15, indicating she was cognitively intact. Review of Resident #19's comprehensive care plan dated 05/13/2025 reflected the care plan had not been completed and only indicated that she had a behavior problem of refusing care and bathing, and that she took anxiety medication. Review of Resident #19's CAA WS dated 6/1/2025 reflected the following: '-Triggering conditions-Impaired ability to make self-understood through verbal and non-verbal expression of ideas/wants as indicated by: ability to express ideas and wants, consider both verbal and non-verbal expression, resident was indicated as sometimes understood. -Characteristics of the communication impairment (from clinical record): expressive communication, difficulty putting sentences together, problem describing objects and events. -Care Plan Considerations, if care planning for this problem, what is the overall objective? Maintain current level of functioning, minimize risks.' Review of Resident #19's physician's orders, dated 04/30/2025, reflected the following standing (a written protocol that allows the healthcare team to perform specific clinical tasks without needing a physician's order) orders: PT, OT, ST may eval and treat as indicated. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PT, OT, ST to eval & treat as indicated. Rehab potential Review of Resident #19's therapy screening form dated 6/12/25 reflected under occupational therapy the following: Would benefit from OT services however is requesting ST/PT services @ this time per patient. Under physical therapy: Would benefit from PT services to address contracture in R LE t o relieve pain, staff report no decline in function upon admission to present. Under speech therapy: Per patient no swallowing or choking, no pain with swallowing. Would benefit from ST services to address deficits with expressive aphasia. Could benefit from a higher tech augmentative alternative communication device. Has communication board. Requires extended time to process information and time to respond. In an observation and interview on 06/10/25 at 3:02 PM with Resident #19 located in her room revealed a communication board on her bedside table. When asked if the communication board helped the resident communicate her needs/wants with facility staff she said sometimes. It was observed that the resident had a difficult time getting the words out that she was trying to say, she took long pauses, looked around, used finger motions such as to draw numbers, and ultimately used a pen and paper to write to communicate some things to the state surveyor. At one point she began to cry and exclaimed that she wished staff would stay longer to hear what she was trying to tell them, because they will leave while she was trying to find the right words. The resident stated that made her feel sad and angry when staff would walk out instead of taking the time to listen to her. She stated that no one had offered her rehab services, but she would like help with her speech and with the healing of her right leg after a fall that happened before she moved into the facility. In an interview on 06/11/25 at 3:42 PM with the SLP who stated that she had not conducted any therapy screenings, evaluations, or assessments on Resident #19. She had only conducted the BIMS and depression questionnaire. She stated that she had not done a screening because the facility's process was to only screen a resident if therapy was notified by nursing that a resident had a decline or showed a need for therapy. She stated she had not been informed by any of the nursing staff that Resident #19 had a communication board and she stated she would verify if the resident admitted with the board. If a decline was to be reported by nursing staff the therapy department would do a screening to determine if a more in-depth evaluation was needed, then they would run a verification of benefits to see if the resident's payor source had benefits to cover therapy services, if there were no benefits the facility could ask for a facility authorization which is where the facility ultimately covers the cost of therapy services. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/11/25 at 5:07 PM with the DOR who stated she would check to see if Resident #19 admitted with the communication board. She stated that the process for screening a resident for therapy would be to screen all short-term (skilled) residents for therapy needs, but for LTC residents they typically do not evaluate unless they get a referral from nursing that there has been a decline. The residents quarterly MDS's would trigger an initial therapy evaluation if a decline had been documented. The DOR would then run a verification of benefits to see if a resident had benefits for therapy, but if they came back with no benefits available, the facility would request a facility authorization, which is where the facility could essentially pay for the services until the resident gets another payor source or the therapy is no longer needed. In a telephone interview on 06/12/25 at 10:23 AM with Resident #19's FM who stated that Resident #19 had been paralyzed on her right side for about 13 years after having a stroke. The FM stated that Resident #19's mind works well, but her speech was difficult to understand especially when she got tired or agitated. The FM stated that Resident #19 had a fall back in February 2025, prior to that fall the resident was able to get around with the use of a walker, the broken leg made it to where she could not walk at all because the leg could no longer bear weight. The FM stated that the resident chose to let her leg heal naturally with assistance of a brace and that she wears it consistently, and she still attended doctor's visits about her leg. The FM stated that during the healing process, the resident was well confined to a wheelchair or her bed but was adjusting well. The FM stated they thought the resident could benefit from speech therapy, and that the socialization aspect would be great for the resident. The FM stated that approximately 3-4 years ago the resident took ST independently. The FM also stated that Resident #19's Medicaid was in limbo, because prior to admitting to the facility she was using community Medicaid, and they were switching her to NF Medicaid. In a follow-up interview on 06/12/25 at 10:47 AM with the SLP who stated that Resident #19 admitted with the communication board and that nursing should have told her the resident admitted with a communication board so the SLP would have been able to conduct a screening. She would have liked to screen her earlier in her stay to determine if she was appropriate for a further in-depth speech evaluation, and then ask the DOR if the resident qualified for therapy based on her payor source. She stated she has in the past educated nursing staff on how to use a communication board with previous residents who had them. She stated that she went to the resident and conducted an initial therapy screening on 6/12/25 and that from her screening the SLP determined the resident could benefit from a higher tech, augmentative alternative communication device. The resident could receive training on how to use the device and communicate her needs more efficiently and reduce her frustration. She stated that she could try to get a company out to the facility to teach the resident how to use the device. A negative impact could be further decline in function, limiting independence and daily tasks, not being able to express her pain, higher risk for hospital readmission, falls and injury, emotional distress, and social isolation. She stated it was also determined from the screening that Resident #19 could benefit from PT to address a contracture in her right leg to relieve pain. Furthermore, the SLP stated that Resident #19 could benefit from OT services but Resident #19 declined wanting to participate in OT. In an interview on 06/12/25 at 10:57 AM with the BOM who stated that Resident #19 admitted with no payor source and that she (BOM) submitted the NF Medicaid application on 6/4/2025 because she stated the residents must reside in the facility for 30 days prior to applying for Medicaid. During those 30 days, if the resident admits without a payor source, the facility treats them as if they are already approved for Medicaid, meaning that all therapies could get started if the resident has a medical need for it. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/12/25 at 11:03 AM with the ADM who stated that nursing staff should have made therapy aware of the communication board that Resident #19 had, and then therapy should have started their verification processes and screenings. He stated that if therapy was given the proper communication from nursing and had done their screen and assessed that the resident could benefit from therapy services, and that resident does not have a payor source with therapy benefits, the ADM could sign an authorization form to begin services, until other payment arrangements could be made. He stated that if nursing didn't notice a decline in the resident, they may not have said anything to therapy. The ADM stated that it was possible therapy should have already looked at Resident #19. In an interview on 06/12/25 at 9:30 AM with LVN A who stated that she was not sure if Resident #19 admitted with the communication board or if it was given to her by the SLP. She stated that she (LVN A) had not told therapy Resident #19 could benefit from therapy because she thought the communication board was already a part of therapy services. When asked how she knew what care to provide to Resident #19 based on an incomplete care plan, she stated she had to go assess the resident herself to get a better picture of who she was and what she needed. She stated that Resident #19 was cognitively intact, and could communicate, but when she tried to hold conversations, she took a long time to get her words out, and they (staff) would have to tend to other residents, and they should have told Resident #19 they would return after providing care to others and follow through with that promise. Review of the facility's undated Therapy Insurance Verification Process policy reflected, Therapy screens all admits and readmits. Review of the facility's undated rehab Screening Policy reflected, New admits and any patient/resident identified by the interdisciplinary team, as requiring a rehabilitation screen will have the screening initiated by Physical, Occupational Therapist or assistant or a Speech Language Pathologist within 48 hours of notification of the request or admit. A patient/resident is referred for rehabilitation screen in response to any of the following: The comprehensive facility nursing assessment, completed upon admission, quarterly and PRN. i. If any triggers are noted in the following areas and if decline has been noted from the previous assessment 4. Modes of expression 5. Making self-understood 7. Communication devices

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 1 of 5 residents reviewed for wound care (Resident #119). LVN B failed to wash or sanitize her hands while going from a dirty to clean surface while performing wound care on 06/11/25 at 9:46 AM for Resident #119. This deficient practice placed residents at risk for cross contamination and the spread of infection. Findings included: Record review of Resident #119's face sheet dated 06/12/25 reflected Resident #119 was an [AGE] year-old female with an admission date of 05/20/25. Resident #119's diagnoses included encephalopathy (a group of conditions that cause brain dysfunction. Brain dysfunction can appear as confusion, memory loss, personality changes and/or coma in the most severe form), congestive heart failure (a serious condition that occurs when the heart can't pump enough blood to meet the body's needs), hypothyroidism (a disorder of the endocrine system in which the thyroid gland does not produce enough thyroid hormones), and muscle weakness (commonly due to lack of exercise, ageing, muscle injury or pregnancy). Record review of the admission MDS assessment dated [DATE] reflected Resident #119's MDS was not completed. Record review of Resident #119's assessment titled Brief Interview For Mental Status (BIMS) Evaluation reflected the resident had a BIMS score of 15 indicating Resident #119 was cognitively intact. Record review of Resident #119's care plan dated 05/29/25 and revised 05/31/25 reflected Focus: At risk of infection due to picking at her wounds with her nails. She has a burn area on her upper medial (midline) abdomen that she picks at frequently. Goal: Resident will not have any complications related to wound healing during the review period. Interventions included: Assess area frequently for signs or symptoms of worsening skin integrity. Record review of Resident #119's clinical physician's orders dated 06/12/25 reflected an order for Wound Care : Right [NAME] (upper side or back)l foot - cleanse area with wound cleanser, pat dry, apply medi-honey to wound, cover with bordered gauze then wrap with kerlix (gauze wrap) every day shift. In an observation on 06/11/25 at 09:46 AM, reveled LVN B performed wound care for Resident #119. LVN B gathered her supplies, entered the resident's room, and informed the resident what she was going to do. LVN B removed Resident #119's soiled dressing and cleansed Resident #119's wound to the top of right foot. LVN B removed her gloves and applied new gloves without washing or sanitizing her hands. LVN B applied a clean dressing to the resident's wound. LVN B disposed of the trash and made sure Resident #119 was comfortable and left the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455670	A. Building B. Wing	06/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Retirement and Healthcare Community	1900 W State Hwy 6 Waco, TX 76712

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/11/25 at 09:55 AM, LVN B stated she had been in-serviced on wound care, handwashing, and infection control. She stated she typically would have washed her hands during wound care when changing her gloves if she had to leave the room to get something, but not when she stayed in the room the entire time. She stated she washed her hands when going from a dirty to clean surface and she had been in-serviced on that. She stated if hands were not washed when going from a dirty to clean surface, it could have caused and increased risk of infection. In an interview on 06/12/25 at 10:28 AM, the DON stated all staff had been trained on infection control and handwashing and the nurses had all been trained on wound care. She stated staff should have always washed or sanitized her hands when going from a dirty to clean surface, even when they changed their gloves when going from a dirty to clean surface. She stated if staff had not washed or sanitized their hands when going from a dirty to clean surface it could potentially have caused an infection. In an interview on 06/12/25 at 01:37 PM, the ADM stated all staff had been trained on infection control and handwashing and he was not sure about all of the nurses, but he knew the DON and WCN had been trained on wound care. He stated it was his expectation that all staff washed or sanitized their hands when they went from a dirty to a clean surface. He stated if staff had not washed or sanitized their hands when going from a dirty to clean surface, it could have possibly caused and infection control issue. Record review of the undated Handwashing/Hand Hygiene policy, reflected the following: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 1. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection. 5. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: b. Before and after direct contact with residents; d. Before performing any non-surgical invasive procedures; g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin: j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc.; l. After removing gloves; Applying and Removing Gloves: 1. Perform hand hygiene before applying non-sterile gloves. 2. When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff. 3. When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out. 4. Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene. Record review of the undated Infection Prevention and Control Program policy reflected the following: Policy Statement: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Policy Interpretation and Implementation: 11. Prevention of Infection: a. Important facets of infection prevention include: (3) educating staff and ensuring that they adhere to proper techniques and procedures .

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to follow their own established smoking policy for 1 (Residents #63) of 2 residents reviewed for smoking. The facility failed on 6/11/2025 to ensure that Residents #63 did not keep their personal cigarette lighters in their room per facility policy. This failure could place residents at risk of an unsafe smoking environment and injury. Findings included: Review of the facility's undated Smoking Residents list provided by the facility, identified Resident #63 as a smoker. Review of Resident #63's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included cancer, high blood pressure, kidney failure, malnutrition, depression (sadness), white matter disease (damage to the white matter of the brain), and vitamin D deficiency. Resident #63's BIMS score was a 15, indicating she was cognitively intact. Review of Resident #63's care plan was attempted on 06/10/25 but there was no comprehensive care plan started for Resident #63. Review of Resident #63's safe smoking assessment dated [DATE] revealed she was safe to smoke without supervision. In an interview and observation on 06/12/25 at 8:57 AM of Resident #63 located in her room revealed that she last smoked 1 cigarette on 06/11/25. She stated that she was able to light her own cigarettes, but that staff go outside with her during the designated smoke breaks. When asked where she keeps her cigarettes and lighter she pointed to her nightstand beside her bed and stated she kept them in there. The resident opened her bedside drawer, and the state surveyor observed the residents' lighter and 1 pack of cigarettes. The resident stated that she would not smoke inside because her roommate has oxygen and that the facility had gone over the smoking rules with her before, and they told her that smoking was not allowed inside the building. In an interview on 06/12/25 at 9:30 AM with LVN A who stated that residents' smoking material stay behind the nurse's station, and she was able to produce the cigarettes and lighter from another resident who was identified as a smoker but was only able to produce a pack of Resident #63's cigarettes, and she stated she was unsure where the lighter was. She stated that residents were not allowed to keep their lighters in their rooms, but that all smoking materials were supposed to be turned into the nurse's station. She stated that they do not log the turning in of smoking materials after smoke breaks, and that the CNA's are usually the responsible staff members who assist residents with their smoke breaks. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/12/25 at 9:28 AM with the DON who stated that residents' smoking materials (lighters and cigarettes) are kept at the nurse's stations. She stated that residents should not keep cigarettes and lighters in their rooms. A negative outcome of residents keeping their smoking materials could have been residents smoking when they were not supposed to and could have caused a fire. Review of the facility's policy Smoking Policy-Residents dated July 2017 revealed, This facility shall establish and maintain safe resident smoking practices. Prior to, and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. Cigarettes, e-cigarettes, pipes, tobacco, and other smoking articles.