STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455684	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longview Hill Nursing and Rehabilitation Center	3201 N Fourth St Longview, TX 75605

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on observations, interviews, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 2 of 2 residents (Resident #66 and Resident #17) reviewed for resident rights. 1. The facility did not ensure CNA Q and CNA R explained the procedure before initiating the transfer and incontinent care provided on 12/21/2024 to Resident #66. 2. The facility failed to provide scheduled smoke breaks for Resident #17 who resided on the memory care, secured unit. The failure could place residents at risk for diminished quality of life, loss of dignity and self-worth. The findings included: 1. Record review of Resident #66's face sheet, dated 01/15/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #66 had diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning), protein-calorie malnutrition (the state of inadequate intake of food), muscle wasting, lack of coordination and cognitive communication deficit. Record review of Resident #66's Quarterly MDS assessment, dated 12/04/2024, reflected Resident #66 sometimes was able to be understood and sometimes was able to understand others . Resident #66 had a BIMS score of 01, which indicated her cognition was severely impaired. Resident #66 had no delusions or hallucinations. Resident #66 had no physical, verbal, or other behavioral symptoms directed toward others. The MDS assessment reflected Resident #66 had functional limitations on both sides of upper and lower extremities and was dependent for assistance with transfers, toileting, shower, upper and lower body dressing, and personal hygiene. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #66's comprehensive care plan, revised on 04/14/2024, reflected Resident #66 had activities of daily living self-care performance deficit and was at risk for not having her needs met in a timely manner. The care plan goal included resident to maintain current level of function through the review date. The interventions included the following: Total assistance by 1 for incontinent care, bathing, grooming, dressing ; resident required extensive by1 staff to turn and reposition for bed mobility ; and total dependent on 2 staff for mechanical lift transfers . During an observation on 01/14/2025 at 02:23 PM of a video, date stamped 12/21/2024 at 10:02 PM, CNA Q and CNA R were observed transferring Resident #66 to her bed using a mechanical lift. Resident #66 could be heard muttering. Resident #66's speech was shaky and incomprehensible. CNA Q put Resident #66 down on the bed from the Hoyer, and they took the sling off the lift. Neither CNA Q nor CNA R explained to Resident #66 what they were doing as they transferred her into her bed. Resident #66's left side assist rail was lowered. Resident #66 was placed close to the edge of the bed on the left side. Both CNAs walked away from the bed for approximately 15 seconds and failed to raise Resident #66's left side assist rail. During this time, Resident #66 swayed her body to the left and then back onto the bed. Neither CNA Q nor CNA R explained to the resident that they were walking away or what they were doing. CNA Q returns with a brief, looks in Resident #66's drawer, then started balling up Resident #66's gown around her arms. CNA Q did not explain to Resident #66 what she was doing. Resident #66's muttering grew louder and the shakiness in her voice increased. CNA R returned and CNA Q proceeded to continue to wrap Resident #66's gown around her arms and was observed holding Resident #66's arms with one hand. With the other hand CNA Q removed Resident #66's dirty brief by pulling it forcefully from both sides. CNA Q did not unfasten the brief prior to pulling it to remove it. CNA R held Resident #66's right arm to pull her to her right side. Resident #66's left arm came out from the gown, and she held onto the assist rail on her right side . During an interview on 01/15/2025 at 2:09 PM, ADON P said she had been employed at the facility since 07/02/24. She said she covered the 300 (secured unit) and 400 halls. After ADON P viewed the video date stamped 12/21/2024 at 10:02 PM, with audio and visual of CNA Q and CNA R providing Hoyer lift transfer and incontinent care to Resident #66, she said the CNAs should have explained what they were doing while providing care for Resident #66. ADON P said by explaining the care being provided to Resident #66, she could have felt more secure and less agitated during the process. ADON P said that it was important to talk to the residents to maintain respect and dignity. During an interview on 01/15/2025 at 03:15 PM, the DON stated she expected staff to explain and interact with residents while providing care. The DON stated it was monitored by random observations during daily angel rounds. After the DON viewed the video date stamped 12/21/2024 at 10:02 PM, with audio and visual of CNA Q and CNA R providing Hoyer lift transfer and incontinent care to Resident #66, the DON stated it was important to ensure staff explained and interacted with residents while providing care to maintain respect of the resident and prevent an invasion of privacy. During an interview on 01/15/2025 at 4:45 PM, the Administrator said she expected staff to ensure they explained what they were doing while providing care. After the DON viewed the video date stamped 12/21/2024 at 10:02 PM, with audio and visual of CNA Q and CNA R providing Hoyer lift transfer and incontinent care to Resident #66, she stated that at least one of the aides should have conversed and explained what was happening to Resident #66 to be respectful of her rights and dignity. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/15/2025 at 06:35 PM, CNA R stated she had worked at the facility for approximately 2 years. CNA R stated she was in-serviced recently on resident dignity. CNA R stated she would let the resident know what care she was going to provide prior to doing the care. CNA R stated it was important to let the resident know so they would not be scared. After CNA R viewed the video date stamped 12/21/2024 at 10:02 PM, with audio and visual of CNA Q and CNA R providing Hoyer lift transfer and incontinent care to Resident #66, she became tearful and stated she should have told Resident #66 what was happening. CNA R said, I bet Resident #66 was scared and that could have made her feel degraded . During an interview on 01/15/2025 at 06:55 PM, CNA Q stated she had worked at the facility for a while. CNA Q stated she was in-serviced on dignity recently. CNA Q stated upon entering a resident's room she would introduce herself and let the resident know what care she was going to provide prior to doing the care. CNA Q stated it was important because the resident had the right to know and participate in the care that was being provided. After CNA Q viewed the video date stamped 12/21/2024 at 10:02 PM, with audio and visual of CNA Q and CNA R providing Hoyer lift transfer and incontinent care to Resident #66, CNA Q said there was nothing wrong with the care she had provided and that was exactly how it must be completed on the resident. CNA Q stated, I had to be fast because Resident #66 is resistant . When CNA Q was asked why it was important to interact and let the resident know what care was being provided, she responded, What is day shift doing? Why am I being targeted?. 44933 2. Record review of Resident #17's face sheet dated 01/13/25 indicated Resident #17 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #17 had diagnoses including dementia (is the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), anxiety (are mental health conditions that cause excessive and uncontrollable fear or worry), major depressive disorder (is a mood disorder that causes a persistent feeling of sadness and loss of interest), and cognitive communication deficit (is a difficulty with communication caused by an impairment in cognitive processes). Record review of Resident #17's annual MDS assessment dated [DATE] indicated Resident #17 was a current tobacco user. Record review of Resident #17's quarterly MDS assessment dated [DATE] indicated Resident #17 was understood and understood others. Resident #17 had a BIMS of 09 which indicated moderate cognitive impairment. Record review of Resident #17's care plan revised on 09/01/23 indicated Resident #17 was a supervised smoker. Intervention included instruct resident about the facility policy on smoking locations, times, and safety concerns. Record review of Resident #17's care plan revised on 11/30/24 indicated impaired cognitive function/dementia or impaired thought process related to dementia. Intervention included cue, reorient, and supervise as needed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/13/25 at 11:15 a.m., Resident #17 said she was a smoker. She said she did not know the smoke schedule. She said her family member took her out to smoke sometimes, too. She said she smoked one to two times a day. She said she would like to do it more often. During an observation on 01/14/25 at 9:00 a.m., there were no residents smoking in the secured unit designated smoking area. A smoking schedule posted near the nursing station reflected times of 9am, 1pm, 4:30pm, and 7pm. During an interview on 01/14/25 at 12:36 p.m., the ADM said the residents on the secured unit had a different schedule than the other residents. She said the residents on the secured unit had to ask staff to smoke. She said the facility did not encourage smoking. She said the facility did not ask the residents on the secured unit if they wanted to smoke at the scheduled smoke times. She said none of the residents on the secured unit were frequent smokers. She said she felt like Resident #17 could tell staff when she wanted to smoke. During an observation on 01/14/25 at 1:05 p.m., there were no residents smoking in the secured unit designated smoking area. During an interview on 01/14/25 at 2:15 p.m., LVN K said Resident #17 was a smoker. She said Resident #17's family member normally visited and took Resident #17 to smoke. She said Resident #17 normally missed the 9am smoke break because she slept in. She said sometimes when they offered to take Resident #17 to smoke, she refused. She said when CNA L worked, she took the residents out to smoke because she also smoked. She said staff did not ask the residents if they wanted to smoke at every smoke break time. She said it was the resident's right to smoke. During an interview on 01/15/25 at 11:10 a.m., the family member of Resident #17 said before Resident #17 was admitted to the facility, Resident #17 was a daily smoker. She said Resident #17 smoked one and half packs a day. She said Resident #17 started smoking when she was [AGE] years old. She said smoking calmed Resident #17 down. She said she wanted the facility to take Resident #17 at the scheduled smoke break times. She said when she visited Resident #17, Resident #17 smoked three cigarettes at a time. She said when she visited Resident #17, it seemed like Resident #17 needed a cigarette. She said when Resident #17 was placed on the secured unit, after she tried to leave the facility, Resident #17 was worried about not getting to smoke while on the unit. She said when CNA L worked, CNA L took Resident #17 out to smoke after lunch. She said Resident #17 never mentioned when CNA L did not work, who took her to smoke. She said Resident #17 had complained to her that she did not get to smoke enough. She said Resident #17 had memory problems so she needed to be asked if she wanted to smoke. During an interview on 01/15/25 at 1:30 p.m., CNA L said she had worked at the facility for 7 years. She said she worked the 3 days on, 2 days off schedule. She said Resident #17 was a smoker. She said she normally took the residents to smoke after lunch at 1pm and before dinner at 4:30 pm. She said she did not know which staff was responsible for taking the residents to smoke at 7:30 pm. She said all the CNAs knew they were supposed to take the residents to smoke at the scheduled times. She said it was important to take the residents who smoked to smoke at the scheduled times. She said it was the resident's right to smoke. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/15/25 at 1:58 p.m., LVN N said she had been at the facility for almost 4 years. She said she worked 3 days on, 2 days off schedule. She said she mostly worked the secured unit. She said the CNAs, LVNs, and AD were responsible for taking the residents who smoked out to smoke. She said the CNAs primarily did it though. She said the secured unit smoke schedule was 9am, 1pm, 4:30pm, and 7pm. She said some residents asked to smoke and others would smoke if they saw another resident doing it. She said she felt like the CNAs asked the residents who smoked at the scheduled smoke break times. She said the residents did not know the schedule because of their dementia. She said Resident #17 had memory issues. She said she would have days she would get upset because her family had not visited but her family had visited. She said Resident #17 probably smoked two to three times a day. She said when Resident #17's family member visited and took her out to smoke, Resident #17 chain smoked. She said when Resident #17 smoked, she sometimes seemed calmer and less anxious. She said sometimes staff skipped taking the residents out to smoke. She said she preferred staff who smoked, to take the residents who smoked out. She said it was the resident's right to smoke. She said the residents who smoked could get upset if they were not taken to smoke at the scheduled break times. During an interview on 01/15/25 at 3:33 p.m., ADON P said the AD was responsible for taking the residents who smoked to smoke. She said she expected the residents to be taken to smoke at the scheduled smoke break times. She said she did not know if the residents were supposed to be taken to smoke only when they asked. She said she did not know if staff were supposed to ask them at every smoke break time if they wanted to smoke. She said taking the residents who smoked to smoke was important because it could be used as an intervention to help with behaviors. She said the residents on the memory care unit probably would not always initiate the smoke breaks. She said the resident's cognition fluctuated and they may not remember the scheduled times. She said Resident #17's cognition fluctuated and she would sometimes probably not remember to ask to smoke. She said it was the resident's right to smoke. She said the residents who smoked could experience withdrawal symptoms, headaches, and increased behaviors when they were not taken to smoke. During an interview on 01/15/25 at 4:27 p.m., the DON said she had been employed at the facility since April 2024. She said all staff on the secured unit, including the AD, were responsible for taking the residents to smoke at the scheduled times. She said the secured unit had a set smoke break schedule. She said the facility did not announce to the residents who smoked, on the secured unit, when it was the smoke break time. She said the facility only took the residents who smoked to smoke, if the residents expressed, they wanted to go smoke. She said sometimes smoking calmed the residents down. She said taking a resident to smoke was a good intervention to calm residents. She said she expected the staff to tell the residents who smoked it was the scheduled smoke break time. She said it was the resident's right to smoke at the scheduled smoke break times. She said smoking for residents was their socialization and behavior intervention. She said the residents could become upset when they were not taken to smoke at the scheduled time. During an interview on 01/15/25 at 6:00 p.m., the ADM said the AD and evening nurse were responsible for taking the residents out to smoke. She said the residents who smoked only needed to be taken, at the scheduled times when they showed signs, they need to smoke. She said she did expect the staff to tell the residents who smoked it was smoke break time. She said the facility did not encourage smoking. She said she felt like the facility met the smoking needs of the residents on the secured unit. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/15/25 at 6:21 p.m., the AD said she worked Monday-Friday, 8am-5pm. She said she took the residents who smoked out to smoke. She said if there was a CNA who smoked working, then they took the residents out to smoke. She said she took the residents to smoke when they asked to be taken at the smoke break times. She said Resident #17 asked for a cigarette most of time. She said if you asked Resident #17 if she wanted to smoke, she would go all day. She said she did not feel like smoking or not smoking affected the residents' behaviors. She said she had not noticed an increase in behaviors when the residents who smoked had not smoked for a long period of time. She said Resident #17 normally smoked in the afternoon. She said Resident #17 on average smoked two to three times a day. She said it was the resident's right to smoke. Record review of a facility's Promoting/Maintaining Resident Dignity policy dated 01/13/2023 indicated, It is the practice of this facility to protect and promote resident rights and treat each resident with respect .explain care or procedures to the resident before initiating the activity . Record review of a facility's Resident Smoking policy dated 10/24/22 indicated .it is the policy of this facility to provide a safe and healthy environment for residents .any resident who is deemed safe to smoke will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan .the interdisciplinary team, with guidance from the physician, will help to support the resident's right to make an informed decision regarding smoking by .including the resident, family, and/or resident representative in discussion regarding the risks associated with smoking .offering pharmacological and/or behavioral interventions to assist with smoking cessation .providing educational materials regarding smoking and smoking cessation .developing a safe smoking plan, or an individualized plan to quit smoking .

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on observation, interviews, and record review the facility failed to ensure residents have the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives and to choose the option he or she prefers for 3 of 17 residents reviewed for the right to be informed. (Resident #68, Resident #79, and Resident #108) 1. The facility failed to ensure Resident #68's Consent for Antipsychotic (used to treat certain mental/mood disorders) or Neuroleptic (also known as Antipsychotic) Medication Treatment HHSC Form 3713 was correctly completed for Abilify (antipsychotic medication used to treat certain mental/mood disorders) as evidenced by there was no clinical indications for use, no dosage or frequency, and no side effects, risks, or benefits listed for the proposed treatment. 2. The facility failed to ensure Resident #68's Consent for Antipsychotic or Neuroleptic Medication Treatment HHSC Form 3713 was correctly completed for Risperdal (antipsychotic medication used to treat certain mental/mood disorders) as evidenced by there was no clinical indications for use, no dosage or frequency, and no side effects, risks, or benefits listed for the proposed treatment. 3. The facility failed to ensure Resident #79's Consent for Antipsychotic or Neuroleptic Medication Treatment HHSC Form 3713 was correctly completed for Quetiapine (antipsychotic medication used to treat certain mental/mood disorders) as evidenced by there was no clinical indications for use, no diagnosis for use, and no side effects, risks, or benefits listed for the proposed treatment. 4. The facility failed to ensure Resident #108's Consent for Antipsychotic or Neuroleptic Medication Treatment HHSC Form 3713 was correctly completed for Quetiapine as evidenced by there was no clinical indications for use, no diagnosis for use, no dosage or frequency, and no side effects, risks, or benefits listed for the proposed treatment. These failures could place residents at risk for treatment or services provided without their informed consent. The findings included: 1. Record review of Resident #68's face sheet dated 1/13/25 revealed she was [AGE] years old and admitted to the facility initially on 6/04/24 and readmitted on [DATE]. Resident #68 had diagnoses including schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly) and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations). Record review of Resident #68's quarterly MDS assessment dated [DATE] indicated she had a BIMS of 10, which indicated she had moderate cognitive impairment. The MDS indicated Resident #68 was taking an antipsychotic medication. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #68's Order Summary Report dated 1/13/25 reflected an order for Abilify oral tablet 15 MG give 15 MG by mouth one time a day related to Schizophrenia with a start date of 1/04/25; an order for Risperdal oral tablet 3 MG give 1 tablet orally one time a day related to Schizoaffective Disorder-Bipolar Type (mental health condition including schizophrenia and mood disorder symptoms), give with 4 MG tab to equal 7 MG; and an order for Risperdal oral tablet 4 MG give one tablet orally one time a day related to Schizoaffective Disorder, Bipolar Type, give with 3 MG tab to equal 7 MG daily. Record review of Resident #68's Medication Administration Record dated 6/01/24-6/30/24 indicated she received Abilify oral tablet 10 MG give one tablet orally one time a day related to Schizoaffective Disorder, Bipolar Type with a start date of 6/05/24; Risperdal oral tablet 3 MG give one tablet orally one time a day related to Schizoaffective Disorder, Bipolar Type give with 4 MG tab to equal 7 MG daily with a start date of 6/05/24; Risperdal oral tablet 4 MG give one tablet orally one time a day related to Schizoaffective Disorder, Bipolar Type give with 3 MG tab to equal 7 MG daily with a start date of 6/05/24. Record review of Resident #68's Medication Administration Record dated 1/01/25-1/31/25 indicated she received Abilify oral tablet 15 MG give one tablet by mouth one time a day related to Schizophrenia with a start date of 1/05/25; Risperdal oral tablet 3 MG give one tablet orally one time a day related to Schizoaffective Disorder, Bipolar Type give with 4 MG tab to equal 7 MG daily with a start date of 6/05/24; Risperdal oral tablet 4 MG give one tablet orally one time a day related to Schizoaffective Disorder, Bipolar Type give with 3 MG tab to equal 7 MG daily with a start date of 6/05/24. Record review of Resident #68's undated Consent for Antipsychotic or Neuroleptic Medication Treatment HHSC Form 3713 reflected there was no clinical indications for use, no dosage or frequency for Abilify, and no side effects, risks, or benefits listed for the proposed treatment. Resident #68's RP signed the consent on 6/04/24. Record review of Resident #68's undated Consent for Antipsychotic or Neuroleptic Medication Treatment HHSC Form 3713 reflected there was no clinical indications for use, no dosage or frequency for Risperdal, and no side effects, risks, or benefits listed for the proposed treatment. Resident #68's RP signed the consent on 6/04/24. During an interview on 1/15/25 at 10:25 AM, Resident #68's RP said she thought the facility did go over the side effects and benefits of the Abilify and Risperdal medications. Resident #68's RP said she was very familiar with the medications because Resident #68 had been on the medications for a long time. 2. Record review of Resident #79's face sheet dated 1/14/25 revealed she was [AGE] years old and admitted to the facility on [DATE]. Resident #79 had diagnoses including depressive episodes and anxiety disorder. Record review of Resident #79's admission MDS assessment dated [DATE] indicated she had a BIMS of 13, which indicated she was cognitively intact. The MDS indicated Resident #79 had active diagnoses of Anxiety Disorder and Depression. The MDS did not indicate Resident #79 was taking an antipsychotic medication in Section N0415 High-Risk Drug Classes. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #79's Order Summary Report dated 1/14/25 reflected an order for Quetiapine Fumarate oral tablet 25 MG give one tablet by mouth one time a day related to Other Specified Depressive Episodes with a start date of 12/12/24. Record review of Resident #79's Medication Administration Record dated 12/01/24-12/31/24 indicated she received Quetiapine Fumarate oral tablet 25 MG give one tablet by mouth one time a day related to Other Specified Depressive Episodes with a start date of 12/12/24 at 2100 (9:00 PM) and received daily. Record review of Resident #79's undated Consent for Antipsychotic or Neuroleptic Medication Treatment HHSC Form 3713 reflected there was no clinical indications for use of Quetiapine, no diagnosis for use, and no side effects, risks, or benefits listed for the proposed treatment. The physician signed the consent form, but he did not date his signature. Resident #79 signed the consent on 12/12/24. During an observation and interview on 1/15/25 at 11:14 AM, Resident #79 was reclined in her recliner and said she did not know why she was taking Seroquel (Quetiapine) or what the side effects or benefits of the medication were. 3. Record review of Resident #108's face sheet dated 1/14/25 revealed he was [AGE] years old and admitted to the facility on [DATE]. Resident #108 had diagnoses including seizures, anoxic brain damage, depressive disorder, persistent mood (affective) disorder, and anxiety disorder. Record review of Resident #108's admission MDS assessment dated [DATE] indicated he was usually understood and usually understood others. The MDS indicated he had a BIMS of 8, which indicated he had moderate cognitive impairment. The MDS indicated Resident #108 had active diagnoses including Seizures, Anxiety Disorder and Depression. The MDS indicated Resident #108 was taking an antipsychotic medication in Section N0415 High-Risk Drug Classes. Record review of Resident #108's Order Summary Report dated 1/14/25 reflected an order for Quetiapine Fumarate oral tablet 100 MG give one tablet by PEG -tube (tube inserted through the abdominal wall into the stomach) at bedtime related to Persistent Mood (Affective) Disorder with a start date of 12/13/24. Record review of Resident #108's Medication Administration Record dated 12/01/24-12/31/24 indicated he received Quetiapine Fumarate oral tablet 100 MG give one tablet by PEG-tube at bedtime related to Persistent Mood (Affective) Disorder with a start date of 12/13/24 and received daily. Record review of Resident #108's Medication Administration Record dated 1/01/25-1/31/25 indicated he received Quetiapine Fumarate oral tablet 100 MG give one tablet by PEG-tube at bedtime related to Persistent Mood (Affective) Disorder with a start date of 12/13/24 and received daily. Record review of Resident #108's undated Consent for Antipsychotic or Neuroleptic Medication Treatment HHSC Form 3713 reflected there was no clinical indications for use, no diagnosis for use, no dosage or frequency for Quetiapine, and no side effects, risks, or benefits listed for the proposed treatment. The physician signed the consent form, but he did not date his signature. Resident #108's RP signed the consent on 12/14/24. (continued on next page)

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Longview Hill Nursing and Rehabilitation Center	3201 N Fourth St Longview, TX 75605

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 10:14 AM, Resident #108's RP said she did not believe anyone went over the indication, benefits, or side effects of Resident #108's antipsychotic medication when he admitted to the facility, but she said she was a RN and could look it up if she was concerned about it. During an interview on 1/15/25 at 1:46 PM, LVN G said she had worked at the facility for about three years and normally worked the day shift. LVN G said she did admissions. LVN G said she did have to get consents signed for medications like antipsychotics. LVN G said they use a check off sheet and the HHSC 3713 form for antipsychotic medications. LVN G said the HHSC 3713 form had to have the medication and dosage and the physician and the resident or RP had to sign it. LVN G said the purpose of the HHSC 3713 form was to inform the resident and/or RP of medication, why they were taking the medication, and of the risks and benefits of the medication. LVN G said she would fill out the HHSC 3713 form to the best of her knowledge. LVN G said the admitting nurse would be the one responsible for ensuring the antipsychotic medication consents were completed correctly. LVN G said the nurse managers also follow-up to ensure consents had been completed. LVN G said if the HHSC 3713 form was not completed correctly, there was a risk that the resident or RP may not have the needed information to make an informed decision. During an interview on 1/15/25 at 3:07 PM, ADON P said the charge nurse who admitted the resident was responsible for getting the consents signed and nurse management followed up to ensure the admits were completed. ADON P said she was familiar with the HHSC 3713 form and their policy was to get the facility's check off consent forms and the HHSC 3713 form signed for antipsychotic medications. ADON P said the providers were actually supposed to complete the HHSC 3713 form, but thought they were delegating HHSC 3713 form to be filled out by the staff. ADON P said the HHSC 3713 form had to have documented dosage of the medication, risks, what it was used for, and be signed by the provider and the resident or RP. ADON P reviewed Resident #108's HHSC 3713 form and said it was incomplete. ADON P said if the HHSC 3713 form was incomplete, then it would not provide the needed information for the residents or their RP to make an informed decision for taking the medication. During an interview on 1/15/25 at 3:32 PM, the DON said the nurses established the consents upon admission or when starting new medications that required a consent. The DON said the ADONs would follow up on the consents to ensure they were completed. The DON said if there was an issue with getting consents signed, then the ADONs would bring it to her to see what needed to happen to get it done. The DON said the purpose of the consents was to ensure the resident or their RP, and the physician were all on the same page, and to inform the resident or RP of the risks and benefits of the medication so everyone was able to make an informed decision. The DON said the HHSC 3713 form was supposed to be filled out by the physician. The DON said when she was giving the surveyor the HHSC 3713 form consents, she noticed the proper verbiage was not on the forms. The DON said if the HHSC 3713 form was not being completed accurately, and not being documented then there was no documentation to prove the education was provided to the patient or RP for them to make an informed decision for treatment. The DON said her staff did verbally educate the resident or their RP, but if it was not captured on the form, then it wasn't done. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 4:20 PM, the ADM said the nursing department was responsible for ensuring the HHSC 3713 form was completed and then they have an admission review done by the nurse managers to ensure they were catching all of the antipsychotic medication consents . The ADM said the purpose of the HHSC 3713 consent form was to ensure the resident or RP were aware of the risks and benefits of the antipsychotic medication and why they were prescribed. The ADM reviewed the HHSC 3713 form and said the HHSC 3713 form for Resident #108 did not say anything about why the resident was taking the medication, risks, side effects, or benefits and the normal resident or lay person (no medical background) would not be able to make an informed decision based on the information on the form. The ADM said she would expect the HHSC 3713 consent form to be completed correctly. Record review of the facility's policy titled, Psychotropic Medication, dated 8/15/22, reflected . Residents were not given psychotropic drugs unless the medication was necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication was beneficial to the resident . Residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use . Record review of the Texas Administrative Code, Title 26, Rule 554.1207 (Texas Administrative Code (state. tx.us)) titled Prescription of Psychoactive Medication revealed . consent to the prescription of psychoactive medication given by a resident, or by a person authorized by law to consent on behalf of the resident, was valid only if . the person who prescribes the medication, that person's designee, or the facility's medical director provides the resident and, if applicable, the person authorized by law to consent of behalf of the resident, with a form containing the following information identified as being for the purpose of consent to treatment with psychoactive medications . the specific condition to be treated . beneficial effects on that condition expected from the medication . probable clinically significant side effects and risks associated with the medication . proposed course of the medication . consent was given in writing by a resident or by a person authorized by law to consent on behalf of the resident, on a form prescribed by HHSC, if the prescription was for antipsychotics or neuroleptics . Record review of Long-Term Care Regulatory Provider Letter, number PL 2022-11, titled Consent for Antipsychotic and Neuroleptic Medications and dated May 5, 2022 reflected . a resident receiving antipsychotic or neuroleptic medications must provide written consent . written consent could also be given by a person authorized by law to consent on the resident's behalf . consent for antipsychotic and neuroleptic medications must be documented on HHSC Form 3713 . the prescriber of the medication, the prescriber's designee, or the nursing facility's medical director must complete Section 1 of Form 3713 . the resident or the resident's legally authorized representative must sign Section 2 of Form 3713 . the person prescribing the medication, the prescriber's designee, or the NF's medical director must provide the resident, and if applicable, the person authorized to consent on behalf of the resident, the following information . condition being treated . beneficial effects on that condition expected from the medication . potential side effects of the medication . associated risks of the medication . proposed course of medication .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable homelike environment for 1 of 4 residents (Resident # 21) reviewed for a homelike environment. The facility failed to ensure Resident #21's floors were free of debris, dust, and shreds of papers. The facility failed to ensure Resident #21's dresser was free from a white creamy substance on the top flat surface, side of dresser and front of the dresser. The facility failed to ensure Resident #21's bathroom cabinet was clean from a dried sticky red liquid . The facility failed to ensure Resident #21's personal refrigerator door was free from white splattered dried substances. These failures could place residents at risk for an uncomfortable, unhomelike environment, and a diminished quality of life. Findings included: Record review of the face sheet dated 01/15/2025 indicated, Resident #21 was an [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included cerebrovascular disease (affects the blood vessels of the brain and circulation) hypertension (high blood pressure), hyperlipidemia (high levels of fat particles in the blood), history of stroke, and dysphagia (difficulty swallowing). Record review of the quarterly MDS dated [DATE] indicated, Resident #21 was understood by others and understood others. The MDS indicated Resident #21 had a BIMS of 11 and was moderately cognitively impaired. The MDS indicated Resident #21 was dependent with toileting, dressing, and bathing and required supervision for eating. Section GG - Functional Abilities B. Oral Hygiene indicated Resident #21 required assistance with her dentures (putting the dentures in mouth prior to eating and cleaning the dentures after meals) Record review of the care plan dated 01/22/2024 and did not indicate Resident #21 wore dentures for eating. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/13/2025 at 2:37 PM, Resident #21 was lying in her bed asleep. Resident #21's floor around and under the dresser, chair and bedside table was covered in a layer of dust and dirt, giving a grimy appearance. There was visible debris such as white paper, and large brown crumbs scattered across the floor's surface. Resident #21's personal refrigerator door was covered in splattered dried flecks of a white substance. The bathroom counter had a sticky pinkish dried liquid spilled in various areas. The dresser had a white creamy substance smeared across the top surface and down the sides and front. Resident #21's closet had several items of clean clothing laying on the bottom of the closet floor. The chair had brownish stains. During an observation on 01/14/2025 at 08:30 AM, Resident #21 was sitting in her bed but unable to interview due to her cognition status. Resident #21's floor around and under the dresser, chair and bedside table was covered in a layer of dust and dirt, giving a grimy appearance. There was visible debris such as white paper, and large brown crumbs scattered across the floor's surface. One dusty sandal was laying under the dresser and the other dusty covered shoe was laying upside down under the chair. Resident #21's personal refrigerator door was covered in splattered dried flecks of a white substance. The bathroom counter had a sticky pinkish dried liquid spilled in various areas. The dresser had a white creamy substance smeared across the top surface and down the sides and front. Resident #21's closet had several items of clothing laying on the bottom of the closet floor. The chair was had brownish stains. During an observation on 01/15/2025 at 08:45 AM, Resident #21 was sitting in her bed but unable to interview due to her cognition status. Resident #21's floor around and under the dresser, chair and bedside table was covered in a layer of dust and dirt, giving a grimy appearance. There was visible debris such as white paper, and large brown crumbs scattered across the floor's surface. One dusty sandal was laying under the dresser and the other dusty covered shoe was laying upside down under the chair. Resident #21's personal refrigerator door was covered in splattered dried flecks of a white substance. The bathroom counter had a sticky pinkish dried liquid spilled in various areas. The dresser had a white creamy substance smeared across the top surface and down the sides and front. Resident #21's closet had several items of clean clothing laying on the bottom of the closet floor. The chair was had brownish stains. During an interview on 01/15/2024 at 09:45 AM, the Housekeeper said she had already cleaned Resident #21's room and had noticed there was some dust behind and under the furniture earlier. The housekeeper said she was not always assigned to Resident #21's room but she cleaned her room assignments once a day and started from the floors, dusting all the surfaces and wiping down the bathrooms. The housekeeper stated she does a walk through later during the day before her shift ends just to pick up the floors and bathrooms. The housekeeper said she had missed the areas on the sides and front of the dresser once pointed out by the surveyor as well as the white splatter specks on the refrigerator door. The housekeeper stated she had attempted to clean the stains off the chair but had not been successful. The housekeeper said she had not reported the brownish chair stains to her supervisor. The Housekeeper said it was important for the Resident's rooms to be clean and fresh because it was their home. The housekeeper said the housekeepers were responsible for keeping the rooms clean. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/15/2024 at 10:05 AM, the Environmental Services Supervisor stated the housekeepers have a 5 step cleaning process that was followed daily which included: empty trash - remove trash, wipe receptacle, replace liner; high dust- wipe flat surfaces with cloth and disinfectant; spot clean walls - wipe with cloth and disinfectant; dust mop - gather debris with mop and pickup with dust pan; damp mop - mop floor with disinfectant from back corner to door. The Environmental Services Supervisor said the importance of a clean room was to decrease the chances of spreading germs causing infections and to create a home space for the residents. The Environmental Services Supervisor said it was the responsibility of the housekeeping department to thoroughly clean the rooms but a group effort from all staff to tidy the rooms throughout the day. During an interview on 01/15/2024 at 11:30 AM., the DON said resident rooms should be repaired , and cleanly maintained to decrease infection. The DON said this was the resident's rooms and they should be nice and homelike. The DON said she expected housekeeping to keep the rooms cleaned as far as dusted, swept and disinfected. During an interview on 01/15/2024 at 4:45 PM., the Administrator said she expected the Resident's rooms to remain clean to prevent the spread of infection and create a home like environment. The Administrator said the resident rooms were monitored daily during angel rounds. The Administrator said they have had some cleaning issues in the past and addressed them by making staff changes. The Administrator said the facility did not have a policy specific to Homelike Environment. The Administrator said it was the responsibility of the housekeeping department to deep clean and daily clean the resident's rooms.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on observation, interview and record review, the facility failed to ensure the right of the residents to be free from abuse for 1 of 4 residents (Resident #66) reviewed for abuse. The facility failed to keep Resident #66 free from abuse when CNA Q and CNA R roughly provided mechanical lift transfer and incontinent care to her on 12/21/2024. This failure could place residents at risk of abuse, creased resistance to care, increased agitation, skin tears, soreness, and injury Findings included: Record review of Resident #66's face sheet, dated 01/15/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #66 had diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning), protein-calorie malnutrition (the state of inadequate intake of food), muscle wasting, lack of coordination and cognitive communication deficit. Record review of Resident #66's Quarterly MDS assessment, dated 12/04/2024, reflected Resident #66 sometimes was understood by others and sometimes was able to understand others . Resident #66 had a BIMS score of 01, which indicated her cognition was severely impaired. Resident #66 had no delusions or hallucinations. Resident #66 had no physical, verbal, or other behavioral symptoms directed toward others. The MDS assessment reflected Resident #66 had functional limitations on both sides of upper and lower extremities and dependent for assistance with transfers, toileting, shower, upper and lower body dressing, and personal hygiene. Record review of Resident #66's comprehensive care plan, revised on 04/14/2024, reflected Resident #66 had activities of daily living self-care performance deficit and was at risk for not having her needs met in a timely manner. The care plan goal included resident to maintain current level of function through the review date. The interventions included the following: Total by assistance by 1 staff member for incontinent care, bathing, grooming, dressing; resident required extensive assistance by 1 staff to turn and reposition for bed mobility; and total dependent on 2 staff for mechanical lift transfers. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/14/2025 at 02:23 PM of a video, date stamped 12/21/2024 at 10:02 PM, CNA Q and CNA R were observed transferring Resident #66 to her bed using a Hoyer lift. Resident #66 could be heard muttering. Resident #66's speech was shaky and incomprehensible. CNA Q put Resident #66 down on the bed from the mechanical lif , and they took the sling off the lift. Neither CNA Q nor CNA R explained to Resident #66 what they were doing as they transferred her into her bed. Resident #66's left side assist rail was lowered. Resident #66 was placed close to the edge of the bed on the left side. Both CNAs walked away from the bed for approximately 15 seconds and failed to raise Resident #66's left side assist rail. During this time, Resident #66 swayed her body to the left and then back onto the bed. Neither CNA Q nor CNA R explained to the resident that they were walking away or what they were doing. CNA Q returns with a brief, looks in Resident #66's drawer, then started balling up Resident #66's gown around her arms. CNA Q did not explain to Resident #66 what she was doing. Resident #66's muttering grew louder and the shakiness in her voice increased. CNA R returned and CNA Q proceeded to continue to wrap Resident #66's gown around her arms and was observed holding Resident #66's arms with one hand. With the other hand CNA Q removed Resident #66's dirty brief by pulling it forcefully from both sides. CNA Q did not unfasten the brief prior to pulling it to remove it. CNA R held Resident #66's right arm to pull her to her right side. Resident #66's left arm came out from the gown, and she held onto the assist rail on her right side. During an interview on 01/15/2025 at 2:09 PM, ADON P said she had been employed at the facility since 07/02/24. She said she covered the 300 (secured unit) and 400 halls. After ADON P viewed the video date stamped 12/21/2024 at 10:02 PM, with audio and visual of CNA Q and CNA R providing Hoyer lift transfer and incontinent care to Resident #66, she said the CNAs should have explained what they were doing while providing care for Resident #66. ADON P said the CNAs should have utilized the draw sheet to move the resident from side to side to prevent the potential shearing and friction rubs or skin tears. ADON P said had the CNAs used the draw sheet, it would have prevented them from tugging and pulling on Resident #66 so roughly. ADON P said the video made her sad to watch for the care Resident #66 received from CNA Q and CNA R. ADON P said all staff are responsible for preventing and reporting abuse to the facility abuse coordinator. ADON P stated a recent in service was held for all staff regarding abuse and neglect. The ADON said leadership from each department monitor daily during angel rounds for staff to resident interactions. During an interview on 01/15/2025 at 03:15 PM, the DON stated that all staff are responsible for preventing and reporting the allegations of abuse to the Administrator which was the facility's abuse coordinator. After viewing the video date stamped 12/21/2024 at 10:02 PM, with audio and visual of CNA Q and CNA R providing Hoyer lift transfer and incontinent care to Resident #66, the DON stated the care provided was done very quickly and too roughly. The DON said the swift and rough movements during the incontinent care and direct skin to skin contact could be reflected as abuse and could result in skin tears. The DON stated the care provided by CNA Q and CNA R was concerning because what kind of care is provided when a camera is not in a resident's room. The DON said the aides should have used a draw sheet to decrease the potential of skin tearing/bruising and make the movements softer and easier for Resident #66. The DON said the rough pushing and pulling on the resident could have also made Resident #66 sore and caused injury. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/15/2025 at 4:45 PM, the Administrator said she expected all staff to protect the residents and prevent abuse and neglect by following the facility's abuse and neglect policy and report to her as the abuse coordinator . The Administrator said she expected the clinical staff to oversee training of the CNAs in providing appropriate care to prevent any type of rough handling of the residents. The Administrator stated the facility monitors for safety and staff to resident interactions daily by leadership roles performing angel rounds . After the DON viewed the video date stamped 12/21/2024 at 10:02 PM, with audio and visual of CNA Q and CNA R providing Hoyer lift transfer and incontinent care to Resident #66, she stated the aides provided the care entirely too swiftly and roughly. The Administrator said she was an aide before and utilizing the draw sheet would have prevented so much roughly handling of Resident #66. The Administrator said she did not feel the actions of CNA Q and CNA R were completed with intent to harm Resident #66 but no one would want care provided to them in that manner. The Administrator said this incident/allegation would immediately be reported to HHSC (Health and Human Services Commission) and the investigation would be launched according to the facility protocol for abuse. During an interview on 01/15/2025 at 06:35 PM, CNA R stated she had worked at the facility for approximately 2 years. CNA R said she had been checked off for competency on mechanical lift transfers and incontinent care. CNA R stated she had been in-serviced on abuse and neglect. CNA R stated any type of rough handling such as tugging/pulling or pushing would be considered abuse and she would immediately report to the abuse coordinator. CNA R said she utilized the draw sheet to reposition residents for care so that the skin was not torn. CNA R viewed the video date stamped 12/21/2024 at 10:02 PM, with audio and visual of CNA Q and CNA R providing Hoyer lift transfer and incontinent care to Resident #66. CNA R was tearful after viewing the video and stated the care provided was rough. CNA R said that tugging and pulling on the resident could cause the resident to be agitated and resistant to care and/or resulted in injury. During an interview on 01/15/2025 at 06:55 PM, CNA Q stated she had worked at the facility for a while. CNA Q stated she had been checked off for competency on mechanical lift transfers and incontinent care probably in October. CNA Q was able to identify the types of abuse. CNA Q stated physical abuse would include hitting or forcibly pushing or touching a resident. CNA Q said any suspicion or abuse allegations should be reported immediately to the Abuse Coordinator/Administrator. CNA Q stated when she provides care to a resident such as incontinent care or repositioning, she utilized the draw sheet to prevent injury to the residents. CNA Q said the residents' skin is mostly fragile, so it is best to not have skin to skin friction to prevent any injuries. After CNA Q viewed the video date stamped 12/21/2024 at 10:02 PM, with audio and visual of CNA Q and CNA R providing Hoyer lift transfer and incontinent care to Resident #66, CNA Q said there was nothing wrong with the care she had provided, and Resident #66 had no injuries. When CNA Q was asked why this resident's care was done differently than she verbally described, CNA Q stated, why are you all targeted at me? Record review of an in-service dated 12/10/24 provided by the ADON P regarding Abuse, Neglect and Exploitation indicated 37 staff members signed the in-service. CNA Q and CNA R were not included on the sign in sheet. Record review of a skills check off entitled Nursing Assistant Clinical Skills Checklist and Competency Evaluation 2024 - Incontinent Care and Mechanical Lifts/Transfers - dated 10/01/2024, indicated CNA R was competent in incontinent care and Mechanical Lifts/Transfers. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a skills check off entitled Nursing Assistant Clinical Skills Checklist and Competency Evaluation 2024 - Incontinent Care - dated 10/02/2024, indicated CNA Q was competent in incontinent care and Mechanical Lifts/Transfers. Record review of the personnel chart of CNA Q indicated completion of Abuse and Neglect training upon hire date of 10/04/2023 and yearly thereafter. There was no disciplinary action related to providing care to residents. Record review of the personnel chart of CNA R indicated completion of Abuse and Neglect training upon hire date of 03/07/2023 and yearly thereafter. There was no disciplinary action documented for CNA R. . Record review of the facility's policy, titled, Abuse, Neglect and Exploitation dated 08/15/2022, indicated, .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455684	A. Building B. Wing	01/15/2025

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on interview and record review, the facility failed to notify the resident and the resident's representative of the transfer or discharge and the reasons for the transfer or discharge in writing at least 30 days before the resident is transferred or discharged or as soon as practicable before transfer or discharge when a resident has not resided in the facility for 30 days for 1 of 1 resident (Resident #169) reviewed for transfer and discharge. The facility failed to provide Resident #169's representative with a written 30-day discharge notice with a reason of discharge. This failure could place residents at risk of improper discharge planning and diminished quality of life. Findings included: Record review of Resident #169's face sheet dated 01/15/2025 indicated she was an [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses of acute respiratory failure with hypoxia (difficulty breathing), congestive heart failure (the heart does not pump efficiently), cognitive communication deficit, diabetes mellitus (too much sugar in the blood), muscle weakness and difficulty walking. Record review of Resident #169's Discharge MDS assessment dated [DATE] indicated Resident #169 was rarely/never understood by others, was usually rarely/never able to understand others, had a BIMS of 0 which indicated Resident #169 was severely cognitively impaired. The MDS also indicated Resident #169 required extensive assistance for dressing and personal hygiene, bed mobility and physical help to transfer with bathing. Record review of Resident #169's electronic medical record did not indicate a discharge summary had been completed or a notice of discharge had been given to the responsible party. Record review of Resident #169's order summary report dated as of 01/15/2025 indicated she had orders as followed: 1. Admit to skilled nursing facility level of care Prescriber Written order date of 12/14/2024. Record review of progress note dated 12/16/2024 indicated Resident #169 was currently under Medicare or Managed Care for skilled services. Record review of the order summary report dated 01/15/2025 did not indicate Resident #169 had an order to discharge from the facility. Record review of Resident #169's nursing progress note dated 12/23/2024 at 2:15 pm indicated she was discharged home. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/14/2025 at 01:30 PM, Resident #169's family member stated on 12/15/2024 she did not receive a 30-day written notice of discharge from the facility when the Business Office Manager and the Social Worker contacted her by telephone and asked, what were the plans for Resident #169. Resident #169's family member stated she left the faciity on [DATE]. Resident #169's family member stated she was told by the Business Office Manager and the Social Worker that she needed to plan for Resident #169 to be discharged home because of no payor source. During an interview on 01/15/2025 at 11:10 AM, the Admission Coordinator stated there had been an issue with the payor source after Resident #169 was admitted to the facility. He stated, initially Resident #169 was admitted from the hospital for skilled nursing and therapy evaluation. Resident #169 was on Hospice services, but those services were revoked when Resident #169 admitted to the hospital. The Admission Coordinator stated somehow the 3-midnight hospital stay requirement was not met by Resident #169 which resulted in no payor source for the facility. The Admission Coordinator stated Resident #169's family member had managed to work with a local agency and the facility and received 10 days of respite care instead which resulted in just a couple of days that would not be paid for. The Admission Coordinator said the facility had arranged for a home health agency to provide services for Resident #169 at the end of paid respite days. The Admission Coordinator was not aware of a discharge notice for Resident #169. The Admission Coordinator said Resident #169 was accepted for admission by the corporate office. The Admission Coordinator said the corporate billing office verifies the payment sources for all new admissions. An attempted telephone interview on 01/15/2025 at 11:30 AM to Business Office Manager (out on medical leave) - left message and requested call back. During an interview on 01/15/2025 at 01:15 PM, the Social Worker said she could not recall much information regarding Resident #169. The Social Worker said she was responsible for discharge planning and assisting the Business Office Manager with the 30-day discharge notices. The Social Worker stated Resident #169 would not have required a discharge notice because she was admitted under 10 days of respite care and didn't require a 30-day discharge notice. During an interview on 01/15/2025 at 1:30 PM, the MDS Coordinator stated that Resident #169 somehow ended up at the facility without a payor source. The MDS Coordinator stated a resident without a payor source did not require a 30-day notice to discharge. An attempted telephone interview on 01/15/2025 at 02:15 PM to Business Office Manager (out on medical leave) - left message and requested call back call to the Business Office Manager During an interview on 01/15/2025, at 04:45 PM, the Administrator said the Business Office Manager and Social Worker were responsible for 30-day discharge notices. The Administrator said Resident #169 was not admitted for skilled nursing. The Administrator said Resident #169 was admitted for respite care. The Administrator said that Resident #169's family members were unable to pay, and it turned out they found a payor source and Resident #169 received a great deal with respite picking up the cost. The Administrator said she did not have all the small details for the incident, but her Business Office Manager knew all the information and unfortunately, she was out on medical leave. The Administrator said the facility's policy does state all admissions should receive a 30-day written notice prior to discharging. Record review of facility's Transfer and Discharge Policy dated 10/13/2022 indicated, (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances .4. a The specific reason .5. Generally, the notice must be provided at least 30 days prior .

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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** 46062 Based on observation, interview, and record review the facility failed to ensure assessments accurately reflected the resident status for 1 of 34 residents (Resident #79) reviewed for MDS assessment accuracy. The facility failed to accurately reflect Resident #79 was receiving Quetiapine Fumarate (Seroquel), an antipsychotic medication (used to treat certain mental/mood disorders). These failures could place residents at risk for not receiving care and services to meet their needs. Findings included: Record review of Resident #79's face sheet dated 1/14/25 revealed she was [AGE] years old and admitted to the facility on [DATE]. Resident #79 had diagnoses including depressive episodes, anxiety disorder, multiple rib fractures (broken bones), repeated falls, lack of coordination, shortness of breath, heart failure, and high blood pressure. Record review of Resident #79's admission MDS assessment dated [DATE] indicated she had a BIMS of 13, which indicated she was cognitively intact. The MDS indicated Resident #79 had active diagnoses of Anxiety Disorder and Depression. The MDS did not indicate Resident #79 was taking an antipsychotic medication in Section N0415 High-Risk Drug Classes. Record review of Resident #79's Order Summary Report dated 1/14/25 indicated: an order for Behavior Monitoring-antipsychotic Quetiapine with a start date of 12/12/24; an order for Side Effect Monitoring-antipsychotic Quetiapine with a start date of 12/12/24; and an order for Quetiapine Fumarate oral tablet 25 mg give one tablet by mouth one time a day related to Other Specified Depressive Episodes with a start date of 12/12/24. Record review of Resident #79's Medication Administration Record dated 12/01/24-12/31/24 indicated she received Quetiapine Fumarate oral tablet 25 mg give one tablet by mouth one time a day related to Other Specified Depressive Episodes with a start date of 12/12/24 at 2100 (9:00 PM) and received daily. During an observation and interview on 1/15/25 at 11:14 AM, Resident #79 was reclined in her recliner and said she did not know why she was taking Seroquel (Quetiapine). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 beginning at 11:19 AM with MDS A and MDS O, they both said they had worked at the facility for thirteen years. MDS A and MDS O said an antipsychotic medication should be marked on the MDS assessment in section N. MDS O said she completed the admission MDS assessment for Resident #79. MDS O reviewed Resident #79's chart and said Resident #79 was taking an antipsychotic medication and it should have been marked on the MDS assessment. MDS O said it was an oversight on her part. MDS O said not coding the MDS accurately had no effect on the resident. MDS O said it did affect the accuracy of assessments and payment. MDS O said she was responsible for ensuring the MDS assessments she did were accurate and MDS A signed off on the assessment that it is complete as the RN. MDS A said the Regional MDS Nurse performed quarterly MDS assessment audits to check behind them for accuracy. Requested a policy on Accuracy of Assessments on 1/15/25 at 1:39 PM from the ADM. During an interview on 1/15/25 at 4:20 PM, the ADM said the MDS coordinators were responsible for ensuring the accuracy of the MDS assessments. The ADM said the MDS assessment was a tool for data gathering and payment and she did not feel it would affect the resident. The ADM said the MDS was a payment system and wouldn't affect patient care. The ADM said she would expect the MDS assessments to be accurate to the best of the staff's abilities. The ADM said the facility did not have an Accuracy of Assessment policy and they followed the RAI Manual. Record review of the Resident Assessment Instrument 3.0 User's Manual (RAI) last revised October 2023, revealed . the RAI process was the basis for the accurate assessment of each resident . Code all high-risk drug class medications according to their pharmacological classification, not how they are being used . N0415A1. Antipsychotic . check if an antipsychotic medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643 Based on interview and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR) Level I assessment accurately reflected the resident's status for 1 of 6 residents (Resident #39) reviewed for PASRR Level I screenings. Resident #39's PASRR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnoses major depressive disorder were diagnosed on [DATE] . This failure could place residents who had a mental illness at risk of not receiving a needed assessment (PASRR Evaluation), individualized care, or specialized services to meet their needs. Findings included: Record review of Resident #39's face sheet, dated 10/2/13 , indicated he was an [AGE] year-old male, admitted to the facility on [DATE], and readmitted most recently on 05/31/24 . His diagnoses included major depressive disorder (A mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (Mental health conditions that cause excessive and uncontrollable feelings of fear or worry), Paraplegia (Paralysis that affects all or part of the trunk, legs, and pelvic organs). Record review of Resident #39's Quarterly MDS assessment, dated 01/1/25, indicated he had a BIMS score of 15, which indicated intact cognition. The MDS further indicated he was paraplegic. Resident #39 required assistance with most activities of daily living. Record review of Resident #39's care plan indicated that a problem initiated on 11/18/2020 shows that Resident #39 uses a psychotropic medication. Staff are to, Monitor/document/report PRN any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia (a chronic condition that causes involuntary movements in the face, limbs, and torso) frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Record review of Resident #39's PASRR Level 1 Screening, dated 11/13/20 , indicated that in Section C, Mental Illness was marked as no, which indicated Resident #39 did not have a mental illness. During an interview on 01/14/25 at 2:45 p.m., MDS Nurse A, said Resident # 39 was diagnosed with major depressive disorder on 9/12/23 . She said that major depressive disorder did not automatically make a resident PASRR positive. She said when Resident #39 was admitted to the facility his family member essentially left him and that was when he was diagnosed with major depressive disorder. She stated that the PASRR level one evaluation for Resident #39 is negative for mental illness. During an interview on 01/14/25 at 4:05 p.m. MDS Nurse A stated that she spoke to the local mental health authority, and they stated that major depressive disorder did qualify for mental illness on the PASRR level one form. She said she was wrong by saying major depressive disorder did not automatically make a resident PASRR positive. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 2:40 p.m. the Director of Nurses said that residents who qualify for a PASRR level two evaluation should be evaluated properly as per regulations. She said that major depressive disorder qualifies as a mental illness and a positive PASRR level one. She said that residents could be placed at risk of not receiving the services they qualify for if they are not evaluated properly. During an interview on 1/15/25 at 3:53 p.m., the Administrator said residents who get a new diagnosis that qualifies as a mental illness are then positive for PASRR and should receive a level two evaluation. Residents may miss services they are eligible for if they are not properly evaluated. In an email sent to the survey team from the Administrator on 1/14/25 at 10:59 p.m., she stated there was no policy regarding PASRR.

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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** 44933 Based on observation, interview, and record review the facility failed to develop, and implement a comprehensive care plan to meet the medical, nursing, mental and psychosocial needs for 4 of 34 residents (Resident #17, Resident #21, Resident #79, and Resident #110) reviewed for care plans. 1. The facility failed to care plan Resident #17's verbal and other behavioral symptoms, the diagnosis of COPD (is a chronic lung disease that makes it difficult to breathe) and use of an antiplatelet medication (work to make your platelets less sticky and thereby help prevent blood clots from forming in your arteries). 2. The facility failed to care plan Resident #110's use of an antiplatelet medication, risk for pressure ulcers (is a localized area of skin damage caused by prolonged pressure on the skin), and the diagnosis of dehydration (occurs when your body loses more water and fluids than it takes in). 3. The facility failed to ensure a care plan was developed and implemented for Resident #21's use of dentures. 4. The facility failed to develop and implement a comprehensive person-centered care plan for Resident #79's high risk for falls evaluation. These failures could place residents in the facility at an increased risk of a decline in physical or functional well-being, of not receiving necessary care or services, and having personalized plans developed to address their needs. Findings included: 1. Record review of Resident #17's face sheet dated 1/13/25 indicated Resident #17 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #17 had diagnoses including dementia (is the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), chronic obstructive pulmonary disease (COPD), and generalized atherosclerosis (is a condition where plaque builds up in the walls of arteries). Record review of Resident #17's quarterly MDS assessment dated [DATE] indicated Resident #17 was understood and understood others. Resident #17 had a BIMS of 09 which indicated moderate cognitive impairment. Resident #17 experienced verbal behavioral symptoms directed toward others that occurred one to three days a week. Resident #17 experience other behavioral symptoms not directed toward others that occurred four to six days, but less than daily. Resident #17 had an active diagnosis of asthma, chronic obstructive pulmonary disease, or chronic lung disease. Record review of Resident #17's care plan revised 11/30/24 did not indicate verbal and other behavioral symptoms, the diagnosis of COPD and use of an antiplatelet medication. Record review of Resident #17's consolidated physician order active orders as of 1/13/25 indicated: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Aspirin (the antiplatelet agent aspirin is recommended in secondary prevention of atherothrombotic events in most patients with established atherosclerotic cardiovascular disease (ASCVD is a condition that occurs when plaque builds up in the arteries, reducing blood flow to the heart and other organs)) Oral Capsule 81mg, give 1 capsule by mouth one time a day for atherosclerosis. Start date 12/05/24. *Trelegy Ellipta (is a prescription inhaler that treats chronic obstructive pulmonary disease (COPD) and asthma in adults) Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG/ACT, 1 inhalation inhale orally one time a day for COPD. Start date 11/08/24. Record review of Resident #17's MAR dated 1/01/25-1/31/25 indicated: *Aspirin Oral Capsule 81mg, give 1 capsule by mouth one time a day for atherosclerosis. Start date 12/05/24. Received 15 of 15 doses. *Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG/ACT, 1 inhalation inhale orally one time a day for COPD. Start date 11/08/24. Received 15 of 15 doses. Record review of Resident #17's progress notes dated 10/01/24-01/14/25 indicated: *12/04/24 at 3:06 p.m. by Social Service indicated .social worker, nurse case manager [MDS Nurse A], AD present for care plan meeting .she has new aspirin medicine .referring to Cardiologist . *12/04/24 at 3:31 p.m. by LVN K indicated, .N.O. [new order] Aspirin 81mg QD and refer to vascular .R/T ECA stenosis 70% . *12/28/24 at 3:59 a.m. by LVN S indicated, .Resident #17 has remained awake for the entire night talking to . cleaning out drawers .continues to insist on leaving all lights on, tv on, awakens roommate .has continued to keep 3 residents awake . *1/01/25 at 12:36 a.m. by LVN S indicated, .refusing to quit visiting back and forth between her room . continue to wake up both roommates that were attempting to sleep . *1/03/25 at 9:20 p.m. by RN T indicated, .resident #17 observed bullying another resident who is wheelchair bound and unable to make needs known . *1/09/25 at 2:00 p.m. by Social Service indicated, .DON, LVN K, and Social Worker are present for care plan meeting .family member of Resident #17 was called to discuss Resident #17 taking other residents' property . will be referred to a local mental health provider to assist her with change in behaviors . *01/09/25 at 5:44 p.m. by LVN K indicated, .Resident #17 yelled across room twice to another residents 'I'll kick your butt!' .Redirected and explained that this behavior was not acceptable . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #110's face sheet dated 1/13/25 indicated Resident #110 was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #110 had diagnoses including cerebral infarction (is a type of stroke that occurs when brain tissue dies due to a lack of blood flow), dehydration, chronic kidney disease (is a long-term condition that occurs when the kidneys are damaged and can't filter blood properly), dementia (a decline in mental abilities that affects a person's ability to perform everyday activities), muscle wasting and atrophy (shortening), and altered mental status (is a general term for a change in a person's level of consciousness, awareness, attention, or cognition). Record review of Resident #110's significant change in status MDS assessment dated [DATE] indicated Resident #110 was understood and understood others. Resident #110 had a BIMS of 04 which indicated severe cognitive impairment. Resident #110 had an additional active diagnosis of dehydration. Resident #110 was at risk for developing pressure ulcers/injuries. Resident #110 had received an antiplatelet medication during the last 7 days, since admission/entry, or reentry if less than 7 days. Record review of Resident #110's Care Area assessment dated [DATE] indicated care areas of cognitive loss/delirium, urinary incontinence, behavioral symptoms, falls, nutritional status, pressure ulcer (at risk for breakdown related to weight loss, reduced mobility), psychotropic drug use, and pain. Record review of Resident #110's care plan revised 12/27/24 did not indicate use of an antiplatelet medication, risk for pressure ulcers, and the diagnosis of dehydration. Record review of Resident #110's consolidated physician orders active orders as of 01/13/25 indicated: *Aspirin Low Dose Oral Tablet Delayed Release 81 MG, give 1 tablet by mouth one time a day for blood clot. Start date 12/09/24. *Clopidogrel Bisulfate Tablet 75 MG, give 1 tablet by mouth one time a day for blood clot prevention. Start date 12/09/24. Record review of Resident #110's MAR dated 01/01/25-01/31/25 indicated: *Aspirin Low Dose Oral Tablet Delayed Release 81 MG, give 1 tablet by mouth one time a day for blood clot. Start date 12/09/24. Received 15 of 15 doses. *Clopidogrel Bisulfate Tablet 75 MG, give 1 tablet by mouth one time a day for blood clot prevention. Start date 12/09/24. Received 15 of 15 doses. Record review of Resident #110's hospital paperwork dated 12/06/24 indicated, .labs are consistent with significant volume depletion and dehydration . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/15/25 at 11:19 a.m., MDS Nurse O, with MDS Nurse A present said the resident's care plan was the interdisciplinary team responsibility. MDS Nurse A said she was responsible for long term care residents. MDS Nurse A said she did the Medicaid, hospice, and private pay residents care plans. MDS Nurse O said she was responsible for skilled nursing, Medicare, and managed care residents. MDS A and MDS O said they had morning meetings with clinical staff and discussed things and the nurses on the floor would also give them clinical updates. MDS Nurse A said care plans were done on admission, quarterly, and with changes in condition. They both said Resident #17's verbal and other behavioral symptoms should have been on her care plan. They said diagnoses that were receiving treatment should be care planned. They said the diagnosis of COPD should be care planned on Resident #17's care plan especially since she received nebulizer medication for it. They said sometimes residents admitted with a diagnosis of COPD but did not take medication for it and may not be care planned. They said they were not aware Resident #17 had started a new medication to treat her COPD. They said if a resident was admitted on an antiplatelet then the MDS Nurses were responsible for care planning it. They said if the resident was recently started on the antiplatelet, then that would be considered an acute change. They said acute changes or new orders were normally care planned by the ADONs. MDS Nurse O said Resident #110 being at risk for pressure ulcers and her new diagnosis of dehydration should have been care planned. They said if Resident #110's dehydration diagnosis was on her hospital paperwork and coded on the MDS then it should be care planned. MDS Nurse O said the care plans addressed the resident's needs. During an interview on 1/15/25 at 1:58 p.m., LVN N said the ADONs, AD, and nursing management were responsible for care plans. She said Resident #17's behaviors, diagnoses, and medication use should be care planned. She said Resident #110's medication and diagnosis should also be care planned. She said she did not review the resident's care plan regularly but nursing management notified staff if there were changes or not to do old interventions. She said the care plans were used to know how to care for the residents. She said the care plans let staff know what appropriate interventions to use. She said care plans helped with prevention, knowing about changes, and family wishes. She said if care plans were not done, the residents may not get the individualized care they needed. During an interview on 1/15/25 at 3:33 p.m., ADON P said the MDS nurses and IDT were responsible for care plans. She said baseline care plans were done by the bedside nurse. She said acute changes were care planned by the IDT. She said comprehensive care plan were done with changes and quarterly. She said behaviors, psychotropic medications, diagnoses, fall and pressure ulcer risk, and dehydration should be care planned. She said the care plans were used to know how to care for the residents, getting to know the resident, and the resident's and family wishes. During an interview on 1/15/25 at 4:27 p.m., the DON said she would expect diagnoses that received treatments, medications, and at-risk problems to be care planned. She said the DON and MDS Coordinators were responsible for comprehensive care plans. She said the MDS Coordinator and IDT were responsible for acute care plans. She said the residents were discussed during wellness Wednesday with and IDT and NP. She said care plans were used as guidelines on how to meet the resident's needs with developed problems, goals, and interventions. During an interview on 1/15/25 at 6:00 p.m., the ADM said she would expect the resident's care plan to address diagnoses, medications, and at risk for pressure ulcers. She said nursing management was responsible for resident's acute and comprehensive care plans. 30527 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of the face sheet dated 1/15/2025 indicated, Resident #21 was an [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included cerebrovascular disease (affects the blood vessels of the brain and circulation), hypertension (high blood pressure), hyperlipidemia (high levels of fat particles in the blood), history of stroke, and dysphagia (difficulty swallowing). Record review of the quarterly MDS dated [DATE] indicated, Resident #21 was understood by others and understood others. The MDS indicated Resident #21 had a BIMS of 11 and was moderately cognitively impaired. The MDS indicated Resident #21 was dependent with toileting, dressing, and bathing and required supervision for eating. Section GG - Functional Abilities B. Oral Hygiene indicated Resident #21 required assistance with her dentures. Record review of the care plan dated 1/22/2024 and did not indicate Resident #21 wore dentures for eating. Record review of the order summary report dated 1/15/2025 indicated remove and wash Resident #21's teeth every day and every shift for clean dentures. During an observation on 1/13/2025 at 12:32 PM, Resident #21 was sitting in the dining hall eating her lunch without her dentures. Resident #21 was chewing slowly and stated she was eating ok today. During an observation and interview on 1/14/2025 at 08:30 AM, Resident #21 was in her room eating from her breakfast without dentures in her mouth. Resident #21's family member stated, She needs her dentures so she can chew her food without choking. She already has difficulty swallowing. The dentures have been in the bathroom soaking in the same brown dirty water for over a week. The family member stated she had requested the staff put in the dentures on several different occasions. During an observation on 1/14/2025 at 12:35 PM, Resident #21 was in the dining hall without her dentures in her mouth for the lunch meal. During an observation on 1/15/2025 at 08:45 AM, Resident #21 was in her room eating breakfast without dentures in her mouth. During an interview on 1/15/2025 at 09:10 AM, CNA U said Resident #21 should have her dentures in her mouth at mealtime. CNA U said after Resident #21 had her meal, her dentures should be removed, brushed, cleaned, and soaked in the water with the blue cleansing tablet. CNA U said Resident #21 did not have the dentures in at breakfast time. CNA U said she had not remembered to put in Resident #21's dentures. CNA U said it was important for the residents to have their dentures in when eating to prevent choking and swallowing issues. During an observation at 12:30 PM on 1/15/2025, Resident #21 was eating in the dining hall without dentures in her mouth. During an interview on 1/15/2025 at 02:00 PM, the ADON said clinical nursing and the MDS Coordinator were responsible for updating the care plans. The ADON said Resident #21's care plan should have reflected and included that she wore dentures for eating. The ADON said it was important for Resident #21's care plan to include that she wore dentures to make sure she was able to meet her nutritional needs and to prevent choking and swallowing difficulties. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/15/2025 at 02:15 PM, the DON said the clinical nursing staff were responsible for updating the care plans. The DON said Resident #21's care plan should have reflected and included that she required dentures. The DON said she did not know why it was not in her care plan. The DON said it was important to include in the care plan that Resident #21 required dentures, so staff knew how to assist and provide the care the residents needed. During an interview on 1/15/2025 at 5:45 PM, the Administrator said she expected the clinical nursing staff which included DON, ADON, and the MDS Coordinators to update and implement the residents' care plans quarterly and yearly. The Administrator said Resident #21's care plan should have included that she required dentures. The Administrator stated it was important for the care plans to be accurate to ensure all residents were provided with continuity of care. 46062 4. Record review of Resident #79's face sheet dated 1/14/25 revealed she was [AGE] years old and admitted to the facility on [DATE]. Resident #79 had diagnoses including multiple rib fractures (broken bones), repeated falls, lack of coordination, shortness of breath, heart failure, and high blood pressure. Record review of Resident #79's admission MDS assessment dated [DATE] indicated she had a BIMS of 13, which indicated she was cognitively intact. The MDS indicated Resident #79 required total to maximum assistance for most ADLs. The MDS indicated Resident #79 was always incontinent of bowel and bladder. The MDS indicated Resident #79 had fallen in the last month prior to admission and had a fall related fracture in the past six months. Record review of Resident #79's Care Plan with an admitted [DATE] revealed there was not a problem area or interventions related to high risk for falls. Record review of Resident #79's Fall Risk Evaluation dated 12/12/24 reflected she scored 13, which indicated she was at high risk for falls. Record review of Resident #79's Progress Notes dated 1/11/25 indicated she rolled out of bed while asleep and was found on the floor with a bruise on her forehead and a skin tear on her left elbow. Record review of Resident #79's Fall Risk Evaluation dated 1/11/25 reflected she scored 14, which indicated she was at high risk for falls. Record review of Resident #79's Progress Notes dated 1/13/25 indicated she was found on the floor and she informed staff she had rolled out of bed again. Record review of Resident #79's Fall Risk Evaluation dated 1/14/25 reflected she scored 10, which indicated she was at high risk for falls. During an observation and interview on 1/13/25 at 2:18 PM, Resident #79 was lying in bed and had wound closure strips to her left elbow and the wound dressing had slid down to her forearm. Resident #79 said she slid out of the bed the night before last (1/11/25) and tore her skin on her elbow. Resident #79 had a fall mat on the floor of Resident's left side of bed. Resident #79's right side of the bed was approximately two foot from the wall and there was no fall mat on the floor. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 1/15/25 at 11:14 AM, Resident #79 was reclined in her recliner and said she did not know why she rolled out of the bed twice and wished everyone would quit asking her. During an interview on 1/15/25 beginning at 11:19 AM with MDS A and MDS O, they both said they had worked at the facility for thirteen years. MDS A and MDS O said the Comprehensive Care Plans were done upon admission, change of conditions, quarterly, and as needed. They said they both were responsible for doing the care plans. MDS O said they used things that triggered on the MDS assessment, ADLs, fall risks, medications, pressure ulcer risks, amount of assistance needed, and mainly the at risk things to develop the Comprehensive Care Plan. MDS A said everyone was a fall risk and she put fall risks on everyone's care plan. MDS O said the acute care plans were the nursing management's responsibility to update. MDS A and MDS O said they had morning meetings with clinical staff and discussed things and the nurses on the floor would also give them clinical updates. MDS O said Resident #79 should have had a high risk for falls care plan on her comprehensive care plan from admission. MDS O said she did not think, not having a high risk for falls care plan would affect the resident, because all the staff treated the residents as fall risks. MDS A said the CNAs all know to keep the call lights in reach and beds in low position. MDS O said the CNA's ADL care plan addressed all the transfer and care assistant needs. During an interview on 1/15/25 at 1:46 PM, LVN G said she had worked at the facility for about three years and normally worked the day shift. LVN G said she could initiate the care plan on admission, but the RN would be responsible for completing the comprehensive care plan because she was an LVN and could not sign off on it. LVN G said the MDS nurses and nurse management were responsible for the comprehensive care plan. LVN G said she would expect high fall risk would be included on the comprehensive care plan. LVN G said not having a care plan for high risk for falls, could cause the resident not to have the needed interventions in place to prevent falls and could negatively affect the resident. During an interview on 1/15/25 at 3:07 PM, ADON P said the Comprehensive Care Plans were done by the MDS Coordinators. ADON P said the floor nurses and nurse management were responsible for the Base Line Care Plan. ADON P said the high risk for falls should be included in the Comprehensive Care Plan. ADON P said the purpose of the Comprehensive Care Plan was to hold all the data of the resident and so the staff know how to meet the resident's needs. ADON P said if the high risk for falls was not included on the care plan, they were not identifying the risks of the resident and putting interventions in place to reduce the risk of falls. During an interview on 1/15/25 at 3:32 PM, the DON said the MDS coordinators were responsible for the Comprehensive Care Plans. The DON said the purpose of the care plan was to identify what the plan of care was for the resident, which included identifying safety needs, nutrition, and how they were going to take care of the resident. The DON said the care plan was used as a guideline to treat and to meet the resident's needs with problems, goals, and interventions to meet the needs of the resident. The DON said high risk for falls should be included in the Comprehensive Care Plans. The DON said if the resident was deemed as high risk for falls, and it was not in the care plan, it could prevent them from having things in place to prevent future falls. The DON said the care plan would alert them to be watchful to keep the resident safe. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/15/25 at 4:20 PM, the ADM said a resident at high risk for falls should have been care planned based off the fall assessment. The ADM said the purpose of the care plan was a tool to direct the resident's care. The ADM said the nursing department was responsible for ensuring the Comprehensive Care Plan was accurate. The ADM said by not having high risk for falls care planned, they could miss something and not meet the resident's needs. The ADM said she would expect the care plans to be accurate to the best of the staff's abilities. Record review of the facility's policy dated 10/24/22 and titled Comprehensive Care Plans, indicated . it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident . that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the resident's comprehensive assessment . comprehensive care plan would describe, at a minimum, . the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . resident specific interventions that reflected the resident's needs and preferences .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612 Based on observations, interviews, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living receive the necessary services to maintain grooming and personal hygiene for 3 of 28 residents reviewed for ADLs. (Resident #5, Resident #46, and Resident #51) The facility did not ensure Resident #5, Resident # 46, and Resident # 51 did not have chin hair on 01/13/2025 and 01/14/2025. These failures could place residents at risk of not receiving care or services, decreased quality of life, embarrassment, and decreased self-esteem. The findings included: 1.Record review of the face sheet, dated 10/17/2024, revealed Resident #5 was a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of multiple sclerosis (a chronic disease that damages the central nervous system), unspecified dementia (general term for dementia that doesn't have a specific diagnosis), muscle weakness (a lack of muscle strength that can be temporary or long-lasting). Record review of the quarterly MDS assessment, dated 10/30/2024, revealed Resident #5 had clear speech and was understood by others. The MDS revealed Resident #5 was able to understand others. The MDS revealed Resident #5 had a BIMS score of 12, which indicated moderate cognitive impairment. The MDS revealed Resident #5 had no behaviors or refusal of care. The MDS revealed Resident #5 was dependent (helper does all of the effort) with personal hygiene. Record review of the comprehensive care plan, initiated 10/15/2024, revealed Resident #5 had an ADL self-care performance deficit related to multiple sclerosis and severe debility. The interventions included: Personal Hygiene Care: The resident was totally dependent on staff for personal hygiene and oral care. During an observation and interview on 01/13/2025 at 10:52 a.m., Resident #5 was laying in the bed with the head of her bed elevated slightly. Resident #5 had approximately 1-inch gray facial hairs to the sides of her mouth and on her chin. Resident #5's eyes became wide, and she placed her hands up to cover her mouth when the surveyor asked if the staff assisted her with facial hair removal. Resident #5 stated the staff had not offered to help her remove it and she was unaware she had facial hair. Resident #5 stated she wanted help from the staff with removing her facial hair. Resident #5 stated she was embarrassed to have facial hair. During an observation on 01/14/2025 at 10:00 a.m., Resident # 5 had approximately 1 inch facial hair to the sides of her mouth and on her chin. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/14/2025 at 1:09 p.m., CNA X stated she assisted female residents with facial hair removal if they asked her. CNA X stated she had not assisted Resident #5 with facial hair removal. CNA X stated she had not asked if she needed assistance. CNA X stated it was important to assist Resident #5 with facial hair removal to respect her rights and maintain her dignity. During an interview on 01/15/2025 at 11:33 a.m., LVN Y stated the facility staff was responsible for ADL care for Resident #5. LVN Y stated facial hair was usually removed with bathing. LVN Y stated if facility staff noticed facial hair, they should have asked if Resident #5 wanted help removing it. LVN Y stated it was important to assist Resident # 5 with facial hair removal to maintain her dignity. 2.Record review of Resident #46's face sheet dated 01/13/25 indicated Resident #46 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #46 had diagnoses including dementia (is a general term for a decline in mental abilities that affects a person's ability to perform everyday activities), generalized muscle weakness, age-related cognitive decline, and muscle wasting and atrophy (shortening). Record review of Resident #46's quarterly MDS assessment dated [DATE] indicated Resident #46 was understood and understood others. Resident #46 had a BIMS of 05 which indicated severe cognitive impairment. Resident #46 did not reject evaluation or care. Resident #46 was independent for personal hygiene and setup for shower/bathe self. Record review of Resident #46's care plan dated 01/26/24 indicated Resident #46 had an ADL self-care performance deficit related to generalized weakness. Intervention included for personal hygiene/oral care able to groom self with set up assistance. Record review of Resident #46's ADL task-bathing dated 30 days look back indicated shower on 12/16/24, 12/30/24, and 01/08/24. Resident #46 refused shower on 12/25/24. Record review of Resident #46's ADL-personal hygiene (including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, and hands) dated 30 days look back indicated personal hygiene had been independent and supervised 01/13/25 and 01/14/25. During an observation on 01/13/25 at 12:33 p.m., Resident #46 was sitting in a recliner. Resident #46 had several small white hairs to her chin. During an observation and interview on 01/14/25 at 8:41 a.m., Resident #46 was sitting in a recliner. Resident #46 had several small white hairs to her chin. Resident #46 said she gave herself showers and took care of her facial hair. Resident #46 touched her chin and said she did not know she had chin hair. She said she would take care of it today. During an observation on 01/14/25 at 2:00 p.m., Resident #46 was sitting in a recliner. Resident #46 had several small white hairs to her chin. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/15/25 at 1:58 p.m., LVN N said she had been at the facility for almost 4 years. She said she worked 3 days on, 2 days off schedule. She said she mostly worked the secured unit. LVN N said Resident #46 required supervision for her ADLs. She said facial shaving should at least be done with showers. She said staff normally gave set up assistance to Resident #46. She said she did not notice Resident #46 had chin hair. She said residents should be showered and shaved to look presentable and to make the family feel good to know the resident was taken care of. 3.Record review of a face sheet dated 01/14/2025 indicated Resident #51 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life without any behaviors). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #51 was understood by others and was able to understand others. The MDS assessment indicated Resident #51 had a BIMS score of 05, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #51 required supervision and assistance with all her ADLs including shower/bathing self. The MDS assessment indicated Resident #51 did no reject care. Record review of the care plan with a revised date of 01/04/2025 indicated Resident #51 had an ADL self-care performance deficit related to cognitive impairment. The care plan indicated Resident #51 required limited assistance for her showers. Record review of the shower sheet dated 01/11/2025 indicated Resident #51 received a bath. During an observation on 01/13/2025 at 10:22 AM, Resident #51 had two patches of white gray hair on each side of her chin approximately one inch long and multiple other chin hairs approximately 0.5 centimeters long. During an observation and interview on 01/14/2025 at 04:30 PM, Resident #51 had two patches of white gray hair on each side of her chin approximately one inch long and multiple other chin hairs approximately 0. 5 centimeters long. Resident #51 stated she does not like the chin hair and had asked on numerous occasions for assistance to remove the chin hairs. Resident #51 said the aides would state they did not have time or that they would come back later. Resident #51 said she had not refused to have the chin hair removed but she was never offered. During an interview on 01/14/2025 at 08:45 AM, CNA U said Resident #51 received her baths on Tuesday, Thursday, and Saturdays. CNA U said Resident #51 had a shower Saturday and should had been shaved at that time. CNA U said Resident #51 did not refuse bathing or shaving. CNA U said it was important for facial hair to be removed because it was part of the resident's everyday appearance and for their dignity. During an interview on 01/15/2025 at 2:05 p.m. with DON stated CNAs were expected to do the task of facial hair removal and this should be offered during shower time. The DON stated it was her responsibility to monitor the CNAs, however all of management do daily rounds to monitor. The DON stated the importance of removing facial hair was dignity and could affect resident's self-esteem. The DON stated she would do an in-service. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/15/2025 at 3:15 p.m. the Administrator stated she expected the CNAs to ensure female residents don't have facial hair. The Administrator stated it was the responsibility of the nurses to monitor the CNAs. The Administrator stated she would do daily rounds to look at each resident. The Administrator stated it was important for resident's emotional wellbeing if she did not want facial hair. Record review of the facility's policy titled Activities of Daily Living dated 05/26/2023, Care and services will be provided for the following activities of daily living .bathing, dressing, grooming, and oral care a resident who was unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal hygiene. 44933 30527

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on observations, interview and record review, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 2 residents reviewed for accidents (Resident #66). The facility failed to ensure a safe environment when CNA Q and CNA R walked away and left Resident #66 unsupervised at bedside during a mechanical lift transfer on 12/21/2024. This failure could place residents at risk of injuries, falls and hospitalization s. Findings include: Record review of Resident #66's face sheet, dated 01/15/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #66 had diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning), protein-calorie malnutrition (the state of inadequate intake of food), muscle wasting, lack of coordination and cognitive communication deficit. Record review of Resident #66's Quarterly MDS assessment, dated 12/04/2024, reflected Resident #66 was sometimes understood by others and sometimes was able to understand others . Resident #66 had a BIMS score of 01, which indicated her cognition was severely impaired. Resident #66 had no delusions or hallucinations. Resident #66 had no physical, verbal, or other behavioral symptoms directed toward others. The MDS assessment reflected Resident #66 had functional limitations on both sides of upper and lower extremities and was dependent for assistance with transfers, toileting, shower, upper and lower body dressing, and personal hygiene. Record review of Resident #66's comprehensive care plan, revised on 04/14/2024, reflected Resident #66 had activities of daily living self-care performance deficit and was at risk for not having her needs met in a timely manner. The care plan goal included resident to maintain current level of function through the review date. The interventions included the following: Total assistance by 1 staff for incontinent care, bathing, grooming, dressing; resident required extensive assistance by 1 staff to turn and reposition for bed mobility; and total dependent on 2 staff for mechanical lift transfers. Record Review of CNA Q's Staff Competency standards of practice for Hoyer Lift/Transfer was documented as met on 10/01/2024. Record Review of CNA R's Staff Competency standards of practice for Hoyer Lift/Transfer was documented as met on 10/02/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/14/2025 at 02:23 PM of a video, date stamped 12/21/2024 at 10:02 PM, CNA Q and CNA R were observed transferring Resident #66 to her bed using a Hoyer lift. Resident #66 could be heard muttering. Resident #66's speech was shaky and incomprehensible. CNA Q put Resident #66 down on the bed from the Hoyer, and they took the sling off the lift. Neither CNA Q nor CNA R explained to Resident #66 what they were doing as they transferred her into her bed. Resident #66's left side assist rail was lowered. Resident #66 was placed close to the edge of the bed on the left side. Both CNAs walked away from the bed for approximately 15 seconds and failed to raise Resident #66's left side assist rail. During this time, Resident #66 swayed her body to the left and then back onto the bed. Neither CNA Q nor CNA R explained to the resident that they were walking away or what they were doing. During an interview on 01/15/2025 at 2:09 PM, ADON P said she had been employed at the facility since 07/02/24. She said she covered the 300 (secured unit) and 400 halls. After ADON P viewed the video date stamped 12/21/2024 at 10:02 PM, with audio and visual of CNA Q and CNA R providing Hoyer lift transfer and incontinent care to Resident #66, she said the CNAs should have explained what they were doing while providing care for Resident #66. ADON P said one of the CNAs should have stayed at bedside to ensure the resident was steady and safe in the center of the bed before walking away. ADON P gasped while watching the video due to Resident #66 swaying off the edge of the bed. ADON P said Resident #66 barely kept from falling off the edge of the bed when both CNAs had walked away from bedside which could have resulted in a fall or injury. During an interview on 01/15/2025 at 03:15 PM, the DON stated the purpose of 2-person assistance with mechanical lift transfers was for one staff member to work the lift and one staff member to secure the safety of the resident. After viewing the video date stamped 12/21/2024 at 10:02 PM, with audio and visual of CNA Q and CNA R providing Hoyer lift transfer and incontinent care to Resident #66, the DON stated the transfer was not done correctly. The DON stated the resident should have been securely placed in the center of the bed before CNA Q and CNA R left the beside. The DON stated Resident #66 almost toppled over off the edge of the side of the bed when nether CNA was watching Resident #66. The DON said had Resident #66 could have had a potential injury from lack of supervision. The DON said the leadership staff monitor for the safety of residents daily during angel rounds. During an interview on 01/15/2025 at 4:45 PM, the Administrator said she expected staff to ensure safety with the mechanical lifts by always utilizing 2 staff and completing the procedure as shown and demonstrated with competency skills checkoffs. After the DON viewed the video date stamped 12/21/2024 at 10:02 PM, with audio and visual of CNA Q and CNA R providing Hoyer lift transfer and incontinent care to Resident #66, she stated that aide should have stayed at bedside and ensured the safety of the resident. The DON said although Resident #66 did not have a fall during the transfer it was a very close call which could have easily resulted in an injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/15/2025 at 06:35 PM, CNA R stated she had worked at the facility for approximately 2 years. CNA R said she had been checked off for competency on mechanical lift transfers. CNA R stated mechanical lift transfers require 2 staff members. CNA R said one staff member will adjust and move the lift while the other staff member guides the resident to ensure their safety until positioned in the bed/chair appropriately. CNA R viewed the video date stamped 12/21/2024 at 10:02 PM, with audio and visual of CNA Q and CNA R providing Hoyer lift transfer and incontinent care to Resident #66. CNA R jumped and said, oh gosh - she almost fell off the bed! CNA R was tearful and stated I did not know that happened when I had turned away. CNA R said CNA Q usually stayed at bedside while she put away the lift. CNA R said because of the lack of supervision, Resident #66 could have suffered injury from a fall. During an interview on 01/15/2025 at 06:55 PM, CNA Q stated she had worked at the facility for a while. CNA Q stated she had been checked off for competency on mechanical lift transfers probably in October. CNA Q stated mechanical lift transfers require 2 staff members to make sure the resident gets transferred safely and for one to work the lift. After CNA Q viewed the video date stamped 12/21/2024 at 10:02 PM, with audio and visual of CNA Q and CNA R providing Hoyer lift transfer and incontinent care to Resident #66, CNA Q said there was nothing wrong with the care she had provided, and Resident #66 did not fall. CNA Q stated even though she had walked away from the resident and her back was turned that she could have easily caught Resident #66 if she had fallen. Record review of the facility's Incidents and Accidents policy dated 08/15/2022, indicated, A successful fall risk management program requires organizational commitment and interdisciplinary team approach to prevent and minimize falls. Care Plan: Planned interventions that address the individualized intrinsic and extrinsic fall risk factors identified during the fall assessment

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interviews and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicated otherwise for 1 of 9 residents (Resident #23) reviewed for nutrition. The facility failed to follow the dietician's recommendation to increase Resident #23's Med Pass 120ml TID to QID ordered on 11/15/24 and 12/06/24. This failure placed resident at risk for malnutrition and weight loss. Findings included: Record review of Resident #23's face sheet dated 01/13/25 indicated Resident #23 was an 86-years-old female admitted to the facility on [DATE]. Resident #23 had diagnoses including dementia (is a general term for a decline in mental abilities that affects a person's ability to perform everyday activities), protein-calorie malnutrition (refers to a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), and dysphagia (swallowing difficulties). Record review of Resident #23's quarterly MDS assessment dated [DATE] indicated Resident #23 was usually understood and usually understood others. Resident #23 had a BIMS of 01 which indicated severe cognitive impairment. Resident #23 had loss of 5% or more in the last month or loss of 10% or more in last 6 months and was not on a physician-prescribed weight loss regimen. Record review of Resident #23's care plan revised 11/20/24 indicated: *Resident #23 was a nutritional risk related to -5% weight loss. Interventions included started on Remeron 12/06/23, to be fed by staff if not eating on her own and started Megace on 02/19/24. *Resident #23 had nutritional problem related to history of dementia. Interventions included provide, serve diet as ordered and monitor intake and record every meal. Record review of Resident #23's progress notes-nutrition/dietary dated 10/01/24-01/14/25 indicated: *11/15/24 at 10:57 a.m. by the Dietician indicated .CBW: 120.3 lbs. (11/11) . weight trends of -6.6% x 30 days, -5.2% x 90 days, -12.5% x 180 days . Diet: Med Pass 2.0 120ml TID .resident with declining appetite . resident has fair/good acceptance medpass 2.0 120 BID .resident likely not meeting nutritional needs at this time as evidence by poor by mouth intakes and decreasing appetite .recommendations: increase med pass to 120ml QID x 60 days .end date 1/15/25 . *12/06/24 at 4:01 p.m. by the Dietician indicated .recommendations: re-enforce previous Registered Dietician recommendations of increase med pass to 120 ml QID x 60 days .end 1/15/25 . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*12/13/24 at 10:31 a.m. by the Dietician indicated .recommendations: re-enforce previous Registered Dietician recommendations of increase med pass to 120 ml QID x 60 days .end 02/13/25 . Record review of Resident #23's consolidated physician order active orders as of 11/01/24 indicated Med Pass 2.0 three times a day for weight management until 12/27/24 120ml by mouth. Start date 10/02/24. Record review of Resident #23's consolidated physician order active orders as of 01/14/25 indicated Med Pass 2.0 four times a day for weight management for 60 days 120 ml by mouth. Start date 12/19/24. Record review of Resident #23's MAR dated 11/01/24-11/30/24 indicated: *Med Pass 2.0 three times a day for weight management until 12/27/24 120 ml by mouth. Start date 10/02/24. Discontinued date 11/03/24. Received 7 out of 7 doses ranging in amounts of 100ml and 240ml. *Med Pass 2.0 three times a day for weight management until 02/01/25 120 ml by mouth. Start date 11/03/24. Discontinued date 12/19/24. Received 74 out of 74 doses ranging in amounts of 50ml, 100ml, and 120ml. Record review of Resident #23's MAR dated 12/01/24-12/31/24 indicated: *Med Pass 2.0 three times a day for weight management until 02/01/25 120 ml by mouth. Start date 11/03/24. Discontinued date 12/19/24. Received 55 out of 55 doses ranging in amounts of 25ml, 100ml, and 120ml. *Med Pass 2.0 four times a day for weight management for 60 days 120 ml by mouth. Start date 12/19/24. Received 38 out of 38 doses. Record review of Resident #23's weights printed 01/15/25 indicated: *10/12/24 126.1 lbs. *11/11/24 120.3 lbs. *12/9/24 121.3 lbs. *01/08/25 119.0 lbs. Record review of the emailed dietary reports provided by the ADM on 01/21/25 indicated: *11/15/24- Recommendation for Resident #23 was increase med pass to 120ml QID x 60 days to end 01/15/25. *12/06/24- No recommendation on report for Resident #23. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*12/13/24- Recommendation for Resident #23 to re-enforce previous RD recommendations of increase med pass to 120ml QID x60 days to end 02/13/25. During an interview on 01/15/25 at 1:58 p.m., LVN N said when dietary recommendations were made by the dietician, the nurse was supposed to get an order for it from the doctor or NP. She said recently, the dietician could also order the dietary recommendations herself. She said she was not aware Resident #23's dietary recommendations were not followed up on by the nursing staff. She said it was important to follow dietary recommendation for weight gain and help with nutrition. She said residents could lose weight and have decrease protein intake when dietary recommendations were not followed. During an interview on 01/15/25 at 4:27 p.m., the DON said RD put dietary recommendation on a report and emailed it to nursing management. She said the ADON got the dietician report and endorsed it. She said the ADON then reported the dietary recommendations to the bedside nurse. She said if the dietary recommendations were in the progress notes, then the nurses were responsible for getting an order for it. She said the RD just got order writing privileges about a month ago. She said the RD can now put the dietary recommendations orders in herself. She said she did not know about Resident #23's missed dietary recommendation. She said Med Pass helped increase calorie intake and provided extra intake the resident needed. She said when dietary recommendations were not followed the resident could have further weight loss. During an interview on 01/15/25 at 6:00 p.m., the ADM said the RD emailed the dietary recommendation report to the ADON, DON and ADM. She said now the RD had order writing privileges. She said before the RD was granted order writing privileges, nursing management was responsible for dietary recommendation orders. She said dietary recommendations were important to supplement for weight loss or potential of weight loss in residents. She said when dietary recommendations were not done the resident could experience weight loss. During an interview on 01/16/25 at 9:30 a.m., the RD said she visited the facility once a week, four times a month. She said after her visit, she emailed her report of dietary recommendations to the administrative staff. She said she sent the report to the ADM, DON, ADON, DM, and NP. She said the facility was responsible for reviewing the report and following through on the recommendations. She said she followed up on her recommendations made from the previous visit by reviewing written documentation or the administrative staff let her know the recommendations had been implemented. She said she noticed after her first visit that Resident #23's Med Pass order had not been changed from TID to QID. She said she had made the recommendation to increase the frequency of the Med Pass because Resident #23's PO intake had declined. She said she thought the increase in frequency would benefit Resident #23. She said even though Resident #23's dietary recommendation on 11/15/24, 12/06/24, and 12/13/24 were not followed through, Resident #23 maintained her weight. She said she recently received order writing privilege about 2-3 weeks ago. She said she put Resident #23's order in herself because the facility still had not done it. She said implementing dietary recommendations were important for the resident's weight management and nutritional health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility's Implementation of Recommendations policy revised 06/01/19 indicated . recommendations submitted by the nutrition professional, or Nutrition and Dietetics Technician Registered (NDTR), as assigned will be implemented as soon as possible, but no later than 72 hours after submission in order to ensure the best nutritional care possible for the residents of the facility .if the medical director has not granted the RD order writing privileges in the facility, the RDN or NDTR will use a communication form to record and submit all nutritional recommendations to the facility .the RDN or NDTR will provide copies to the Unit Manager, Nutrition & Foodservice Manager, Director of Nursing and any other staff specified by the facility .the facility staff will sign and date the communication form when the recommendations have been implemented and forward the form to the CDM to be given to the RDN or NDTR .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate administering of all drugs and biologicals, to meet the needs of 1 of 28 residents (Resident #17) reviewed for pharmacy services. The facility failed to ensure Resident #17's Wellbutrin (is a prescription medicine used to treat adults with a certain type of depression called major depressive disorder, and for the prevention of [NAME]-winter seasonal depression (seasonal affective disorder)) SR Oral Tablet Extended Release 200mg was available for administration on 10/13/24, 10/14/24 and 11/04/24. This failure could place residents at risk for inaccurate drug administration. Findings included: Record review of Resident #17's face sheet dated 01/13/25 indicated Resident #17 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #17 had diagnoses including dementia (is the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), anxiety (are mental health conditions that cause excessive and uncontrollable fear or worry), major depressive disorder (is a mood disorder that causes a persistent feeling of sadness and loss of interest), and cognitive communication deficit (is a difficulty with communication caused by an impairment in cognitive processes). Record review of Resident #17's quarterly MDS assessment dated [DATE] indicated Resident #17 understood and understood others. Resident #17 had a BIMS of 09 which indicated moderate cognitive impairment. Resident #17 was taking an antidepressant during the last 7 days. Record review of Resident #17's care plan dated 09/08/23 indicated Resident #17 used antidepressant medication Wellbutrin related to depression. Record review of Resident #17's consolidated physician order active as of 10/01/24 indicated Wellbutrin SR Oral Tablet Extended Release 12-hour 150mg (Bupropion HCL), give 1 tablet by mouth two times a day for major depressive disorder. Start date 11/01/23. Record review of Resident #17's consolidated physician order active as of 11/01/24 indicated Wellbutrin SR Oral Tablet Extended Release 12-hour 150mg (Bupropion HCL), give 1 tablet by mouth two times a day for major depressive disorder. Start date 11/01/23. Record review of Resident #17's MAR dated 10/01/24-10/31/24 indicated Wellbutrin SR Oral Tablet Extended Release 12-hour 150mg (Bupropion HCL), give 1 tablet by mouth two times a day for major depressive disorder. Start date 11/01/23. Discontinued 11/21/24. The MAR indicated other/see progress notes on 10/13/24, 6a (MA Z) and 10/14/24, 6a (MA Z). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #17's MAR dated 11/01/24-11/30/24 indicated Wellbutrin SR Oral Tablet Extended Release 12-hour 150mg (Bupropion HCL), give 1 tablet by mouth two times a day for major depressive disorder. Start date 11/01/23. Discontinued 11/21/24. The MAR indicated other/see progress notes on 11/04/24, 6a (LVN N). Record review of Resident #17's progress notes dated 10/01/24-01/14/25 indicated: *10/13/24 at 9:16 a.m. by MA Z indicated, .Wellbutrin SR Oral Tablet Extended Release 12-hour 150mg .on order . *10/14/24 at 8:18 a.m. by MA Z indicated, .Wellbutrin SR Oral Tablet Extended Release 12-hour 150mg .on order . *11/04/24 at 12:17 p.m. by LVN N indicated, .Wellbutrin SR Oral Tablet Extended Release 12-hour 150mg . on order waiting for RX . During an interview on 01/15/25 at 1:58 p.m., LVN N said she had been at the facility for almost 4 years. She said she mostly worked on the secured unit. She said the MAs told the LVNs when a resident medication needed to be refilled. She said the facility had a pyxis machine (is an automated medication dispensing system) with emergency medications that staff could pull from if needed. She said the MAs should notify the nurses when the blister pack (is a form of tamper-evident packaging where an individual pushes individually sealed tablets through the foil in order to take the medication) only had pills in the blue section. She said the blue section on the blister pack normally indicated the resident only had 7 days of pills left. She said when the residents needed a refill, the MAs normally placed the medication label on a piece a paper to give to the nurses. She said then the nurse ordered the refill on the computer. She said if there were issues refilling the medication then she notified the ADON or DON. She said she did not remember Resident #17 missing doses of Wellbutrin in October 2024 and November 2024. She said the medication refill could have been delayed because of insurance or a medication change. She said the pharmacy company was fast refilling medications. She said once the order was placed, the pharmacy company delivered the medication the same day or the next day. She said Resident #17 could have experienced crying episodes or feeling anxious when she missed her doses. During an interview on 01/15/25 at 3:24 p.m., MA Z said she notified the nurses when a resident needed a medication refill. She said the blister pack had a section on the card, about 8 pills or so left, that prompted her to notify the nurse for a refill. She said when a medication needed a refill, she placed the medication label on a piece of paper and gave it to the nurse on duty. She said most medication refills took about 2-3 days to be delivered. She said she did not remember Resident #17 not getting her Wellbutrin in October 2024. She said when the resident missed doses of a medication, they would not get the desired effect of the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/15/25 at 4:27 p.m., the DON said the nurses ordered medications on the computer. She said she expected a medication to be ordered before the staff had to use the pills in the blue section on the blister pack. She said the pharmacy company delivered medications to the facility twice a day. She said the new admission medications were delivered sooner than routine or newly ordered medication. She said medication refills normally took 3 days to be delivered. She said which was why it was important to refill the medication sooner rather than later. She said the facility had a pyxis machine the nursing staff could pull medications from. She said it was important for medications to be refilled timely because the resident needed the medication and they are supposed to have it. She said Resident #17 not receiving her Wellbutrin could cause her to experience depression. During an interview on 01/15/25 at 6:00 p.m., the ADM said the nurses were responsible for ordering the resident's' medications. She said the nurse ordered the medication on the facility's electronic medical record system. She said the nurses should refill the medication when the blister pack had 10 days left of pills available. She said the medication blister pack had a section on the card that indicated when it was time for a refill. She said when a resident did not receive their medications, they could experience low level of the medication in their system. She said nursing management should be ensuring the nurses were ordering the resident's medications timely. Record review of a facility's Medication Administration policy dated 10/24/22 indicated .medications are administered by licensed nurses, or other staff who are legally authorized .as ordered by the physician and in accordance with professional standards of practice .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview, and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications (a medication used in excessive doses and including duplicate therapy or for excessive duration; or without adequate monitoring, or without adequate indications for its use; or in the presence of adverse consequences which indicated the dose should be reduced or discontinued) for 3 of 6 residents reviewed for unnecessary medications. (Resident #66, Resident #71, and Resident #78) The facility failed to ensure Resident #66 did not receive an antibiotic, Cephalexin 250mg BID for an UTI, without appropriate lab work. The facility failed to ensure Resident #71's antibiotic, Macrobid 100mg BID, was discontinued after her urine culture (checks urine for germs (microorganisms) that cause infections) results showed no organism growth. The facility failed to ensure Resident #78 did not receive antibiotics, Rocephin (Ceftriaxone) 2gm IM 1 time dose and Levaquin (Levofloxacin) 750mg one time a day for 7 days without an appropriate indication of use. These failures could place residents receiving antibiotics at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased antibiotic-resistant infections (happens when germs like bacteria and fungi develop the ability to defeat the drugs designed to kill them). Findings included: 1. Record review of Resident #66's face sheet dated 01/15/25 indicated Resident #66 was an [AGE] year-old female admitted to the facility on [DATE]. Resident #66 had diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), weakness and malaise (is a feeling of weakness, overall discomfort, illness, or simply not feeling well). Record review of Resident #66's significant change in status MDS assessment dated [DATE] indicated Resident #66 was sometimes understood and rarely/never understood others. Resident #66 was unable to complete a BIMS due to being rarely/never understood. Resident #66 had short- and long-term memory recall problems. Resident #66 was severely impaired of cognitive skills for daily decision making. Resident #66 had received an antibiotic during the last 7 days. Record review of Resident #66's care plan dated 03/31/22 indicated Resident #66 had recurrent UTIs. Intervention included follow facility policy for line listing, summarizing, and reporting infections. Record review of Resident #66's consolidated physician orders active as of 10/01/24 indicated Cephalexin Oral Tablet 250 mg, give 1 tablet by mouth two times a day for suspected UTI until 10/07/24. Start date 09/30/24. End date 10/07/24. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #66's MAR dated 10/01/24-10/31/24 indicated Cephalexin Oral Tablet 250 mg, give 1 tablet by mouth two times a day for suspected UTI until 10/07/24. Start date 09/30/24. Resident #66 received 14 of 14 doses. Record review of Resident #66's progress notes dated 10/01/24-01/15/25 indicated: *10/01/24 at 2:15 a.m. by LVN S indicated, .eating desserts and supplement .initiating Cephalexin 250mg bid for possible UTI . *10/04/24 at 1:13 p.m. by LVN K indicated, .appetite remains poor .Resident #66 appears to be in acute distress or discomfort .Continues Cephalexin 250mg r/t possible UTI per daughter . Record review of the facility's Infection Control Log dated September 2024 indicated Resident #66, onset date of 09/30/24, symptoms of UTI, no culture, Treatment of Cephalexin, date resolved 10/06. Record review of the facility's Consultant Pharmacist Report dated October 2024 indicated Resident #66, Cephalexin 250 mg BID for UTI, add culture and screen to chart when available. 2. Record review of Resident #71's face sheet dated 01/15/25 indicated Resident #71 was an [AGE] year-old female admitted to the facility on [DATE]. Resident #71 had diagnoses including Alzheimer's (is a brain disorder that gradually destroys memory and thinking skills), cerebral infarction (stroke), and senile degeneration of brain (is a general term for a group of neurological disorders that cause a decline in cognitive function). Record review of Resident #71's admission MDS assessment dated [DATE] indicated Resident #71 was understood and usually understood others. Resident #71 had a BIMS of 00 which indicated severe cognitive impairment. Resident #71 was always continent of urine and bowel. Record review of Resident #71's care plan dated 11/08/24 did not indicate a care plan problem for infections. Record review of Resident #71's consolidated physician order active as on 10/01/24 indicated Macrobid Oral Capsule 100mg (Nitrofurantoin Monohyd Macro), give 1 capsule by mouth two times a day for suspected UTI until 10/12/24. Start date 10/02/24. Record review of Resident #71's MAR dated 10/01/24-10/31/24 indicated Macrobid Oral Capsule 100mg (Nitrofurantoin Monohyd Macro), give 1 capsule by mouth two times a day for suspected UTI until 10/12/24. Start date 10/02/24. Resident #71 received 21 out of 21 doses. Record review of Resident #71's UA received on 10/01/24 indicated no pathogens detected. Record review of Resident #71's progress notes dated 10/01/24-01/15/25 indicated: *10/01/24 at 1:54 a.m. by LVN S indicated, .u.a. negative . *10/02/24 at 11:42 a.m. by LVN N indicated, .Hospice Nurse visited with resident [Resident #71] .N.O. received for Macrobid 100 mg capsule 1 cap PO 4 times daily x 5 days for suspected UTI .Lorazepam 0.5 mg tablet PO 1 tab every 4 hours PRN for anxiety . (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* 10/09/24 at 1:14 p.m. by LVN K indicated, .Day 8/10 Macrobid 100 mg po BID x10 days related to suspected UTI .no s/s of UTI apparent . Record review of Resident #71's antibiotic clinical review 10/09/24 indicated Resident #71's symptoms were first noted on 10/06/24, daughter suspected that resident had UTI because of behaviors during outing with family, including polyuria, requested UA , unable to collect urine due to dementia, antibiotics ordered by hospice for suspected UTI, potential urinary infection, community acquired, no catheter, no fever, no leukocytosis or labs incomplete, acute onset, new or increased burning pain on urination, frequency or urgency, new or increased incontinence, Macrobid 100mg bid x 10 days ordered. 3. Record review of Resident #78's face sheet dated 01/15/25 indicated Resident #78 was a 64-years-old male admitted to the facility on [DATE] and readmitted [DATE]. Resident #78 had diagnoses including paraplegia (the inability to voluntarily move the lower parts of the body), neuromuscular dysfunction of bladder (is a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition), artificial openings of urinary tract (is the body's system for producing and removing urine) status, and pressure ulcer (is a localized area of skin damage caused by prolonged pressure on the skin) of sacral, right and left buttock. Record review of Resident #78's quarterly MDS assessment dated [DATE] indicated Resident #78 was understood and understood others. Resident #78 had a BIMS of 15 which indicate intact cognition. Resident #78 had an indwelling catheter (is a thin, flexible tube that is inserted into the bladder to drain urine) and ostomy (is a surgical procedure that creates an opening in the body to allow waste to exit). Resident #78 had three stage 4 pressure ulcers (full thickness tissue loss with exposed bone, tendon, or muscle). Resident #78 had received antibiotics during the last 7 days. Record review of Resident #78's care plan revised 12/03/24 indicated Resident #78 was on long term prophylactic antibiotics for recurrent UTIs. Intervention included follow facility policy for line listing, summarizing, and reporting infections. Record review of Resident #78's consolidated physician order active as of 01/01/25 indicated: *Levaquin Oral tablet 750 mg (Levofloxacin), give 1 tablet by mouth one time a day for ID now for 7 days. *Ceftriaxone Sodium Injection Solution Reconstituted 2 gm, inject 2 grams intramuscularly one time only for preventative/fever for 1 day. Start date 12/22/24. Record Review of Resident #78's MAR dated 12/01/24-12/31/24 indicated: *Levaquin Oral tablet 750 mg (Levofloxacin), give 1 tablet by mouth one time a day for ID now for 7 days. Start date 12/23/24. Received 6 out of 7 doses. *Ceftriaxone Sodium Injection Solution Reconstituted 2 gm, inject 2 grams intramuscularly one time only for preventative/fever for 1 day. Start date 12/22/24. Received 1 of 1 dose. Record review of Resident #78's progress notes dated 10/01/24-01/15/25 indicated: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*12/22/24 at 4:01 a.m. by LVN AA indicated, .0200 resident [Resident #78] c/o being very cold, this CN [LVN AA] noted resident shaking profusely with numerous of blankets covering him .100.9 T .resident denies pain, discomfort or any other symptoms .prn Tylenol administered and effective with 98.0 temp noted at 0300 . NPBB notified .n.o. cbc (is a blood test that providers use to monitor or diagnose health conditions), cmp (is a blood test that measures the levels of various substances in your blood), and Rocephin 2gm IM x1 time only . *12/23/24 at 12:00 a.m. by author unknown indicated, .NP called on 12/22 with pt [Resident #78] having complaints of chills and fever .PT [Resident #78] was recently discharged from hospital with UTI admission however, he was treated for wound infection per hospital records .pt [Resident #78] urine in hospital was wnl with no concerns .told nurse this is most likely r/t his wound and nurse stated pt [Resident #78] wound did appear to have drainage .Pt [Resident #78] given IM Rocephin r/t fever/chills and Levaquin PO 750mg ordered for wound infection . *12/23/24 at 1:44 a.m. by LVN AA indicated, .d1 post Rocephin 2gm IM x1 time only r/t low grade fever chills . resident [Resident #78] afebrile with other vs wnl . *12/23/24 at 6:20 p.m. by LVN CC indicated, .new order noted to start Levaquin 750 mg 1 po qd x7 days for infection . *12/23/24 at 9:45 p.m. by LVN AA indicated, .d1 Levaquin 750mg po daily x 7days r/t preventative/post low grade fever . resident [Resident #78] afebrile with other vs wnl . *12/24/24 at 10:10 p.m. by LVN DD indicated, .resident [Resident #78] day 2 post cbc and cmp r/t low grade fever .Levaquin 750 for 7 days r/t preventative post low grade fever . *12/27/24 at 6:05 p.m. by LVN EE indicated, .Day 5/7 of Levaquin 750mg po qd x7 days for low grade fever/chills . Record review of Resident #78's lab results dated 12/23/24 indicated normal lab results related to percentage and amount of WBC (is a count of your total white blood cells (of all types).), Neutrophil (these are the first responders of white blood cells. They fight bacterial and fungal infections), Lymphocytes (are a type of white blood cell that fights viral infections and helps your immune system remember previous infections.), Eosinophils (white blood cells fight parasitic infections and cause allergic reactions), Basophils (are a type of white blood cell that releases histamine during allergic reactions and heparin, which prevents blood from clotting) and Monocytes (Monocytes are white blood cells that clean up cell debris during an infection) percentage slightly elevated (14.4% (4.0-12.0 reference range)) and Monocytes number slightly elevated (1.2 (0.1-1.1)). Record review of the facility's Infection Control Log Report dated December 2024 indicated Resident #78 had a UTI with a catheter, did not meet McGreers criteria (a set of guidelines for identifying infections in long-term care facilities), and Levaquin 750mg 1 po qd x 7 days. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/15/25 at 1:58 p.m., LVN N said the ADONs were responsible to ensure the residents only received antibiotic when needed. She said the resident's urinalysis with culture and sensitivity was important to know what to treat. She said if the resident had signs and symptoms of an UTI and refused a urinalysis, then antibiotics may have to be started. She said lab work was important because to treat the infection, you needed the right antibiotics to kill the bacteria and fix behaviors caused by the UTI. She said when the antibiotics were given without the known organism then the residents could develop MDROs. She said it could be considered an unnecessary medication. During an interview on 01/15/25 at 3:33 p.m., the ICP, ADON P, said she had been at the facility since 07/02/24. She said she was responsible for the antibiotic stewardship program. She said she was responsible for monitoring infections, ensuring the antibiotic stewardship program was followed, make sure the facility was clean, education on EBP and immunizations of staff and residents. She said the facility used the McGreers criteria to define and treat infections. She said the McGreers criteria for UTI treatment required certain symptoms, experiencing several of the symptoms, and positive cultures. She said the facility had a system that made a prepopulated form that indicated if McGreers criteria was met or not. She said the residents and the antibiotic orders were discussed during morning meeting with the IDT. She said some nursing management and NPs ordered lab work and antibiotics without an appropriate indication and unnecessarily. She said Resident #71's antibiotics should have stopped when the UA C/S result was negative. She said when families, like Resident #66's family member, requested antibiotics the facility staff and/or NP/MD should educate the family on antibiotic stewardship. She said Resident #78's infection was logged as an UTI not a wound infection on the December 2024 infection control log. She said Resident #78 received antibiotics without a culture and it did not meet McGreers criteria. She said all antibiotics ordered should have an indication for use. She said prescribing antibiotics without appropriate signs and symptoms and lab work placed the residents at risk for MDROs. During an interview on 01/15/25 at 4:27 p.m., the DON said the ICP was responsible for the antibiotic stewardship program. She said the ICP was responsible for ensuring antibiotics were appropriately prescribed and looked for lab work results. She said Resident #66 and Resident #71 prescribed antibiotics were unnecessary medications. She said if the McGreers criteria was not met then antibiotics treatment was appropriate. She said she spoke with NP BB about Resident #78's infection in December 2024. She said NP BB said she had not prescribed the antibiotic for an UTI but a possible wound infection. She said NP BB placed a note in Resident #78's chart today explaining what she was treating. She said Resident #78's antibiotic order should have been clear for what it was treating. She said the facility wanted to make sure the resident's treatment was for the right organism and received the benefits. During an interview on 01/15/25 at 6:00 p.m., the ADM said IDT and ICP were responsible in make sure the McGreer criteria was followed for ordering antibiotics. She said new antibiotics orders and the resident's chart were reviewed in the morning meeting. She said also during the morning meeting, staff were asked for things missing like labs. She said the antibiotic use was also discussed in QAPI. She said the resident could develop drug resistance organisms when antibiotics were prescribed without a good reason. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/16/25 at 2:13 p.m., NP BB said LVN AA called her about Resident #78 in December 2024. She said LVN AA reported Resident #78 had a fever and chills. She said Resident #78 thought it was an infection in his suprapubic catheter. She said she ordered Rocephin and Levaquin, CBC, and CMP. She said Resident #78 had recently returned from the hospital and they believed his suprapubic catheter was colonized. She said because the hospital felt his suprapubic catheter was colonized, she felt his pressure ulcers had a possible infection. She said when she told LVN AA it could be a wound infection, LVN AA said there was some drainage from his wounds. She said she ordered Levaquin because it was a broad-spectrum antibiotic. She said the broad-spectrum antibiotic could also treat an UTI, if Resident #78 indeed had one. She said she did not usually order wound culture for a possible infection. She said wound cultures were not picked up by the lab soon enough to prevent colonization. She said after 24 hours of the wound culture being drawn, it was colonized. She said she would only send a wound culture if an antibiotic was prescribed for a possible wound infection and it seemed like it was not working. She said Resident #78's CBC results looked okay. She said she did not know what diagnosis LVN AA put on the antibiotic orders. She said she thought LVN AA left the indication of use blank on the antibiotic order. She said she normally put her orders in herself except when she was on call. Record review of a facility's Infection Prevention and Control Program policy dated 05/13/23 indicated . Antibiotic Stewardship: a. An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program. b. Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program. c. The Infection Preventionist, with oversight from the Director of Nursing, serves as the leader of the antibiotic stewardship program. d. The Medical Director, consultant pharmacist, and laboratory manager will serve as resources for the antibiotic stewardship program . Record review of a facility's Antibiotic Stewardship Program policy dated 10/24/22 indicated .It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use . The program includes antibiotic use protocols and a system to monitor antibiotic use. a. Antibiotic use protocols: Laboratory testing shall be in accordance with current standards of practice. b. The facility uses the updated McGeer criteria to define infections. c. The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics. d. All prescriptions for antibiotics shall specify the dose, duration, and indication for use. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Whenever possible, narrow-spectrum antibiotics that are appropriate for the condition being treated shall be utilized. f. Monitoring antibiotic use: g. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made (e.g., antibiotic time-out) .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure each residents' drug regimen was free from unnecessary psychotropic drugs (without adequate behavior monitoring and diagnosis) for 3 (Resident # 17, Resident #23, and Resident #110) of 5 residents whose medications were reviewed. The facility failed to ensure Resident #17's behaviors were documented to justify her Wellbutrin (is a prescription medicine used to treat adults with a certain type of depression called major depressive disorder, and for the prevention of [NAME]-winter seasonal depression (seasonal affective disorder)) dosage increase on 11/22/24. The facility failed to ensure Resident #23 had behavior and side effect monitoring for her prescribed anticonvulsant, Depakote. The facility failed to ensure Resident #110 had side effect monitoring for her prescribed Trazadone. These failures could place residents at risk of not receiving the intended therapeutic benefits of their psychotropic medications and unnecessary medication use. Findings included: Record review of Resident #17's face sheet dated 01/13/25 indicated Resident #17 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #17 had diagnoses including dementia (is the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), anxiety (are mental health conditions that cause excessive and uncontrollable fear or worry), major depressive disorder (is a mood disorder that causes a persistent feeling of sadness and loss of interest), and cognitive communication deficit (is a difficulty with communication caused by an impairment in cognitive processes). Record review of Resident #17's quarterly MDS assessment dated [DATE] indicated Resident #17 understood and understood others. Resident #17 had a BIMS of 09 which indicated moderate cognitive impairment. Resident #17 experienced verbal behavioral symptoms directed toward others that occurred one to three days a week. Resident #17 experience other behavioral symptoms not directed toward others that occurred four to six days, but less than daily. Resident #17 rejected evaluation or care occurred four to six days, but less than daily. Resident #17 received an antidepressant during the last 7 days of the assessment period. Record review of Resident #17's care plan dated 09/08/23 indicated Resident #17 used antidepressant medication Wellbutrin related to depression. Intervention included administer antidepressant medication as ordered by physician. And monitor/document side effects and effectiveness every shift. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #17's consolidated physician order active as of 01/13/25 indicated Wellbutrin SR Oral Tablet Extended Release 12-hour, 200 mg (Bupropion HCL), give 1 tablet by mouth every 12 hours for depression. Start date 11/22/24. Record review of Resident #17's MAR dated 11/01/24-11/30/24 indicated: *Wellbutrin SR Oral Tablet Extended Release 12-hour, 150 mg (Bupropion HCL), give 1 tablet by mouth two times a day for major depressive disorder. Start date 11/01/23. Discontinued 11/21/24. Resident #17 received 40 out of 41 doses. *Wellbutrin SR Oral Tablet Extended Release 12-hour, 200 mg (Bupropion HCL), give 1 tablet by mouth every 12 hours for depression. Start date 11/22/24. Resident #17 received 18 out of 18 doses. *Behavior Monitoring-Antidepressants Behavior Code: 0. None. Interventions: Document in Progress Note every shift. Start date 06/02/23. Resident #17 had '0. None' document 60 out of 60 shifts. Record review of Resident #17's progress notes dated 11/01/24-11/21/24 did not indicated any behaviors related to depression. Record review of Resident #17's progress notes dated 10/01/24-01/14/25 indicated: *11/22/24 at 10:34 p.m. by RN T, indicated .Day 1 Wellbutrin SR increased to 200mg po bid .resident [Resident #17] tolerating well . *12/10/24 at 12:00 p.m. by NP BB indicated, .Pt [Resident #17] is seen in her room in the memory care unit for monthly visit and eval of depression .has had some increase sadness since moving to the memory care unit and her dementia increasing .Wellbutrin was increased to help with s/s of sadness and tearfulness .staff report pt [Resident #17] has had some improvement since increasing Wellbutrin . Record review of Resident #23's face sheet dated 01/13/25 indicated Resident #23 was an [AGE] year-old female admitted to the facility on [DATE]. Resident #23 had diagnoses including dementia (is a general term for a decline in mental abilities that affects a person's ability to perform everyday activities), anxiety disorder (involve repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes (panic attacks)), and insomnia (is a sleep disorder that makes it difficult to fall or stay asleep). Record review of Resident #23's quarterly MDS assessment dated [DATE] indicated Resident #23 was usually understood and usually understood others. Resident #23 had a BIMS of 01 which indicated severe cognitive impairment. Resident #23 had verbal behavior symptoms directed toward others and other behavioral symptoms not directed toward others that occurred 1 to 3 days. Resident #23 behavioral symptoms significantly interfered with the resident's care and with the resident's participation in activities or social interactions. Resident #23 received antianxiety, antidepressant, and anticonvulsant during the last 7 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #23's care plan dated 08/17/24 indicated Resident #23 had potential to be verbally aggressive (yelling out and to staff) related to dementia, ineffective coping skills, and poor impulse control. Intervention included administer medications as ordered. Monitor/document for side effects and effectiveness. Record review of Resident #23's consolidated physician order active as of 11/01/24 indicated: *Behavior monitoring- Antianxiety [Buspirone, Ativan], Behavior Code: 0. None, Intervention(s): Document in Progress Notes every shift for behaviors. Start date 11/28/23. *Behavior Monitoring-Antidepressants [Fluoxetine] Behavior Code: 0. None, Intervention(s): Document in Progress Notes every shift for behaviors. Start date 11/28/23. *Behavior Monitoring- Antipsychotic Behavior Code: 0. None, Intervention(s): Document in Progress Notes every shift for behaviors. Start date 05/27/24. *Side Effect Monitoring- Antianxiety [Buspirone] Side Effect Codes: 0. None, every shift for S/E Monitoring. Start date 11/28/23. *Side Effect Monitoring- Antidepressants [Fluoxetine] Side Effect Codes: 0. None, every shift. Start date 11/28/23. *Side Effect Monitoring- Antipsychotic Side Effect Codes: 0. None, every shift. Start date 05/27/24. *Side Effect Monitoring- Opioid Medication Side Effect Codes: 0. None, every shift. Start date 12/26/24. *Depakote Oral Tablet Delayed Release 250mg (Divalproex Sodium), give 3 tablets by mouth in the evening for agitation/anxiety. Start date 10/22/24. * Depakote Oral Tablet Delayed Release 500mg (Divalproex Sodium), give 1 tablet by mouth one time a day for agitation/anxiety. Start date 10/23/24. Resident #23's consolidated physician order did not indicate behavior or side effect monitoring for anticonvulsant. Record review of Resident #23 consolidated physician order active as of 01/14/25 indicated Depakote Sprinkles Oral Capsule Delayed Release, 125 mg, give 6 capsules by mouth two times a day related to dementia. Start date 12/30/24. Resident #23's consolidated physician order did not indicate behavior or side effect monitoring for anticonvulsant. Record review of Resident #23's MAR dated 11/01/24-11/30/24 indicated: *Behavior monitoring- Antianxiety [Buspirone, Ativan], Behavior Code: 0. None, Intervention(s): Document in Progress Notes every shift for behaviors. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longview Hill Nursing and Rehabilitation Center	3201 N Fourth St Longview, TX 75605

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Behavior Monitoring-Antidepressants [Fluoxetine] Behavior Code: 0. None, Intervention(s): Document in Progress Notes every shift for behaviors. Start date 11/28/23. *Behavior Monitoring- Antipsychotic Behavior Code: 0. None, Intervention(s): Document in Progress Notes every shift for behaviors. Start date 05/27/24. *Side Effect Monitoring- Antianxiety [Buspirone] Side Effect Codes: 0. None, every shift for S/E Monitoring. Start date 11/28/23. *Side Effect Monitoring- Antidepressants [Fluoxetine] Side Effect Codes: 0. None, every shift. Start date 11/28/23. *Side Effect Monitoring- Antipsychotic Side Effect Codes: 0. None, every shift. Start date 05/27/24. *Side Effect Monitoring- Opioid Medication Side Effect Codes: 0. None, every shift. Start date 12/26/24. *Depakote Oral Tablet Delayed Release 250mg (Divalproex Sodium), give 3 tablets by mouth in the evening for agitation/anxiety. Start date 10/22/24. Resident #23 received 30 of 30 doses. * Depakote Oral Tablet Delayed Release 500mg (Divalproex Sodium), give 1 tablet by mouth one time a day for agitation/anxiety. Start date 10/23/24. Resident #23 received 30 of 30 doses. Resident #23's MAR did not indicate behavior or side effect monitoring for an anticonvulsant. Record review of Resident #23's MAR dated 12/01/24-12/31/24 indicated: *Behavior monitoring- Antianxiety [Buspirone, Ativan], Behavior Code: 0. None, Intervention(s): Document in Progress Notes every shift for behaviors. Start date 11/28/23. *Behavior Monitoring-Antidepressants [Fluoxetine] Behavior Code: 0. None, Intervention(s): Document in Progress Notes every shift for behaviors. Start date 11/28/23. *Behavior Monitoring- Antipsychotic Behavior Code: 0. None, Intervention(s): Document in Progress Notes every shift for behaviors. Start date 05/27/24. *Side Effect Monitoring- Antianxiety [Buspirone] Side Effect Codes: 0. None, every shift for S/E Monitoring. Start date 11/28/23. *Side Effect Monitoring- Antidepressants [Fluoxetine] Side Effect Codes: 0. None, every shift. Start date 11/28/23. *Side Effect Monitoring- Antipsychotic Side Effect Codes: 0. None, every shift. Start date 05/27/24. *Side Effect Monitoring- Opioid Medication Side Effect Codes: 0. None, every shift. Start date 12/26/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Depakote Oral Tablet Delayed Release 250mg (Divalproex Sodium), give 3 tablets by mouth in the evening for agitation/anxiety. Start date 10/22/24. Resident #23 received 18 out of 18 doses. * Depakote Oral Tablet Delayed Release 500mg (Divalproex Sodium), give 1 tablet by mouth one time a day for agitation/anxiety. Start date 10/23/24. Resident #23 received 16 out of 16 doses. * Depakote Sprinkles Oral Capsule Delayed Release, 125 mg, give 6 capsules by mouth at bedtime for agitation/anxiety. Start date 12/16/24. Discontinued date 12/30/24. Resident #23 received 13 out of 14 doses. * Depakote Sprinkles Oral Capsule Delayed Release, 125 mg, give 6 capsules by mouth two times a day related to dementia. Start date 12/30/24. Received 2 out of 2 doses. Resident #23's consolidated physician order did not indicate behavior or side effect monitoring for anticonvulsant. Record review of Resident #110's face sheet dated 01/13/25 indicated Resident #110 was an 83-years-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #110 had diagnoses including cerebral infarction (is a type of stroke that occurs when brain tissue dies due to a lack of blood flow), dementia (a decline in mental abilities that affects a person's ability to perform everyday activities), insomnia ((is a sleep disorder that makes it difficult to fall or stay asleep)) and anxiety disorder (involve repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes (panic attacks)). Record review of Resident #110's significant change in status MDS assessment dated [DATE] indicated Resident #110 was understood and understood others. Resident #110 had a BIMS of 04 which indicated severe cognitive impairment. Resident #110 received an antidepressant during the last 7 days of the assessment period. Record review of Resident #110's care plan dated 12/27/24 did not indicate the use of an antidepressant for insomnia. Record review of Resident #1110 consolidated physician order active as on 01/13/25 indicated: *Trazodone HCL Oral Tablet, 50mg, give 1 tablet by mouth at bedtime for insomnia. Start date 12/08/24. *Behavior Monitoring- Antidepressants. Start date 11/22/24. *Behavior Monitoring- Sedative/Hypnotics. Start date 11/22/24. *Side Effect Monitoring- Antianxiety, two times a day related to anxiety disorder. Start date 08/14/24. No side effect monitoring for antidepressant indicated on Resident #110's consolidated physician order. Record review of Resident #110's MAR dated 01/01/25-01/31/25 indicated: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Trazodone HCL Oral Tablet, 50mg, give 1 tablet by mouth at bedtime for insomnia. Start date 12/08/24. Resident #110 received 14 of 14 doses. *Behavior Monitoring- Antidepressants. Start date 11/22/24. *Behavior Monitoring- Sedative/Hypnotics. Start date 11/22/24. *Side Effect Monitoring- Antianxiety, two times a day related to anxiety disorder. Start date 08/14/24. No side effect monitoring for antidepressant indicated on Resident #110's MAR. During an interview on 01/15/25 at 1:58 p.m., LVN N said the nurses were responsible for ordering and documenting behavior and side effect monitoring. She said the behavior and side effect monitoring was documented on the resident's' MAR. She said resident's' behaviors should be documented in the progress notes and if the behavior improved after medication or interventions. She said the nurses should document if the behavior improved after the interventions, so the resident's' medication dose did not get increased. She said the behavior and side effect monitoring for Resident #23 should be for an antianxiety medication. She said Resident #23 was receiving the medication for yelling. She said the nurses should document the resident's' behaviors on the MAR and progress notes to verify the need of the medication. During an interview on 01/15/25 at 4:27 p.m., the DON said the nurses were responsible for ordering and documenting the behavior and side effect monitoring. She said the medication would need to be monitored based on the diagnosis the medication was treating. She said the nurse should assign the behavior and side effect monitoring based on what it was treating. She said Resident #23's Depakote documented it was related to the diagnosis of dementia. She said Depakote was an anticonvulsant. She said the resident's behaviors should be documented on the progress notes and behavior monitoring. She said the behavior and side effect monitoring and progress notes helped the provider know if the medication needed to increase or decreased. She said the resident could get medication they needed, decreased if the medical record did not show behaviors. She said if the resident's medication was increased without sufficient documentation than it could appear it was done without reason. During an interview on 01/15/25 at 6:00 p.m., the ADM said she expected the residents' psychotropic medications to have behavior and side effect monitoring. She said she expected the nursing staff to document behaviors and the interventions used to manage the behaviors. She said the nurses were responsible for ordering and documenting the behavior and side effect monitoring. She said the nursing management should make sure it was done. During an interview on 01/16/25 at 2:13 p.m., the NP BB said Resident #17's Wellbutrin was increased because of episodes of being upset. She said Resident #17 was experiencing confusion about her family not visiting and looking for them. She said Resident #17 was getting depressed due to the confusion and being placed on the secured unit. She said when she increased and added medications, she reviewed the nurse notes and spoke with nursing staff about the resident. She said sometimes resident's behaviors were not adequately documented. She said the medication change could appear unnecessary from lack of documentation. She said she would like for the nursing staff to document the resident's behaviors more. She said it did help she was at the facility every day and could lay eyes on the residents herself. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility's Psychotropic Medication policy dated 08/15/22 indicated .Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s) . Psychotropic drugs include, but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics . The indications for initiating, withdrawing, or withholding medications(s), as well as the use of non-pharmacological approaches, will be determined by .Assessing the resident's underlying condition, current signs, symptoms, expressions, and preferences and goals for treatment . Identification of underlying causes (when possible) . The resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observation, record review and interview the facility failed to store all drugs and biologicals in locked compartments for 1 of 9 med carts and 2 of 36 Residents (Resident #10, Resident # 39) reviewed for medication storage. 1.The facility failed to securely store prescription medication Nystop powder 100,000 units and Venelex 60-gram ointment for Resident #10. 2. The facility failed to keep medication being administered under the direct observation of the person administering medications. Resident #39 had a medication cup, with approximately 10 medications in pill form in it, sitting on his bedside table. 3. The facility failed to ensure CMA J secured the medication cart for Hall 200. These failures could place residents at risk for health complications and not having received the intended therapeutic benefit of their medications and adverse reaction. Findings included: 1.Record review of the face sheet dated 1/15/2025 indicated Resident #10 was [AGE] years old and was readmitted on [DATE] with diagnoses including Cerebral Palsy (a congenital disorder of movement , muscle tone or posture), muscle wasting and atrophy (a reduction of muscle mass and strength, leading to decreased muscle function), morbid obesity (a disorder that involves having too much body fat, which increases the risk of health problems) , and diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Record review of physician's orders dated 1/13/2025 for Resident #10 did not indicate an order for Nystop powder. There was an order dated 11/14/2024 for Venelex external ointment to be applied to bottom topically two times a day for barrier. Record review of the quarterly MDS dated [DATE] indicated Resident #10 was understood and understood others. The MDS indicated a BIMS score of 14 indicating Resident #10 was cognitively intact. Record review of a care plan revised on 4/23/2024 indicated Resident #10 was at risk for impaired skin integrity related to immobility, bowel incontinence and paraplegia. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 1/13/2025 at 2:14 p.m., Resident #10 was sitting up in bed. Resident #10 said he had a wound on his bottom and reported there were CNA's who would not apply his powder to his bottom. Resident #10 said he had been trying to get another mattress. Resident #10 said the powder the CNA applies to his bottom was in the top dresser drawer. There was a bottle of Nystop powder 100,000 Units with no label identifying resident information. There was a red and white tube labeled with Resident #10 identifying information located on his bookshelf where he kept additional food. The white and red tube had a red piece of tape over the lid and was not opened. The resident said he returned from the hospital with the medication. The resident did not have a roommate. During an observation on 1/14/2025 at 2:53 p.m., CNA D and LVN G assisted Resident #10 from wheelchair to bed using the Hoyer lift for his skin assessment. Observed dry skin to bilateral buttock and scattered excoriation that were scabbed over. Resident #10 received a bed bath and LVN applied the Venelex ointment she had prepared from her medication cart. Observed Venelex ointment on the bookshelf during observation of care . During an interview on 1/15/2025 at 11:34 a.m., CMA B said she did not know if residents were allowed to have prescription ointments or creams in their room. During an interview on 1/15/2025 at 2:28 p.m., CNA D said residents were not allowed to have prescription ointments or medications in their room. She said she would report medication or ointments to the charge nurse if identified. During an interview on 1/15/2025 at 2:42 p.m., CNA E said CNA's were able to apply barrier cream to residents, but the nurse applies ointments. CNA E said she had never observed medications in resident rooms. CNA E said residents were not allowed to have powders or ointments in their room and should be stored in the supply room. She said she would report identified medications to the nurse. During an interview on 1/15/2025 at 2:48 p.m., LVN G said medications were not to be stored in a resident's room. She said the residents should not have prescription ointments, creams, or powders. LVN G said the aides have one use packets of barrier cream they could apply to a resident's skin. LVN G said medicated ointments are stored on the medication cart. LVN G said the CNA and/or nurses should remove medications from a resident's room if identified. She said a resident with dementia could eat or apply the medication incorrectly that could make them sick. LVN G said the nurses were responsible for ensuring medications were securely stored. During an interview on 1/15/2024 at 3:30 p.m., LVN F said Venelex was used as a barrier ointment and was considered a medication. LVN F said medicated ointments and powders were not to be stored in a resident room. She said the ointments and powders should be stored on the medication cart or the treatment cart. LVN F said all staff should ensure medications are stored properly. LVN F said aides should not be applying medication to skin or bottom. LVN F said Resident #10 did not have an order for Nystop powder. She said Nystop could dry out the skin and cause irritation. LVN F said the nurses are responsible for ensuring residents returning from the hospital have all medication accounted for and stored properly. LVN F said another resident could get the medication and have a reaction. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/2025 at 4:09 p.m., ADON H said medications should not be stored in a resident's room. She said the nurses were responsible for ensuring medications were locked up. ADON H said Venelex and Nystop were considered a medication. She said these medications should be locked up at all times and away from those not authorized to be in contact with those medications. ADON H said CNAs should not administer ointments or powders that were prescription. ADON H said Resident #10 did not have an order for Nystop powder. ADON H said the Nystop powder could cake up on a resident skin and dry out the skin. ADON H said a resident's skin could break down if too dry. During an interview on 1/15/2025 at 5:50 p.m., the DON said she expected nurses to remove medications and identify new medications when returning from the hospital. The DON said Venelex and Nystop should not be stored in a resident's room and should be stored on the medication cart or medication storage. The DON said the medication has the potential to cause an adverse reaction if the medication got in the wrong hands. The DON said the nurses were responsible for ensuring medications were stored properly and secure. During an interview on 1/15/2025 at 6:07 p.m., the ADM said she expected the nurses to keep prescribed medications stored in medication cart or storage. She said she expected the staff to identify if a resident has medications in their room and return it to the nurse's station. The ADM said a wondering resident could take something that was not theirs. The ADM said she did not know what could happen and depended on what medication it was. 2. Record review of Resident #39's face sheet, dated 10/2/13, indicated he was an [AGE] year-old male, admitted to the facility on [DATE], and readmitted most recently on 05/31/24. His diagnoses included major depressive disorder (A mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (Mental health conditions that cause excessive and uncontrollable feelings of fear or worry), Paraplegia (Paralysis that affects all or part of the trunk, legs, and pelvic organs). Record review of Resident #39's Quarterly MDS assessment, dated 01/1/25, indicated he had a BIMS score of 15, which indicated intact cognition. The MDS further indicated he was paraplegic. Resident #39 required assistance with most activities of daily living. Record review of Resident #39's care plan indicated that a problem initiated on 11/18/2020 shows that Resident #39 uses a psychotropic medication. Staff are to, Monitor/document/report PRN any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. During an interview and observation on 01/13/25 at 10:18 a.m. Resident #39 was observed with a paper cup on his bedside table with approximately 10 medications in pill form. He said that staff had entered the room and left the medication there and he just forgot to take them. Resident #39 said he will take the medication as he forgot to take it when the aide was in the room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/15/25 at 9:04 a.m., CMA B said it was the facility policy that staff were to administer medications to residents and that staff were not to leave medication in their rooms. She said that if a resident did not take their medication, then she would have taken the medication and inform the nurse on duty. She said there was a risk that a resident who was not prescribed the medication would take the medication if it was left unattended. During an interview on 1/15/25 at 2:52 p.m., the Director of Nurses said that it was the facility policy that residents are not to have their medications left with them unsupervised. She said it was the responsibility of whomever was passing medications out to ensure the resident either took the medications or refused them so that person could then remove the medications. She said that residents could be placed at risk for taking someone else's medication by mistake. During an interview on 1/15/25 at 3:53 p.m., the Administrator said staff are to make sure residents swallow their medications and if they refuse to take them then staff are directed to take the medication back. She said residents could be placed at risk of not receiving their daily dose of medication and other residents could take medications that was not theirs. 3. During an observation and interview on 1/14/2025 at 3:57 p.m., the 200-hall nurse medication cart was left unlocked and unattended. There were no staff present at the medication cart. Observed CMA J returning down Hall 200 toward the nurse's station from room [ROOM NUMBER] B. CMA J said she was getting another resident ice and she did not know why her medication cart was unlocked. CMA J said she was the only staff with the key to her medication cart. CMA J said her medication cart should not be left unlocked and unattended. CMA J said a visitor, or another resident could get in her medication cart and take medication not prescribed to them. She said they could overdose or have an adverse reaction. CMA J said nurses and CMAs were responsible for keeping medication carts locked. During an interview on 1/15/2025 at 2:48 p.m., LVN G said medication carts should never be unlocked unless the nurse or medication aid was using it. LVN G said the staff should never leave a medication cart unlocked and unattended. She said a resident or visitor could get in the medications and take them. She said the cart has needles and scissors on the cart that could be harmful. LVN G said the nurses or medication aides were responsible for ensuring the medication carts are locked. During an interview on 1/15/2025 at 4:09 p.m., ADON H said nurses and medication aides should never leave an unattended unlocked medication cart. She said the nurse or medication aide must be standing in front of the cart and pulling medications. She said a resident, visitor or child could get in the medication cart and take medication that was not prescribed to them. ADON H said if a resident, visitor, or child took medication, it could cause death or make them sick. ADON H said the nurse or medication aide was responsible for ensuring their medication carts were locked. During an interview on 1/15/2025 at 5:50 p.m., the DON said she medication carts should be unlocked only when the nurse or medication aide was right next to the cart. She said the cart should only be unlocked when accessing to pass medications. The DON said a drug diversion could occur. The DON said a resident or visitor could have an adverse reaction if they took a medication not prescribed to them. The DON said the nurse or medication aide was responsible for keeping their cart locked. The DON said she expected the nurse and medication aide to keep their medication cart locked when not in use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/2025 at 6:07 p.m., the ADM said she expected the nurse to keep the medication cart always locked unless the nurse was at the cart. The ADM said someone could take medications that were not prescribed to them or steal medications from the medication cart. The ADM said it depended on what was taken and what the warnings were on the package. She said there was potential for minimal harm or severe if someone took medication not prescribed to them. Review of a Storage of Medication and disposal titled Bedside Medication Storage policy revised on 10/1/2019 indicated, Bedside medication storage is permitted for residents who wish to self-administer medications, upon the written order of the prescriber and once self-administration skills have been assess and deemed appropriate . Procedure .1. A written order for the bedside storage of medication is present in the resident's medical record .2. Bedside storage of medication is indicated on the resident medication administration record and care plan .3. For residents who self-administer medications .A. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required .B. The medication provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy or in the original container .6. All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage . Record review of facility policy Medication Administration, dated 10/24/22 indicated that, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection Observe resident consumption of medication. Review of a facility policy revised 10/1/2019 titled Medication carts and supplies for administering meds indicated The facility maintains equipment and supplies necessary for the preparation and administration of medications to residents. Med Carts .1. Only licensed nurse or certified medical aide may carry keys to the medication cart. 2. The medication cart is locked at all times when not in use.3. Do not leave the medication cart unlocked or unattended in the resident care areas . 45643

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	455684	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longview Hill Nursing and Rehabilitation Center	3201 N Fourth St Longview, TX 75605

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47612 Based on observation, interview, and record review, the facility failed to provide food that was palatable and served at an appetizing temperature for 7 of 28 residents (Resident's #10, #13, #17, #34, # 60, # 86 and #101) reviewed for palatable food. The facility failed to provide palatable food served at an appetizing temperature or taste to Resident #10, Resident #13, Resident #34, Resident #60, Resident #86 and Resident #101, who complained the food was bland, and did not taste good. This failure could place residents who ate food from the kitchen at risk of weight loss, altered nutritional status, and diminished quality of life. The findings included: During an interview on 01/13/2025 at 10:54 a.m., Resident #34 stated the food was terrible, no taste at all. During an interview on at 01/13/2025 11:08 a.m., Resident #60 stated the food was not good, it had no flavor. During an interview on 01/13/25 at 11:15 a.m., Resident #17 said the flavor and temperature of the food was not good sometimes. During an interview on 01/13/2025 at 11:16 a.m., Resident #86 stated the food was horrible, very bland. During an interview on 01/13/2025 at 11:27 a.m., Resident # 13 stated the food was not good. Resident # 13 stated they was served a lot of baked fish or chicken and plain white rice which was not good. During an interview on 01/13/2025 at 2:14 p.m., Resident # 10 stated the food was terrible. During an interview on 01/13/2025 at 2:50 p.m., Resident # 101 stated he did not like the food. During an observation and interview on 01/14/2025 at 1:25 p.m., a lunch tray was sampled by Dietary Manager and six surveyors. The sample tray consisted of beef stew, which was bland but hot, mashed potatoes which was bland but warm, and carrot cake that was bland. Mixed green salad was cool and crisp. Baked apple slices were cold but flavorful. The Dietary Manager agreed that the food were bland, and stated the baked apple slices was supposed to be warm not cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/14/2025 at 10:15 a.m., the Dietician stated she was aware of a few food complaints. The Dietician stated she had a test tray this month. The Dietician stated dietary staff were responsible for ensuring the residents received food that was palatable and the appropriate temperature. The Dietician stated it's the cook's responsibility to prepare the meals and ensure that it's the correct temperature, however it's the Dietary Manager's responsibility to follow up to ensure the temperatures were correct. The Dietician stated it was important for the residents to receive food that was palatable and the appropriate temperature for their overall wellbeing and nutritional status. During an interview on 01/14/2025 at 11:00 a.m., the Dietary Manager stated all the dietary staff were responsible for making sure the food was palatable, attractive and the correct temperature. The Dietary Manager stated it was important because nobody wanted to eat hot food cold or cold food hot. The Dietary Manager stated if the food did not look and taste appetizing the residents would not eat it. The Dietary Manager stated the cooks were supposed to taste the food prior to serving it to the residents. The Dietary Manager stated she had food complaints in the past. The Dietary Manager stated it was important for the food to be palatable, attractive and the correct temperature so the residents would not have weight loss. During an interview on 01/15/2025 at 10:15 a.m., [NAME] W stated she had never had any food complaints. [NAME] W stated she tried to taste the food to ensure it was seasoned correctly [NAME] W stated the was bland, but the resident had salt and pepper packs on their trays. [NAME] W stated it was important for the meals to be appetizing, attracting and the correct temperature because otherwise the residents would not want to eat it. During an interview on 01/15/2025 at 3:15 p.m., the Administrator stated residents had complained about the taste of the food or the food being cold. The Administrator stated the kitchen staff were responsible for ensuring the food was good, and when the food left the kitchen, it was all the facility's staff responsibility to ensure the residents had food that tasted good and was the correct temperature. The Administrator stated management did rounds daily with the residents to see if the residents had any food complaints and to monitor the food complaints. The Administrator stated she had not had any problems with test trays. The Administrator stated she had a test tray almost every day. The Administrator stated it was important for the meals to be palatable, attractive, and the correct temperature for the resident's health and their weight and because food was an important part of the residents' lives. Record review of the policy Test Tray was asked for but not received. 44933

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. The facility failed to ensure: 1. Food items were sealed and dated. 2. Hair restraints were worn appropriately by dietary staff. These failures could place residents at risk for foodborne illness. Findings included: During an initial tour observation in the kitchen on [DATE] at 9:30 a.m. there were 2 undated containers of instant mashed potatoes in the dry storage, 1 unsealed box of biscuit in the freezer. During an observation in the kitchen on [DATE] at 9:40 a.m., [NAME] W was not wearing a hair restraint appropriately while preparing the lunch meal. [NAME] W's hair was visible outside of the hairnet in the back approximately four inches. During an observation in the kitchen on [DATE] at 11:15 a.m., [NAME] W was not wearing a hair restraint appropriately while preparing the lunch meal. [NAME] W's hair was visible outside of the hairnet in the back approximately four inches. During an interview on [DATE] at 10:15 a.m., the Dietician stated she expected food items to be labeled and dated when received. The Dietitian stated she expected food items to be sealed in the freezer. The Dietitian stated she expected hair nets to be worn properly while in the kitchen. The Dietitian stated if she noticed an issue in her sanitation audit, she had an in-serviced. The Dietitian stated there was a daily and weekly cleaning schedule that each staff member should have signed off prior to completing their shift. The Dietitian stated the Administrator was responsible for monitoring and overseeing in between. The Dietitian stated these failures mentioned above put residents at risk for food contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 1:20 p.m., [NAME] W stated food in the dry storage, refrigerator and freezer should be labeled with the expiration date. [NAME] W stated all food items should have a received date and an open date. [NAME] W stated the person who put an item in the dry storage, refrigerator, or the freezer should make sure it was labeled correctly, and the person that opened an item was responsible for putting an open date on the food item. [NAME] W stated food in the freezer should be sealed. [NAME] W stated she did not know why food items in the dry storage and freezer were not dated and not sealed. [NAME] W stated it was important for food items to be labeled, and sealed, so the residents would not get sick because bacteria could grow on the food if it was expired. [NAME] W stated she did not realize her hair was not covered. [NAME] W stated it was important to keep the hair cover, so it does not fall in the food. [NAME] stated the harm to the resident was they could get sick from germs. During an interview on [DATE] at 1:51 PM, the Dietary Manager stated all food items should have a receive date, open date, and if a box was opened it needed to be sealed and dated. The Dietary Manager stated she was responsible for making sure everything was labeled and stored correctly. The Dietary Manager stated she went through the refrigerator and freezer and did a walkthrough weekly to make sure everything was labeled and stored correctly, and food items were discarded and to check for cleanliness. The Dietary Manager stated she did trainings weekly to educate staff on labeling food items. The Dietary Manager stated it was important to label and store food items correctly and for the kitchen to be clean so the residents would not get sick. The Dietary Manager stated the cook should have all of her hair covered. The Dietary Manager stated it was important for to keep hair from getting in the food. The Dietary Manager stated the residents may not want to eat if they find hair in the food and could lose weight. During an interview on [DATE] at 3:15 p.m., the Administrator stated she did random walkthroughs of the kitchen twice a week sometimes more depending on the week. The Administrator stated the Dietary Manager was responsible for ensuring hairnet were worn correctly, food items were labeled, dated, stored properly and for cleanliness of the kitchen. The Administrator stated it was important for hairnets to be worn correctly, the food items to be labeled, dated, stored properly and for the kitchen to be clean so the residents did not get sick, and it was required by the state of Texas. Record review of the facility's policy titled, Food Storage, dated [DATE] indicated, All containers must be labeled and dated Store frozen foods in moisture-proof wrap or containers that are labeled and dated Record review of the facility's policy titled, Employee Sanitation, dated [DATE] indicated, .Hairnets, headband, caps, beard coverings or other effective hair restraints must be worn to keep hair from food and food-contact surfaces .

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643 Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 1 of 12 resident personal refrigerators reviewed for food safety (Resident #61). The facility failed to ensure the refrigerator for Resident #61 did not contain spoiled milk and the surfaces were clean. This failure could place resident at risk for food borne illnesses. Findings included: Record review of a face sheet dated 01/25/22 indicated Resident #61 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses including Paranoid Schizophrenia (A person believes something that is not real is real. For example, they may believe that people are trying to harm them), Dysphagia (Difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage), and Dementia (a general term for a group of neurological conditions that affect the brain and cause a decline in mental abilities). Record review of the MDS dated [DATE] indicated Resident #61 understood others and made himself understood. The MDS indicated Resident #61 had severe cognition impairment with a BIMS score of 07. Record review of a care plan for Resident #61 revealed Resident #61 had a problem initiated on 8/7/21 in which he has a communication problem regarding pressured speech at times. During an interview and observation on 1/13/25 at 10:27 a.m., Resident #61's personal refrigerator interior was covered in a dark substance and there was a glass of milk growing a white fuzzy substance . Resident #61 said no one cleans his refrigerator out. Resident #61 said that he drinks and eats from his refrigerator. He said that eating the food from his refrigerator has made him shit himself. During an observation on 1/15/2025 at 8:59 a.m., Resident #61's personal refrigerator was still covered in a dark substance and the cup of spoiled milk had not been thrown out. During an interview on 01/15/25 at 9:05 a.m., CNA C said sometimes she will throw things out from residents' refrigerators. She said she had never cleaned Resident #61's refrigerator out. She said that residents could be at risk for foodborne illness if they drink or eat bad food. During an interview on 1/15/25 at 2:49 p.m., the Director of Nurses said staff are required to check on residents' personal refrigerators. She said that if staff find that a resident's refrigerator was dirty or had spoiled food, they would clean out the refrigerator and throw out the spoiled food. She said that a resident would be placed at risk for foodborne illness if they consume spoiled food. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 3:53 p.m., the Administrator said department heads should complete Angel Rounds which were rounds that the staff look for problems in the residents' rooms. She said as part of these rounds staff should check refrigerators and ensure that they were clean and spoiled food was thrown out. She said residents who eat spoiled food would be at risk for foodborne illness. Record review of a facility policy dated, 7/3/23, titled, Resident Refrigerators revealed that, This facility does not provide a refrigerator in a resident's room. However, it is the policy of this facility to ensure safe and sanitary use of any resident-owned refrigerators Staff shall clean the refrigerator weekly and discard any foods that are out of compliance. Nursing staff shall clean up spills as needed or refer to housekeeping staff.

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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** 30527 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 2 of 4 residents (Resident #51 and Resident #66). 1. LVN G failed to use enhanced barrier precautions by donning a gown when performing gastrostomy tube feeding on Resident #51. 2. CNA Q and CNA R failed to change their gloves while performing incontinent care on Resident #66 and touched the resident and clean surfaces with soiled gloves . These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: 1. Record review of a face sheet dated 01/14/2025 indicated Resident #51 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life without any behaviors). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #51 was understood by others and was able to understand others. The MDS assessment indicated Resident #51 had a BIMS score of 05, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #51 required supervision and assistance with all her ADLs including shower/bathing self. The MDS assessment indicated Resident #51 did not reject care. Record review of the care plan with a revised date of 12/03/2024 indicated Resident #51 required tube feedings related to a history of dysphagia . Resident #51's care plan indicated the resident needs the head of bed elevated to a 45 degrees angle during and thirty minutes after her tube feeding. Resident #51's care plan indicated she required enhanced barrier precautions due to the presence of the gastric feeding tube. Resident #51's care plan indicated the following interventions: Administer medication as ordered. o Assess for signs and symptoms of infection such as: Increased white blood cell count, fever, redness, swelling, purulent drainage of areas of non-intact skin, changes in urine or sputum and report to the NP/MD as indicated. Record review of the order summary report dated 01/14/2025 indicated the following: Enteral Feed Order at bedtime Glucerna 1.5 bolus feeding via peg tube. 240ml per day order date - 07/29/2024 start date - 07/29/2024 Enteral Feed Order four times a day Give 120mL water flush (60mL before each bolus and Give 60mL after each bolus) order date - 07/29/2024 - start date - 07/29/2024 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Enteral Feed Order with meals Give Glucerna 1.5 240ml bolus feeding via peg tube Feeding to provide 1440kcal; 79g protein; 729ml of free water (If Glucerna is unavailable, may give Jevity 1.5) order date -07/29/2024 - 07/29/2024 During an observation and interview on 01/15/2025 at 08:45 AM, LVN G entered Resident #51's room and donned gloves after washing her hands. LVN G did not wear a gown for enhanced barrier protection. LVN G began to perform enteral gastric feeding for Resident #51. After surveyor entered Resident #51's room another staff entered and assisted LVN G to put on a gown while continuing the feeding. LVN G stated the purpose of utilizing enhanced barrier precautions was to protect the resident. LVN G said she forgot to put the gown on before starting the feeding. LVN G said there was no sign indicating enhanced barrier precautions but there had been one a few days ago. LVN G said all residents with wounds, foley care, gastric feedings and intravenous care required enhanced barrier precautions for protection and to prevent cross contamination. LVN G stated she had been in-serviced and trained in the last few months on enhanced barrier precautions. During an interview on 01/15/2025 at 2:09 PM, ADON P said she was the infection preventionist. ADON P said it was the facility's goal for her to train, educate and complete skills check evaluations on the clinical staff for enhanced barrier precautions to prevent the spread of infections in the facility but currently the regional corporate nurse had been completing the task. ADON P said it was her responsibility to monitor the staff through random checks, observations, and education to ensure infection control practices were being followed by the staff as well as ensuring the stations continued to be stock with necessary PPE and supplies. ADON said the clinical staff had recently made sure the rooms had signs to alert the staff of residents that required enhanced barrier precautions. ADON P said she had started the position in July of 2024. ADON P said any resident that gastric tube feedings would require a gown prior to administering the feeding. During an interview on 01/15/2025 at 03:15 PM, the DON said she expected the staff to follow the procedures for enhanced barrier precautions per the policy which required wearing the gown during gastric tube feeding. The DON said infection control was vital for all staff to adhere to in order to prevent cross contamination. During an interview 01/15/2025 at 04:45 PM, the Administrator said she expected staff to follow best practices learned when obtaining their licensure. The Administrator said enhanced barrier precautions were important to protect the residents as well as the staff from infections and should be utilized with residents that had a wound, foley, gastric feedings, intravenous care. The Administrator said all staff were responsible for infection control. Record review of an Inservice entitled Enhanced Barrier Precautions - dated 10/25/2024, indicated LVN G was educated on Enhanced Barrier Precautions. 2. Record review of Resident #66's face sheet, dated 01/15/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #66 had diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning), protein-calorie malnutrition (the state of inadequate intake of food), muscle wasting, lack of coordination and cognitive communication deficit. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #66's Quarterly MDS assessment, dated 12/04/2024, reflected Resident #66 sometimes understood and sometimes was able to understand others. Resident #66 had a BIMS score of 01, which indicated her cognition was severely impaired. Resident #66 had no delusions or hallucinations. Resident #66 had no physical, verbal, or other behavioral symptoms directed toward others. The MDS assessment reflected Resident #66 had functional limitations on both sides of upper and lower extremities and dependent for assistance with transfers, toileting, shower, upper and lower body dressing, and personal hygiene. Record review of Resident #66's comprehensive care plan, revised on 04/14/2024, reflected Resident #66 had activities of daily living self-care performance deficit and was at risk for not having her needs met in a timely manner. The care plan goal included resident to maintain current level of function through the review date. The interventions included the following: Total by (1) for incontinent care, bathing, grooming, dressing; resident required (extensive) by (1) staff to turn and reposition for bed mobility; and total dependent on (2) staff for Hoyer lift transfers. During an observation on 01/14/2025 at 02:23 PM of a video, date stamped 01/12/2024 at 4:27 AM, with audio and visual showed CNA Q and CNA R provided incontinent care to Resident #66. CNA Q and CNA R entered the room with gloves on. CNA Q and CNA R tugged Resident #66's brief loose. CNA R tucked Resident #66's brief underneath her between her legs. CNA R rolled Resident #66 onto her right side. CNA Q and CNA R failed to wipe Resident #66's front peri area. CNA Q wiped Resident #66's buttocks, and she used the same wipe and wiped Resident #66 back and forth multiple times. Then CNA Q rolled up the soiled wipe and brief under Resident #66's hip and tucked the clean brief underneath. CNA Q failed to change gloves and perform hand hygiene prior to applying the clean brief. CNA Q and CNA R rolled Resident #66 onto her left side. CNA R removed the dirty brief and placed it on the lower left side of the foot of the bed. CNA Q and CNA R proceeded to apply the clean brief with their dirty gloves. CNA R failed to change gloves and perform hand hygiene prior to applying the clean brief. CNA Q and CNA R continued to reposition Resident #66 in the bed, straighten her gown up, and touch Resident #66's clean linens with their dirty gloves. During an interview on 01/15/2025 at 2:09 PM, ADON P said she was the Infection Preventionist. ADON P said it was the facility's goal for her to train, educate and complete skills check evaluations on the clinical staff for enhanced barrier precautions to prevent the spread of infections in the facility but currently the regional corporate nurse had been completing the task. ADON P said it was her responsibility to monitor the staff through random checks, observations, and education to ensure infection control practices were being followed by the staff as well as ensuring the stations continued to be stock with necessary PPE and supplies. ADON P said it was her job to train, educate and complete skills check evaluations on the clinical staff for incontinent care to prevent the spread of infections such as urinary tract infections in the facility. ADON P said she started as the infection preventionist in July 2024. After ADON P viewed the video date stamped 01/12/2024 at 4:27 AM, with audio and visual of CNA Q and CNA R providing incontinent care to Resident #66, she stated the incontinent care was done incorrectly in several aspects and could result in cross contamination. ADON P said the CNAs should have changed gloves, sanitized their hands, not used the dirty wipe more than once, not laid the soiled brief on the bed, not touch the clean linens with dirty gloves as well as the resident, and the list goes on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/15/2025 at 03:15 PM, the DON said she expected the staff to follow the procedures for proper incontinent care. The DON said infection control was vital for all staff. The DON said all staff should adhere to the facility's policy on incontinent care to prevent cross contamination, which could result in a urinary tract infection. After the DON viewed the video date stamped 01/12/2024 at 4:27 AM, with audio and visual of CNA Q and CNA R providing incontinent care to Resident #66, she stated the incontinent care was not completed per the facility's incontinent care policy. During an interview on 01/15/2025 at 4:45 PM, the Administrator said she expected all the staff to follow the policy on hand washing, changing gloves, and proper incontinent care to prevent any infection risk to the residents. After viewing the video, date stamped 01/12/2024 at 4:27 AM, with audio and visual of CNA Q and CNA R providing incontinent care to Resident #66, the Administrator stated the CNAs had not followed the infection control policy for incontinent care. During an interview on 01/15/2025 at 06:35 PM, CNA R stated she had worked at the facility for approximately 2 years. CNA R stated she was in-serviced on incontinent care recently. CNA R stated she would let the resident know what care she was going to provide prior to doing the care. CNA R stated it was important to let the resident know so they would not be scared. CNA R stated she always took extra supplies into the resident's room for incontinent care such as trash bags, gloves, and wipes. CNA R stated she placed the extra trash bag inside the trash can. CNA R stated she would put the trash can beside her on the floor next to the bed to prevent spreading any germs and infections while getting rid of the soiled diaper. CNA R stated she changed her gloves after cleansing her hands with hand sanitizer between dirty and clean briefs before touching any other surfaces or the resident. CNA R said she uses one wipe to swipe once and then discarded the wipe in the trash. CNA R stated once she changed her gloves or took them off and put them in the trash, she would reposition the resident in the bed. CNA R said, she would gather the trash bag with the dirty brief and remove it from the resident's room. CNA R stated the purpose of preventing cross contamination was to keep the residents' healthy. CNA R was shown the video, date stamped 01/12/2024 at 4:27 AM, CNA R identified herself and CNA Q in the video immediately. CNA R stated the incontinent care being provided to Resident #66 was done incorrectly and could result in cross contamination and an infection control issue. CNA R stated peri care was not performed in the correct manner and the resident was at risk of infection such as a UTI from not properly cleaning the private area. CNA R stated the wipe should have been thrown away to the trash after one wipe on the dirty peri area. CNA R said the gloves should have been changed between dirty and clean diaper changes and hand hygiene should have been performed to prevent cross contamination. CNA R stated she was the helper for CNA Q and Resident #66 was not her resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455684	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longview Hill Nursing and Rehabilitation Center	3201 N Fourth St Longview, TX 75605

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/15/2025 at 06:55 PM, CNA Q stated she had worked at the facility for a while. CNA Q stated she was in-serviced on incontinent care recently. CNA Q stated upon entering a resident's room she would introduce herself and let the resident know what care she was going to provide prior to doing the care. CNA Q stated she always took extra supplies into the resident's room for incontinent care such as trash bags, gloves, and wipes. CNA Q stated she placed the extra trash bag inside the trash can. CNA Q stated she would put the trash can beside her on the floor next to the bed to prevent spreading any germs and infections while getting rid of the soiled brief. CNA Q stated she changed her gloves after cleansing her hands with hand sanitizer between dirty and clean briefs before touching any other surfaces or the resident. CNA Q said she wiped the resident's private area once and then discarded the wipe in the trash. CNA Q stated once she changed her gloves or took them off, she would put them in the trash, and she would reposition the resident in the bed. CNA Q said, she would gather the trash bag with the dirty brief and remove it from the resident's room. CNA Q stated the purpose of preventing cross contamination was to keep the residents from sickness. CNA Q was shown the video, date stamped 01/12/2024 at 4:27 AM, CNA Q identified herself and CNA R in the video immediately. CNA Q stated the incontinent care being provided to Resident #66 was done correctly and that was exactly how it must be completed on the resident. When CNA Q was asked why this resident's incontinent care was done differently that she verbally described, CNA Q stated, why are you all targeted at me? Record review of a skills check off entitled Nursing Assistant Clinical Skills Checklist and Competency Evaluation 2024 - Incontinent Care - dated 10/01/2024, indicated CNA R was competent in incontinent care. Record review of a skills check off entitled Nursing Assistant Clinical Skills Checklist and Competency Evaluation 2024 - Incontinent Care - dated 10/02/2024, indicated CNA Q was competent in incontinent care. Record review of the facility policy titled Enhanced Barrier Precautions, dated 04/05/2024, indicated: Enhanced Barrier Precautions are a CDC guidance to reduce the transmission of multi-drug resistant organisms in health care setting, including nursing homes .requires team members to wear a gown and gloves while performing high contact care who have open wounds or indwelling catheters. Record review of the facility's policy titled Infection Control Policy, dated 05/13/2023, indicated: Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures .