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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455748	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Hall	2021 Shoaf Dr Irving, TX 75061

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489 Based on interview and record review, the facility failed to ensure notification and receipt of Medicare Provider Non-Coverage letters (CMS 10123 or CMS 10055) which included information about their right to appeal were reviewed for Medicare Beneficiary Notification Review (Residents #71 and Resident #95). The facility failed to provide the Medicare Provider Non-Coverage letters to Resident #71 and Resident #95. This failure could place residents who receive Medicare Part A benefits at risk of not being fully informed of their right to appeal. Findings included: Record review of the document titled Beneficiary Notice - Resident discharged within the last 6 months, dated 08/24 through 12/2024 naming residents discharged from Medicare part A with benefit days remaining. Record review of the facility's Beneficiary Protection Notification indicated Resident #71's Medicare Part A skilled service start date was 08/24/2024 and last covered day of Part A service was 10/26/2024. Record review of the facility's Beneficiary Protection Notification indicated Resident #95's Medicare Part A skilled service start date was 07/27/2024 and last covered day of Part A service was 10/04/2024. Record review of Resident #71's face-sheet dated 01/24/2025, revealed a [AGE] year-old female, initially admitted to facility on 01/25/2025 and discharged from skilled services on 10/26/2024. Resident's diagnosis included: Unspecified cirrhosis of liver (a medical diagnosis that refers to a type of liver disease where the specific cause of the scarring (fibrosis) of the liver is unknown); Chronic respiratory failure with hypercapnia (a chronic condition where the body cannot effectively eliminate carbon dioxide from the blood, causing hypercapnia - CO_2 - carbon dioxide levels), and End stage renal disease (a condition which the kidneys lose the ability to remove waste and balance fluids). (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #71's quarterly MDS (Minimum Data Set) dated 12/28/2024 revealed BIMS (Brief Interview of Mental Status) score was 14/15 with memory intact. Record review of Resident #95's face-sheet dated 01/24/2025, revealed an [AGE] year-old male, initially admitted to facility on 07/27/2024, readmission on 12/21/2024 and discharged from skilled services on 10/04/2024. The resident's diagnosis included: Hypertensive urgency(a condition where the blood pressure is significantly elevated but there no evidence of acute organ damage), encephalopathy, unspecified (a condition where there is a general disturbance of brain function, but the specific cause is unknown), dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a person is presenting signs and symptoms of dementia and has a dementia diagnosis, but they lack any symptoms of behavioral disturbances). Record review of Resident #95's quarterly MDS (Minimum Data Set) dated 12/27/2024 revealed BIMS (Brief Interview of Mental Status) score was 07/15 with cognitive status severely impaired. In an interview on 01/24/2025 at 3:17 pm with the Admission Coordinator revealed that the facility did not have an MDS coordinator at that time. The former MDS Coordinator, who was responsible for completing the NOMNCs, was no longer employed at the facility. The Admission Coordinator could not find the copies of the completed NOMNCs nor proof that the NOMNCs were sent. She stated providing residents with a NOMNC at the end of their Medicare Skilled Services was important because the patient had the right to be informed and know when their agreement, care, and coverage would change with the facility. In an interview on 01/24/2025 at 3:25 pm with the ADM revealed after speaking to the former MDS Coordinator, he said he left the NOMNC forms on a pile on the desk but ADM could not find them or proof that they were sent. The forms were not in a binder or anything. The former MDS Coordinator left his position in early January 2025. The residents have to be provided the NOMNCs because they had a right to appeal any financial decisions and they had a right to know what the decisions were. Facility did not provided copies of NOMNCs or evidence NOMNCs were sent by the time of exit. Record review of Form Instructions for 10123-NOMNC (Notice of Medicare Non-Coverage) revealed the following, in part: - The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. - Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual. - The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CMS requires that notification of changes in coverage for an institutionalized beneficiary/enrollee who is not competent be made to a representative. Providers are required to develop procedures to use when the beneficiary/enrollee is incapable or incompetent and the provider cannot obtain the signature of the enrollee's representative through direct personal contact. If the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered. The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested. Record review of the facility, Medicare Advance Beneficiary and Medicare Non-Coverage Notices, revised September 2022, revealed, Residents are informed in advance when changes will occur to their bills. 1. If the resident's Medicare covered Part A stay or when all of Part B therapies are ending, a Notice of Medicare Non-Coverage (CMS form 10123) is issued to the resident at least two calendar days before benefits end. 2. The Notice of Medicare Non-Coverage informs the resident of the pending termination of coverage and of his/her right to an expedited review by a Quality Improvement Organization. 44894

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507 Based on observation, interview and record review the facility failed to ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for one of one residents (Resident #350) reviewed for nephrostomy care. The facility failed to ensure staff kept Resident #350's nephrostomy (tube placed in the back that drains urine from the kidney) bag below the kidney while the resident was in bed. This failure could place residents at risk of infection. Findings included: Record review of Resident #350's face sheet dated, 01/22/2025, revealed a [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of Malignant neoplasm of cervix uteri (cervical cancer). Record review of Resident #350's Admission MDS, dated [DATE] revealed a BIMS score of 6, indicating severe cognitive impairment. Record review of Resident #350's order summary dated 01/24/2025, revealed .Resident has BL Nephrostomy tube . dated 01/05/2025 . Record review of Resident #350's careplan, undated, did not indicate resident had a nephrostomy bag. Observation and interview on 01/22/2025 at 10:53 AM, revealed Resident #350 was lying in bed, and a bag with yellow fluid was on the bed near the resident's left shoulder. When the Surveyor asked what the bag was, Resident #350 said she had a nephrostomy tube. Interview on 01/23/2025 at 4:46 AM, LVN A stated Resident #350 had 2 nephrostomy tubes and the bags should be below the insertion point so that it would drain via gravity. She stated she was not sure what could happen if the bag was higher than the kidney. Interview on 01/23/2025 at 5:06 AM, CNA G stated she had been told to keep the nephrostomy bag above the kidney. Interview on 01/24/25 at 2:35 PM, RN F stated the nephrostomy bag should be below the waste for infection control and to maintain the pressure. She stated the urine could fluctuate back and it could possibly cause an infection. She said no other residents had nephrostomy tubes and the nurse was responsible for ensuring the bag was in the correct position. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/24/25 at 4:58 PM, the DON stated the nephrostomy bag should have been draining below the kidneys and best practice was it should have been hung in a bag like a F oley [catheter bag]. The DON stated it could stop the bag from draining, cause an infection and be a dignity issue. She said staff should have been trained when the nephrostomy came into the building. Interview on 01/24/25 at 5:42 PM, the Administrator stated the bag should have been below the kidney so urine would flow. Review of facility policy titled, Nephrostomy Tube, Care of revised October 2010, revealed in part: 2. Check placement of the tubing and integrity of the tape during assessments. 1. Drainage should be below the level of the kidneys. 2. There should be no kinks in the tubing .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to ensure that a resident who was fed by enteral means received the appropriate treatment and services for one (Resident #10) of four resident's observed for checking g-tube for placement. The facility failed to verify that placement of the feeding tube for Resident #10 was confirmed by x-ray (Imaging that is taken with electromagnetic waves to show pictures of the inside of your body) upon initial insertion and that the tube length was marked and documented before it was flushed with water, medications were given, and bolus feedings were administered on 01/22/25. These failures could place residents with g-tubes at risk of aspiration pneumonia, infection, discomfort, malnutrition, and a decline in the residents' health. Findings included: Review of Resident #10's face sheet dated 01/22/25 revealed a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included acute respiratory failure with hypoxia (this is a failure to breath due to lake of oxygen), critical illness myopathy (this is a neuromuscular complication that makes muscles weak and wasting), gastrostomy malfunction, contracture of muscles (shortening of muscles that causes pain to strengthen), bacterial infection, Gastrointestinal hemorrhage (this is stomach bleeding), and other post procedural complications, disorder of digestive system, constipation, and dementia (cognitive decline) Record review of Resident #10's quarterly MDS (minimum data set), dated 12/03/24, revealed cognitive skills for daily decision making was a 0 which indicated he was severely impaired. It was further revealed he was extensively dependent on two staff for bed mobility and was totally dependent on one staff for eating. His quarterly MDS also revealed he received 51% or more of his nutrition was received from a feeding tube. Record review of Resident #10's Care plan last reviewed on 12/13/24 revealed he required a tube feeding due to difficulty swallowing. The goal was for Resident #10 was to not have significant weight loss. Interventions included the resident was dependent on g-tube for tube feeding, water flushes, and medications per physician orders. The care plan further revealed Resident #10 was at risk of bleeding r/t taking antiplatelet (Aspirin). The Goal was that the resident would be free from discomfort or adverse reactions r/t antiplatelet use through the review date. Interventions were Administer the medication as ordered by the MD. Monitor for side effects and effectiveness per shift. Review of Resident #10's order summary for January 2025 reflected the following: Record Review of Resident #10's MAR dated01/01/25 to 01/22/25 reflected the following: -Aspirin tablet, chewable; 81 mg tablet; Amount to administer: 1; gastric tube daily (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- baclofen 20 mg tablet, three times a Day. 1, gastric tube, Three Times A Day for Contracture of muscle, unspecified site. - famotidine 20mg tablet, twice a Day. 1 gastric tube, Twice Times A Day for abdominal distension. - MiraLAX (Polyethylene glycol 3350) 17 gram/dose powder. Once a Day. 17 g oral once a day for constipation. - Senna 8.6 mg tablet. Once a Day. 2 oral, once a Day. 1 oral, gastric tube, once a day, assist with wound healing for Constipation. - Vitamin C (Ascorbic acid (vitamin c)) 500 mg tablet. Once a Day for Gastrostomy malfunction. - zinc sulfate 50 mg zinc (220 mg) tablet. Once a Day. 1 oral once a day - [Brand Name]1.5 bolus-administer 260 ml feeding via free flow QID four times a Day for unspecified protein calorie malnutrition. -May insert gastric tube due to malfunction/tear. One time. Diagnosis: gastrostomy malfunction. Start date 01/21/25-01/21/25 . -Standard Abdomen (KUB); Other test: Abdominal X-ray to confirm placement of G-tube. One time. Diagnosis: gastrostomy malfunction. Start date 01/21/25-01/21/25. Record Review of Resident #10's MAR dated01/01/25 to 01/22/25 reflected the following: -Aspirin tablet, chewable; 81 mg tablet; Amount to administer: 1; gastric tube. Administered 1/22/2025 8:41:55AM by RN B - baclofen 20 mg tablet, three times a Day. 1, gastric tube, Three Times A Day for Contracture of muscle, unspecified site. Administered 1/22/2025 8:41:55AM by RN B. - famotidine 20mg tablet, twice a Day. 1 gastric tube, Twice Times A Day for abdominal distension. Administered 1/22/2025 8:41:55AM and at 1:00 PM by RN B. - MiraLAX (Polyethylene glycol 3350) 17 gram/dose powder. Once a Day. 17 g oral once a day for constipation. Administered 1/22/2025 8:41:55AM by RN B. - Senna 8.6 mg tablet. Once a Day. 2 oral, once a Day. 1 oral, gastric tube, once a day, assist with wound healing for Constipation. Administered 1/22/2025 8:41:55AM by RN B - Vitamin C (Ascorbic acid (vitamin c)) 500 mg tablet. Once a Day for Gastrostomy malfunction. Administered 1/22/2025 8:41:55AM by RN B. - zinc sulfate 50 mg zinc (220 mg) tablet. Once a Day. 1 oral once a day - [Brand Name]1.5 bolus-administer 260 ml feeding via free flow QID four times a Day for unspecified protein calorie malnutrition. 260 ml administered at 08:00 AM and at 12:00 PM by RN B. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-May insert gastric tube due to malfunction/tear. One time. Diagnosis: gastrostomy malfunction. Start date 01/21/25-01/21/25 at 11:30 PM. Order entered by LVN A. -Standard Abdomen (KUB); Other test: Abdominal X-ray to confirm placement of G-tube. One time. Diagnosis: gastrostomy malfunction. Start date 01/21/25-01/21/25 at 11:34 PM. Order entered by LVN A. Record review of Resident #10's progress notes dated 01/21/2025 by LVN A at 11:33PM, reflected Received verbal/telephone order for replacement of G-tube due to leaking/malfunction. G-tube replaced with same size 18fr 7-10 ml. Procedure tolerated well. Placement verified via air bolus/auscultation (this is a process of pushing air into the G-tube while listening with a stethoscope). Pending abdominal x-ray to confirm placement at this time. Record review of Resident #10's progress notes dated 01/22/2025 by RN B at 1:37PM, reflected Abdominal x-ray pending to confirm placement at this time. Feeding tolerated well. Active bowel sounds in all 4 quadrants. Record review of Resident #10's progress notes by LVN C dated 01/22/2025 at 6:36PM, reflected the resident Xray result was out, impression: G tube not identified, follow up with contrast or air injection (iodine-based contrast injected to enhance X-ray or CT images) suggested. gas distended bowel (this is when the abdomen becomes distended due to gas formation due to digestive problems) and increased fecal material. On assessment, the abdomen was slightly distended and R side abdominal pain. MD ADON DON notified. resident sent to the [hospital name] via EMS. family notified. Observation and interview of g-tube feeding on 01/22/25 at 08:35 AM with RN B revealed Resident #10 lying in the bed. RN B then attached the syringe with a plunger to the g-tube and checked the residual of g-tube and stated it had only 0.2 ml in it. She then removed the syringe and filled it with 30 ml of water and reattached the syringe and pushed the 30 ml of water into the g-tube using the plunger. RN B then removed the syringe plunger. After the water flush Resident #10 was given a bolus feeding (feeding method using a syringe to deliver formula through feeding tube) using the free flow method as ordered by the physician. RN B stated that she had to use the syringe plunger to help push anything that might prevent the flow of the bolus feeding. She stated that Resident #10 had issues with his g-tube in the past. She stated Resident #10 had a new g-tube that had been replaced the night before (01/21/25) by LVN A. She stated the x-ray was still pending but LVN A and the ADON had told her that it was ok to use the g-tube since the placement had been verified by checking the residual. She stated that she was aware that the x-ray had been ordered to verify the new g-tube placement. Observation on 01/22/25 at 11:34 AM revealed an x-ray tech went to Resident #10 to do the ordered x-ray. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/23/2025 at 9:43 AM with the ADON revealed when a g-tube was leaking she would call the doctor. She said it would depend on where it was leaking from, if it was from the stoma (opening into the stomach area) would want to look at the whole thing, or if the device was cracked, she would reach out to the doctor. The ADON stated she would do an assessment, check for residual, bowel sounds, anything physical that could be going on. She stated she had replaced g-tubes but not in several years and did not know the facility policy. She said before a g-tube was replaced a doctor's order was needed, then after the tube was replaced, she would check air, auscultation, and call to get an x-ray to verify placement before it was used. She stated she would ensure she had an order to give nothing by tube before placement was confirmed unless the doctor directed her differently. The ADON stated that needed to be done to ensure the medicine was going into the stomach. The ADON said prior to working at the facility she had been delegated the task of replacing a g-tube at her previous facility, and she said some tasks had to be delegated by RN. She was unsure of the facility policy of who could replace a g-tube and stated she would not change a g-tube without a doctor's order and looking at the policy to make sure it was within her scope of practice. The ADON stated she did not advise Resident #10's nurses to use the g-tube before the x-ray had been read and knew nothing about the g-tube being replaced overnight by LVN A. An interview on 01/23/2025 at 10:03 AM with the DON revealed when a g-tube was leaking, they called the physician to get an order to get it replaced. She stated nobody in the facility was allowed to place a g-tube, but if it had been replaced in-house by a nurse, the next thing they did was order a stat x-ray. She said using the g-tube (for feeding or medication) was not allowed until they received verification of correct placement by x-ray or CT scan. She said they could only use auscultating (listening for air sounds in the stomach with a stethoscope) and checking for residual (checking the amount of fluid in the stomach) to check placement after placement had been verified by x-ray or CT scan. The DON stated the x-ray was to make sure the g-tube was in the right spot, so it did not leak inside the body where it was not supposed to. She said when that happened, it could cause an infection, and a person could die from it. She stated it was a serious problem, and she would never advise a nurse to go ahead and use it. She said the nurses who used the g-tube just took it upon themselves to do what they did and had begun an investigation into it. The DON stated she learned at about 7:15 AM on the day of this interview that the hospital had verified placement of the g-tube, and it was in place. She said she could not remember the name of the nurse who had replaced the g-tube, but she was working on referring her, and any nurse who had used the g-tube before verification. She said in the short time (approximately two weeks) she had been at the facility; she had not done any competency checkoffs with the nurses. She said she did not know it an issue, because they sent people out to get them replaced. She said she thought it was out of an LVN's scope of practice to replace a g-tube, and even if they had training, she would probably not allow it. The DON said she was not even sure she would be comfortable doing it herself, because she did not work with them regularly, and it was better to send them out and have someone who did that all the time take care of it. She expressed frustration that no nurses had called her about changing the g-tube, or about using it after it was changed. The DON said the first she heard of it was on the night of 01/22/25, when the ADON was talking to her about Resident #10 needing to be sent to the hospital due to his abdomen being a little distended, and he was not feeling well, and was having pain. The ADON told her about the g-tube and did not say anything about telling any nurse it was OK to use it for anything. She said the ADON had been trying to get Resident #10 sent out to get the tube replaced, and she did not have any idea yet why the nurse had taken it upon herself to change it. She said knowing not to use the g-tube before placement was verified correctly was nursing 101. She said at the time of this interview she had not started doing training with the nurses on g-tubes, because she was gathering the policies and training materials, and printing forms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Hall	2021 Shoaf Dr Irving, TX 75061

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/23/25 at 10:37 AM with RN B revealed she had administered medication to Resident #10 on 01/22/25. She said she was aware that the resident's g-tube was replaced by LVN A, the night nurse. She stated the information was provided to her at shift change. She said that LVN A told her it was OK to use the g-tube, and that the ADON knew about it. RN B said she knew an x-ray had to be done. She said that LVN A verbally informed her that it was OK to use the tube, and she checked the progress note, and it was there. She said she did not wait for the x-ray result, because she went with the progress note and checked the residual, and it was there. She said when she used Resident #10's g-tube, he tolerated it well, meaning that on her shift there were no bad results from the administration. She said the first time she did it, she panicked because the surveyor was in the room, and forgot to auscultate, but the next time she did it, she also auscultated. She said she believed LVN A also fed the resident on the night shift, before she did. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/23/25 at 12:28 PM with the MD revealed the facility tried to send Resident #10 to one hospital, but he was told the next day that hospital would not accept an electronic signature, but instead required a wet signature (a handwritten signature on paper) on the orders, and he was not in a position to do that, at that time. He said when he was in the building, they decided to send Resident #10 to a different hospital, because the first one had given them a lot of other problems with another resident they sent there, but the second hospital would not take Resident #10, because they had not placed his g-tube originally. He said Resident #10 had his g-tube for years, so it was healed, and established, and replacing it was a simple procedure. He said LVN A called him that night (01/21/25) and said that she could replace the peg tube (another name for the g-tube) and she had been trained. Resident #10 had not been able to eat because of the leaking for a couple of days, and that was serious. The MD said he told the nurse Fine. Put it in. He said they ordered an x-ray to check it, and it was fine. The next day, the ADON notified him that Resident #10's abdomen was distended. The MD said when Resident #10 went to the hospital, they said the g-tube was fine, and Resident #10 was constipated. The constipation and a distended abdomen had been an on-going problem for Resident #10, and they had done everything they could think of, medication changes, GI consults, nutritional consults, and he still had the same problem. The MD said when a g-tube was replaced, he would not necessarily wait for an x-ray to determine placement. He said it was just a hole into the stomach and Resident #10's was a mature, healed stoma. He said the stomach wall was sealed to the interior wall, stuck there, and putting a tube in there, it just goes in, and you are in there. He said there were other methods of determining placement, like listening to it, or aspirating the stomach contents out. He said one could get an x-ray, but the x-ray was not the only way to determine placement. He said he did not order the KUB, the nurses did, and he was informed after the fact. He said he did not require it, he just required them to determine the tube was in the stomach. He said the tube could not go anywhere else. The MD likened the g-tube to a Foley catheter, which would go into the bladder, because where else would it go?. He said if the g-tube had been new, under a month old, he would have required an x-ray, because it might not be healed fully. He said they usually took a week or two to completely seal where they were attached. The MD said the reason an x-ray was not necessary was that they were not reliable and did not show plastic. He said that they needed to use contrast, and the facility did not need to go to the trouble to store radioactive materials. He said nursing homes did not do that. The MD said he believed it to be in an LVNs scope of practice, and that the Texas Board of Nursing allowed nurses to place a g-tube with a physician's consent. He explained that there were two types of g-tubes, the type done initially, and those had to be replaced by a physician, but the other type could be placed by a nurse. He said that LVN A went over the procedure with him on the phone, and she knew what she was doing, and she did it correctly. He said they normally sent the residents out to get them done, because he had not been aware any of the nurses were trained to do it. The MD said LVN A had training at a prior facility and had that skill. He said there was no risk to the resident in changing it, or in feeding it, because it was a fully healed hole into the stomach. An interview on 01/23/25 at 12:12 PM, at [hospital name], the hospital nurse stated she did not see anything wrong with Resident #10's g-tube and it did not have to be replaced. The hospital nurse stated Resident #10's diagnosis was severe sepsis (this is a systemic infection that is triggered by the body's extreme response to an infection) and pneumonia, and the cause of sepsis was unknown. The hospital charge nurse stated Resident #10's did not need his g-tube replaced and the CT scan showed the tube to be in place when he arrived. Record Review of facility policy titled Confirming Placement of Feeding Tubes, revision date November 2018 reflected .revealed in part (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The purpose of this procedure is to ensure proper placement of an existing feeding tube prior to administering enteral feedings or medication. 1. Verify that there is a physician's order for this procedure. 2. Verify that placement of the feeding tube was confirmed by X-ray upon initial insertion and that the tube has been marked, or the tube length has been documented. Review the resident's care plan and provide for any special needs of the resident .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489 Based on interviews and records reviewed, the facility failed to ensure that licensed nurses had the specific competencies, and skill sets necessary to replace a g-tube and to follow g-tube verification of placement procedure, as identified through the physician orders and facility policy for one of four residents (Resident #10) reviewed for nursing services in that: 1.The facility failed to ensure LVN A had a competency validation course before replacing Resident #10's g-tube on 01/21/25. 2.The facility failed to provide training for RN B and LVN C regarding when it was safe to feed a resident or give medications via g-tube. RN B and LVN used Resident #10's G-tube before placement was verified via x-ray or CT scan. These failures could place residents at risk of being cared for by insufficiently trained staff, resulting in serious injury or infection. Findings included: Review of Resident #10's face sheet dated 01/22/25 reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included acute respiratory failure with hypoxia (this is a failure to breath due to lake of oxygen), critical illness myopathy (this is a neuromuscular complication that makes muscles weak and wasting), gastrostomy malfunction, contracture of muscles (shortening of muscles that causes pain to strengthen), bacterial infection, Gastrointestinal hemorrhage (this is stomach bleeding), and other post procedural complications, disorder of digestive system, constipation, and dementia (cognitive decline) Record review of Resident #10's quarterly MDS (minimum data set), dated 12/03/24, revealed cognitive skills for daily decision making was a 0 which indicated he was severely impaired. It was further revealed he was extensively dependent on two staff for bed mobility and was totally dependent on one staff for eating. His quarterly MDS also revealed he received 51% or more of his nutrition was received from a feeding tube. Record Review of Resident #10's MAR reflected: - [Brand Name]1.5 bolus-administer 260 ml feeding via free flow QID four times a Day for unspecified protein calorie malnutrition. 260 ml administered at 08:00 AM and at 12:00 PM by RN B. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 01/22/25 at 08:35 AM revealed RN B providing a g-tube feeding to Resident #10, who was lying in his bed. RN B checked the residual of g-tube, then flushed the g-tube with water, and proceeded to provide Resident #10 a bolus feeding. She did not listen for bowel sounds as part of the procedure. She stated that Resident #10 had issues with his g-tube in the past, and a new g-tube that had been replaced the night before (01/21/25) by LVN A. She stated the x-ray was still pending but LVN A and the ADON had told her that it was ok to use the g-tube since the placement had been verified by checking the residual. She stated that she was aware that the x-ray had been ordered to verify the new g-tube placement. Observation on 01/22/25 at 11:34 AM revealed an x-ray tech went to Resident #10 to do the ordered x-ray. In an interview with RN B on 01/22/25 at 08:35 AM, she stated she had been at the facility for three months and this was her first nursing job. She stated she had not been checked off for competency for g-tube management, policy, and procedures. She stated that she had just started working on the hallway with Resident #10 for a week. She stated she did not listen for bowel sounds as part of the g-tube nursing assessment because she was nervous. She said she did not wait for the x-ray result before she fed him because she went with the progress note and checked the residual, and it was there. She said when she used Resident #10's g-tube, he tolerated the feeding well, meaning that on her shift, there were no bad results from her feeding him. She said the first time she gave Resident #10's bolus feeds, she panicked because the surveyor was in the room and she forgot to auscultate (acts of listening to the stomach using a stethoscope), but the next time she gave Resident #10's bolus feeds at noon, she also auscultated. She stated there was no potential risk because she had checked the residual which showed the G-tube was in the stomach. In a phone interview with LVN A on 01/24/25 at 12:13 PM, revealed she had been at the facility for eight months. She stated she had g-tube competency at another facility about six years ago. She said she was trained by the DON at another facility and had done three other g-tube replacements in the time since then. LVN A said she did not remember doing any continuing education specifically for g-tubes. She stated she had not been checked off for g-tube replacement before she replaced Resident #10's g-tube, and she did not have the training or check-off to provide for record review. She stated she did not do anything out of the scope of her practice because she had replaced g-tubes at another facility and had the physician's approval. She stated the Administrator told her, There was nothing against it as long as there was an order. She stated she called the physician and got an order to replace Resident #10's g-tube and the physician said, Yes of course as long as you know how to do it. She stated the physician did not have any follow up questions on how she would perform the procedure. She stated the physician did not stay on the phone with her to walk her through the procedure. She stated the risk of not having up-to-date training was that there could be new information about the procedure, or new risks. She said she should have been checked off for competency. In an interview with LVN C on 01/23/25 at 4:08 PM he stated he had not replaced a g-tube. He stated he had done it in school once. He stated he knew how to check for residual for the g-tube and how to auscultate but he had had no competency done at the facility. He stated the training for g-tube was from nursing school. He stated he worked with residents with G-tubes and knew what signs to look for with G-tube. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview with LVN D on 01/24/25 at 04:59 PM, she stated she had been working with LVN A the night that LVN A replaced Resident #10's g-tube. She stated she was with her in the room. She stated LVN A called the physician to inform him that Resident #10's g-tube was still leaking, and she told him that she knew how to change it. LVN D said the physician gave LVN A a verbal order over the phone to go ahead. LVN D said that LVN A asked the physician if she could also order an x-ray after she was done with g-tube replacement, to verify placement, to which the physician gave a verbal order for the x-ray, and he hung up the phone. LVN D stated the physician did not stay with LVN A on the phone during the procedure, nor did he have her go over the procedure with him verbally before she changed Resident #10's g-tube. In an interview on 01/23/2025 at 9:43 AM with the ADON revealed she had replaced g-tubes but not in several years and did not know the facility policy. She said before a g-tube was replaced a doctor's order was needed, then after the tube was replaced, she would check air, auscultation, call and get an x-ray so that they could come and verify placement before it was used. She stated she would ensure she had an order to have nothing to give by tube before placement was confirmed unless the doctor directed her differently. The ADON stated this needed to be done to ensure the medicine was going into the stomach. The ADON said prior to working at the facility she had been delegated the task of replacing a g-tube at her previous facility, and she said some tasks have to be delegated by RN. She was unsure of the facility policy of who could replace a g-tube and stated she would not change a g-tube without a doctor's order and looking at the policy to make sure it was within her scope of practice. The ADON stated she did not advise Resident #10's nurses to use the g-tube before the x-ray had been read and knew nothing about the g-tube being replaced overnight by LVN A. An interview on 01/23/2025 at 10:03 AM with the DON revealed not verifying the placement of the newly placed g-tube by x-ray before using it could cause an infection, and a person could die from that. She stated it was a serious problem, and she would never advise a nurse to go ahead and use it. She said the nurses who used the g-tube just took it upon themselves to do what they did and she had begun an investigation into it. She said she could not remember the name of the nurse who had replaced the g-tube, but she was working on referring her, and any nurse who had used the g-tube before verification. She said in the short time (approximately two weeks) she had been at the facility, she had not done any competency check-offs with the nurses. She said she had not even known replacing a g-tube was an issue , because they sent people out to get them replaced. She said she thought it was out of an LVN's scope of practice to replace a g-tube, and even if they had training, she would probably not allow it. The DON said she was not even sure she would be comfortable doing it herself, because she did not work with them regularly, and it was better to send them out and have someone who did that all the time take care of it. She expressed frustration that no nurses had called her about changing the g-tube, or about using it after it was changed. She stated The ADON told her about the g-tube, and did not say anything about telling any nurse it was OK to use it for anything. She said knowing not to use the g-tube before placement was verified correctly was nursing 101. She said at the time of this interview she had not started doing training with the nurses on g-tubes, because she was gathering the policies and training materials, and printing forms. An interview on 01/23/25 at 11:45 AM with the Administrator revealed the facility did not have any documentation of training for g-tubes for LVN A. An interview on 01/24/25 at 1:03 PM with the Administrator revealed the facility did not have any nurse competencies for g-tubes. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/24/25 at 5:41 PM with the Administrator revealed she had not told LVN A it was OK to replace Resident #10's g-tube. She said LVN A asked if she could replace it, and she told her to call the physician and the DON and left it at that. She said she did not feel LVN A was acting out of her scope, and that LVN A had talked to the MD, who was fine with her doing it, and she was comfortable with doing it. She said normally the MD had been the only person to replace them in-house, and the nurses did not, but LVN A was concerned about Resident #10, and her biggest purpose was to take care of him. She said the staff was not following policy, and if the policy said they needed to get an x-ray first, they should have got an x-ray. She said if the physician said it was OK, and the policy said otherwise, she would call him and talk to him about the policy. She said they had not done checkoffs with the nurses regarding the g-tubes, and they should have been doing them annually, and as-needed. The Administrator stated they had a lot of change with nurse managers, and every time she had a new one, she would give them the online training, and the nursing competencies that needed to be done with staff, and they would not follow through. She said the ADON was currently working on checkoffs, and they had engaged the MD to do g-tube training with the nurses. She said the competencies were important for making sure the nurses were trained to do their job, and that they comprehended the training. She said the DON and ADON were responsible for doing the hands-on training and competencies, but she was responsible for making sure they followed through, even though she was not qualified to do the training herself. An interview on 01/24/25 at 5:03 PM with the DON revealed she thought LVN A should not have called the Administrator, who was not a nurse, and should have called her, but she did not. She said she felt the g-tube was out of her scope, because as an LVN she was working independently, and had she consulted her she would have told her she could not change a g-tube, and that the emergency room was an option for Resident #10. She said only an RN should work independently. She said the competencies were important for safety reasons, and the nurses should not do a task if they had not done a competency check-off. She said she wanted them to be trained, and safe, and not doing procedures like that without calling her first. The DON stated nobody at the facility should be doing anything without verifiable training. She said she had only been there for about two weeks but planned on doing a lot of training. Record review of The Board of Nursing Section 15.24 Nursing Engaging In Reinsertion of Permanently Placed Feeding Tubes revealed in part . The Board does allow LVNs and RNs to expand their practice beyond the basic educational preparation through post-licensure continuing education and training for certain tasks and procedures . LVNs and RNs should not engage in the reinsertion of a permanently placed feeding tube through an established tract until the LVN or RN successfully completes a competency validation course congruent with prevailing nursing practice standards. Training should provide instruction on the nursing knowledge and skills applicable to tube replacement and verification of correct and incorrect placement The nurse should complete training designed specifically for the type or types of permanent feeding tubes the nurse may need to replace, including overall patient assessment, verification of proper tube placement, and assessment of the tube insertion site . The facility has resources available to develop an educational program for initial instruction of LVNs and/or RNs, as well as for ongoing competency validation. Documentation of each nurse's initial education and ongoing competency validation should be maintained by the nurse and/or the employer in accordance with facility policies. Regardless of training, policies and procedures of the facility must also permit the nurse to engage in the procedure . 48520

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507 48520 51826 Based on interviews and record reviews, the facility failed to provide pharmaceutical services, including procedures that assured the accurate accountability of controlled narcotic drugs for 1 of 2 Residents (Resident #350) reviewed for pharmacy services. The facility failed to ensure that narcotic count sheet records were consistent with the remaining amount of narcotics. The facility failed to ensure that nursing staff signatures required for the narcotic count sheet were obtained and consistent with documentation of narcotics administered to Resident #350. These failures could place residents at risk for medication errors, potentially leading to overdose of narcotic pain medications, or diversion of narcotic pain medications. Findings included: Record review of Resident #350's face sheet dated, 01/22/2025, revealed a [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of Malignant neoplasm of cervix uteri (cervical cancer). Record review of Resident #350's Admission MDS, dated [DATE] revealed a BIMS score of 6, indicating severe cognitive impairment. Record review of Resident #350's order summary dated 01/24/2025 reflected the following: - Hydromorphone-Schedule II liquid; 4mg/ml; Amount to Administer: 0.25 ml; oral Every Hour-PRN. Start Date: 01/04/2025 End Date: Open Ended - Hydromorphone-Schedule II liquid; 4mg/ml; Amount to Administer: 0.50 ml; oral Every Hour-PRN. Start Date: 01/04/2025 End Date: Open Ended - Hydromorphone-Schedule II liquid; 4mg/ml; Amount to Administer: 0.75 ml; oral Every Hour-PRN. Start Date: 01/05/2025 End Date: Open Ended - Hydromorphone-Schedule II liquid; 4mg/ml; Amount to Administer: 1 ml; oral Every Hour-PRN. Start Date: 01/04/2025 End Date: Open Ended (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #350's narcotic count sheet dated January 2025 for hydromorphone reflected: - Lack of nursing staff signatures from 01/22/2025 at 1:05 PM through 01/24/2025 at 3 PM. - The most recent documentation of administered hydromorphone was on 01/24/2025 at 3 PM; the recorded left (remaining) amount was 4 ml. Observation and interview with the DON and ADON on 01/24/2025 at 4:02 PM revealed that upon the surveyor's request to review the narcotic count sheet, they identified the lack of required nursing staff signatures. Further observation of the hydromorphone count, with the DON and ADON, revealed there was 4. 5ml in the bottle and 4 ml written on the narcotic count sheet. Interview with RN F on 01/24/2025 at 4:23 PM revealed she administered narcotics to Resident #350 during the 6AM-2PM shift. RN F stated that nursing staff signatures were required as part of the documentation procedure for the narcotics count sheet. She did not realize that she had not signed the narcotic count sheet. RN F discussed that the importance of signatures was to make sure the narcotics accounted for were accurate with the documented left amount on the narcotic count sheet. She stated she received training regarding controlled substances during orientation. Interview with the DON on 01/24/2025 at 4:58 PM revealed that nursing staff signatures were required as a part of the procedure when narcotics were signed out. She explained that she had worked at the facility for two weeks, but the lack of signatures was likely due to the recent hire of many new nurses that had not been trained and new nursing management oversight. The DON explained the narcotic count sheet signatures were important so that staff know who checked out the narcotic. Interview with the Administrator on 01/24/2025 at 4:58 PM revealed that the expectation for administration and record keeping of medications included signing out all narcotics, narcotic count at end of shift, and to ensure signatures were there (on the narcotic count sheet). She explained the importance of these expectations are to make sure the narcotic count was correct, that nobody stole medications, and the wrong dose was not given to residents. Interview on 01/24/25 at 5:21 PM with LVN E revealed that she administered medication to Resident #350 during the 2PM-10:30PM shift. LVN E explained that signing out narcotics allowed staff to know what time, when, and how much medication was given to the resident. She further explained that signatures show which nurse gave how much (amount of narcotic). LVN E stated that the risk of not signing the narcotic count sheet was the resident can be given too much medication, causing an overdose. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE 2021 Shoaf Dr Irving, TX 75061	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Controlled Substances policy, dated 2001, last modified 04/09/2024, reflected Policy Interpretation and Implementation: Handling Controlled Substances (.) 4. (.) an individual resident controlled substance record is made for each resident who will be receiving a controlled substance . This record contains: (.) l. signature of nurse administering medicate . Dispensing and Reconciling Controlled Substances: 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records; and d. Destruction, waste and return to pharmacy records. 3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. 4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489 Based on observation, interview and record review, the facility failed to ensure complete and accurate smoking assessments for one (Resident #26) of two residents' records reviewed for smoking assessments. The facility failed to ensure Resident #26's smoking assessments were done quarterly, and that his smoking assessments were accurate. This failure could affect residents who smoke by placing them at risk of inaccurate information, resulting in a lack of appropriate safety interventions when smoking. Findings included: Review of Resident #26's face sheet, dated 01/23/25, reflected Resident #26 was a [AGE] year-old male, admitted on [DATE], with diagnoses of Nicotine dependence, dementia, and Other epilepsy, not intractable, without status epilepticus (a seizure disorder, easily managed, and without prolonged seizures which affect consciousness.) Review of Resident #26's care plan, dated 10/13/2020, reflected: Category: Smoking; I AM a smoker and at risk for injury.; Long Term Goal Target Date: 04/05/2025; (Resident #26) will not have any injury r/t smoking thru next review.; Approach Start Date: 07/15/2021; Assist to and from designated area for smoking. Approach Start Date: 07/15/2021 Offer mosquito spray ([NAME] or natural alternative) to smokers and any outside activity. As Needed; Approach Start Date: 07/15/2021; SUPERVISE SMOKING PER FACILITY POLICY. Review of Resident #26's quarterly MDS assessment, dated 10/25/24, reflected he had clear speech, was able to be understood, and was usually able to understand others. He had minimal difficulty in hearing (ie. difficulty hearing conversation in noisy setting). The Staff Assessment for Mental Status reflected his memory was okay, and he had moderately impaired decision making capability for tasks of daily life. No indicators of psychosis, or behaviors affecting others were noted, but Resident #26 did reject care from one to three days in a seven-day look-back period. He had no range-of-motion impairment, and was independent in most ADL's and movement tasks. Resident #26 ambulated without an assistive device (cane, wheelchair, walker.) Review of Resident #26's smoking risk assessment, completed on 03/13/24 by the Activity Director, reflected Resident #26 smoked cigarettes less than hourly, and did not have any smoking problems, like lack of awareness and orientation including the ability to understand the smoking policy, problems with interpersonal interactions, or dropping smoking materials. The document also reflected Resident #26 did not have any behavioral problems related to smoking, like begging or stealing smoking materials from others, smoking cigarette butts from ashtrays, or smoking in unauthorized areas. He was able to follow the facility safe smoking policy, and was deemed a safe smoker with no referrals necessary. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #26's smoking risk assessment, completed on 06/14/24 by the Activity Director, reflected Resident #26 was a none-smoker (sic) and had no information about smoking capability or behaviors noted. Review of Resident #26's smoking risk assessment, completed on 01/22/25 by the Activity Director, reflected Resident #26 was a none-smoker (sic) and had no information about smoking capability or behaviors noted. Review of Resident #26's smoking assessments in the electronic medical record reflected no smoking assessments dated between 06/14/24 and 01/22/25. Interview and observation on 01/22/25 at 10:42 AM revealed Resident #26 ambulating into his room while the surveyor was interviewing his roommate. When the surveyor asked Resident #26 if she could speak with him for a few minutes, he politely declined to be interviewed at that time, or any later time. Observation on 01/22/25 at 1:22 PM revealed Resident #26 seated outside in an enclosed courtyard with one other resident and a staff member (unknown identity). Resident #26's hands were steady, and he did not appear to have any problems smoking. When he was almost done with one cigarette, he asked the staff member for another. The staff member retrieved another cigarette from a pack in a metal box, and when Resident #26 finished his first, the staff member handed the second to him, and lit it for him. Observation on 01/24/25 at 8:00 AM revealed Resident #26 ambulating in the hall. He was friendly when greeted by the surveyor, and when asked how his smoke breaks were going, he said they were good, but it was cold out. He again declined to be interviewed any further. An interview on 01/24/25 at 10:02 AM with the Activity Director revealed she was responsible for arranging smoke breaks at the facility, and for doing smoking assessments. She stated the smoking assessments were supposed to be done with the quarterly reports (MDS) if it showed up in the EMR, and when they popped up, she did them. She said there was an initial assessment, which was a little different from the others. She said she marked on the assessment if someone was a safe smoker, or if they needed additional interventions to keep them safe. She said the assessment is there to determine if someone needs an apron to prevent them from dropping ashes on themselves, or any other interventions. She said along with training staff for smoke breaks, monitoring and assessing residents, and arranging breaks and acquiring and storing smoking materials, she is responsible for noting changes in the resident which could change their safe smoking status. She said the Administrator trained her, and sometimes reminded her to check smoking documentation. She said she was out sick, and in the hospital, for part of the month of June 2024, and the month of July 2024, and she might have missed something at that time . While going over Resident #26's most recent smoking assessment with her, she said she was surprised, and must have made an error on it. She said the assessments were important because they helped the staff know how to keep the residents safe. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Activity Director on 01/24/25 at 10:23 AM revealed the Activity Director returned to inform the surveyor that she did not know how, but she clearly made an error on Resident #26's smoking assessments. She said sometimes when she pulled up the EMR a smoking assessment popped up for her to do, and sometimes it did not. She said she just learned that she could add one if it did not automatically show up for her. She brought her binders, to show the surveyor how her system worked. The Activity Director said she thought she would be able to correct the 01/22/25 assessment, because it was so recent, but she could not correct the older one. She explained to the surveyor that she printed out the activity assessments, and hand wrote on the top margin if they were a smoker, and she made a big, red checkmark on the page when she completed the smoking assessment, to keep track of what she had completed. She said she knew the date it was due, but the due date the EMR printed out on the activity assessment. She said the document had the check mark on it for the smoking assessment, and she did not know what happened to the smoking assessment for September 2024. Review of the activity assessment, completed on 09/16/24, from the Activity Director's binder, reflected she had written smoker and the document had two red checkmarks on it. An interview on 01/24/25 at 2:53 PM with the ADON revealed she had not been at the facility very long, so was not familiar with the policy regarding how often the smoking assessments were done, but she knew the purpose of them was to keep residents safe. An interview on 01/24/25 at 5:03 PM with the DON revealed she had not been at the facility long, but she thought the smoking assessments would be done on admission, and as needed, if there was an issue with the resident. She said they were important because the needed to make sure the resident was safe, and the assessment would let them know if additional equipment, like an apron, would be needed. Review of the facility policy Smoking Policy - Residents, revised October 2023, reflected: Policy Statement: This facility has established and maintains safe resident smoking practices.; Policy Interpretation and Implementation (.) 7. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes: a. current level of tobacco consumption; b. method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.); c. desire to quit smoking; and d. ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). (.) 9. A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. (.)