STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. Building B. Wing	03/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town and Country Nursing and Rehabilitation Center	625 N Main St Boerne, TX 78006

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564 48366 Based on interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey Agency, for 4 of 24 residents (Residents #15, #50, #52, and #47) reviewed for allegations of abuse, neglect, exploitation, and mistreatment, in that: 1. The Administrator and the DON did not report to the state agency and or investigate Resident #52's incident on 11/22/2023, when she was hospitalized and diagnosed with overdose related to self-medication with Diphenhydramine (an antihistamines; used for relief from symptoms related to hay fever, upper respiratory allergy, or cold symptoms) and hydrocodone (a narcotic analgesic agent for the treatment of moderate to moderately severe pain). 2. The Administrator and the DON did not report to the state agency and or investigate Resident #50's multiple incidents of drinking beer and receiving quetiapine (used to treat the symptoms of mental illness that caused disturbed or unusual thinking), Zolpidem (used to treat difficulty falling asleep or staying asleep; a class of medications called sedative-hypnotics) and hydrocodone (a narcotic analgesic agent for the treatment of moderate to moderately severe pain) with subsequent falls, possession of cigarettes and a personal lighter while assessed as a smoker who needed supervision. 3. The Administrator and the DON did not report to the state agency and or investigate Resident #15's multiple incidents of drinking beer and receiving methadone with subsequent falls, possession of cigarettes and a personal lighter while assessed as an unsafe smoker who needed supervision. 4. The Administrator and the DON did not report to the state agency and or investigate Resident #47's separate incidents that included alcohol and percocets. This failure could place residents at risk for abuse, neglect, exploitation, and/ or mistreatment. The findings included: (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	1. Resident #52. A record review of Resident #52's admission record revealed an initial admitted [DATE] with diagnoses which included depression, cirrhosis of the liver (permanent scarring that damages your liver and interfere with its functioning), altered mental status, and need for assistance with personal care. A record review of Resident #52's annual MDS assessment dated [DATE] revealed Resident #52 had a BIMS of 06 out of 15 indicating severe mental cognition impairment. A record review of Resident #52's care plan, undated, revealed the following: [Resident #52] is resistive to care at times. Refuses certain medications often . with an intervention Educate resident/family/caregivers of the possible outcome(s) of not complying with treatment or care., initiated 05/30/2023. [Resident #52] has liver disease [related to] cirrhosis with an intervention Give medications as ordered, initiated 10/04/2022. [Resident #52] uses anti-anxiety medications [related to] Anxiety with an intervention Monitor the resident for safety. The resident is taking ANTI-ANXIETY meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia ., initiated 10/04/2022. A record review of Resident #52's hospital documents, dated 02/19/24, revealed Resident #52 was admitted [DATE] with chief complaint of loss of consciousness. The hospital documents reflected EMS was called and on their arrival there was note of a large bottle of Benadryl as well as Norco. There was some concern for polypharmacy. The hospital documents further revealed likely altered mental status secondary to medication effect . The toxicology report on 02/16/2024 at 05:47 PM revealed urine opiates screen was positive. A record review or Resident #52's Medication Administration Record for February, dated 03/28/24, revealed Resident #52 was not administered Norco Tablet 7.5-325 MG (Give 1 tablet by mouth every 6 hours as needed for pain. Ensure resident drinks full glass of water after medication. Do not exceed 3 grams of acetaminophen in 24 hours) from 02/13/24 to 02/19/24. Acetaminophen-Codeine Tablet 300-30 MG (Give 1 tablet by mouth every 6 hours as needed for Pain. Do not exceed 3Gm of [acetaminophen] in 24 hour period) was last given on 02/15/24 at 06:00 AM and at 02:27 PM. During an interview on 03/28/24 at 12:26 PM, the DON stated she can't answer why Resident #52's hospitalization on [DATE] was not reported to the state. The DON stated the administrator was aware of the incident. A record review on 03/27/2024 of the Texas Unified License Information Portal (TULIP) website revealed no facility related report for Resident #52 in February 2024. 2. Resident #50 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A record review of Resident #50's admission record dated 03/27/2024 revealed an admitted [DATE] with diagnoses which included schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood), alcohol abuse, ataxia (Loss of coordination of voluntary muscle movements), nicotine dependence, dementia (A group of symptoms that affects memory, thinking and interferes with daily life) and malignant neoplasm of skin of nose (a cancer that can spread). A record review of Resident #50's admission MDS assessment, dated 01/17/2024, revealed Resident #50 was a [AGE] year-old male admitted for long term care and was assessed with a BIMS score of 15 out of a possible 15 which indicated no cognitive impairment. Further review reveled resident #50 used a walker and needed set up or clean up assistance .supervision or touching assistance with ADL's. A record review of Resident #50's care plan dated 03/26/2024, revealed, (Resident #50) enjoys drinking beer and may have one 12 0z. beer as desired one time a day per MD order (Resident #50) is suspected of drinking while off facility premises when he signs himself out to go out on pass. Patent education unsuccessful Date Initiated: 02/09/2021 Revision on: 08/19/2023 .Administer beer as per MD orders Date Initiated: 02/09/2021; Beer to be kept in medication room refrigerator. Date Initiated: 02/09/2021; Resident must supply own beer Date Initiated: 02/09/2021 . further review revealed (Resident #50) is a smoker. (Resident #50) refused to sign the facility smoking policy. Educated resident of facility policy, still refused to sign (Resident #50) is non-compliant with facility policies, and smoking policies Date Initiated: 12/26/2018 Revision on: 05/10/2023 . The resident requires SUPERVISION while smoking. Date Initiated: 05/10/2023 . The resident's smoking supplies are stored in secure area behind the nurses station; Date Initiated: 12/26/2018; Revision on: 05/21/2021 . (Resident #50) has impaired cognitive function and impaired thought processes r/t Dementia Date Initiated: 03/21/2019 A record review of Resident #50's Nursing - Smoking Safety Screen dated 01/17/2024, signed by LVN R, revealed Resident #50 needed supervision while smoking. A record review of Resident #50's physician's orders dated 03/27/2024 revealed Resident #50 was prescribed the following: *quetiapine 500mg oral tablets by mouth at bedtime, 01:00 AM, for schizophrenia disorder; *zolpidem 5mg by mouth at bedtime, 01:00 AM, for insomnia; and *hydrocodone - acetaminophen 7.5mg/325mg by mouth 4 times a day (02:00 AM, 08:00 AM, 02:00 PM, and 08:00 PM, for pain in knees . Further review revealed Resident #50 was also prescribed 1 12-ounce beer daily at 07:00 PM. A record review of resident #50's doctors progress note dated 08/15/2023 revealed [MD S] documented resident 50's HPI (History of Present Illness), [AGE] year-old white male at facility for long term care, seen today for regulatory physician visit, and follow up of multiple complex medical issues. He has a past medical history of EtOH (alcohol) dependence, weakness with falls, COPD, . tobacco use disorder . he has a history of surreptitious (secret) EtOH (alcohol) use .assessment and plan .EtOH abuse: ongoing chronic intermittent issue. Is allowed a small agreed upon amount of beer (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A record review of Resident #50's nursing progress note dated 08/18/2023 at 05:38 AM, LVN Z documented Resident (#50) pulled bathroom light, aids reported patient was on the floor, in between bathroom and bed, facing up. Patient had a strong odor of alcohol. Nurse asked Resident if he has been drinking alcohol, patient answers yes, free beer, when nurse question where he received it from he did not answer and only states it was free beer patient vitals were taken upon arrival blood pressure 98/67, 96.8 temp(erature), R(espirations) 18, 02% 95, patient refused full assessment, nurse was able to do a quick assessment, no skin tear, no redness noted to head, back, arms or legs. Patient denies pain, patient denies hitting his head, patient denies range of motion assessment, patient denies help too bed, CNA moved his [NAME] to his side and he was able to get up on his own. Patient denies neuro checks and further assessment. Resident was given his 12 AM, 1:00 AM, and 2:00 AM meds; at that time nurse did not notice any alcohol odor on him. The patient was hanging out in the front of the building and the back patio area with other residents this evening. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's August 2023 Medication Administration Record revealed LVN Z documented on 08/18/2023 she administered Resident #50's zolpidem 5mg at midnight, hydrocodone 7.5mg at 02:00 AM, and quetiapine 400mg at 01:18 AM. A record review of Resident #50's nursing progress note dated 08/20/2023 at 02:07 AM LVN Y documented, Resident was found on the floor by the CNA. Resident awake and responsive. He was on the floor close to the restroom with walker by his feet. Resident unable to state what happened or how he fell . He kept repeating I'm OK Resident did report he was drinking outside. He had been back for less than an hour when found on floor. Vital signs within normal limits. No injury noted. No complaints of pain voiced. Resident was assisted up to his feet and he was able to use walker but needed staff to hold him up. He made it to the bed where he immediately fell asleep and started snoring. [NAME] and call bell within reach. Door left open to keep a lookout for him. No other complaints at this time. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's August 2023 Medication Administration Record revealed LVN Y documented on 08/20/2023 she administered Resident #50's zolpidem 5mg at midnight, hydrocodone 7.5mg at 02:00 AM, and quetiapine 400mg at 01:01 AM. A record review of Resident #50's nursing progress note dated 09/02/2023 at 02:30 AM LVN A documented, Resident finally in bed. Slurs words. Resident does not smell like alcohol but behaving the same on days he is inebriated. Resident already had night meds and is drowsy. Blood pressure earlier tonight around 12:00 AM was 140/92. Blood pressure lower at this time. Will sometimes get up from laying position and has blood pressure drop and will have fall where he sits down. Gets up by himself. Assisted tonight. Still no injury noted. neuros within normal limits for him. Has range of movement in all extremities. No complaint of pain. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's September 2023 Medication Administration Record revealed LVN A documented on 09/02/2023 she administered Resident #50's zolpidem 5mg at midnight, hydrocodone 7.5mg at 02:00 AM, and quetiapine 400mg at 12:52 AM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A record review of Resident #50's progress note dated 09/12/2023 at 02:39 PM the Activities Director T documented, Resident (#50) was sitting on the patio at 1:30 PM (staff) let resident know it was not smoke break time yet. Resident replied angrily 'I am allowed to sit out here.' I walked out to the patio at 1:45, Resident asked if (staff) had told me to come. I saw a lighter tightly held in his right hand and he had a cigar (unlit) hidden behind the ashtray. Resident did not move the cigar or lighter until (staff) came out at 2:00 PM for smoke break, he then hid them quickly and accepted two more cigars from her. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's nursing progress note dated 10/01/2023 at 12:56 AM LVN A documented, Resident (#50) had recent fall outside and hit face. Has not complained of pain so far tonight. Gets scheduled pain med at night. Able to move all extremities. Uses rollator, ambulates. Had X-ray done recently of right ankle. No fractures, injury. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's October 2023 Medication Administration Record revealed LVN A documented on 10/01/2023 she administered Resident #50's zolpidem 5mg at midnight, hydrocodone 7.5mg at 02:00 AM, and quetiapine 400mg at 01:16 AM. A record review of Resident #50's nursing progress note dated 10/02/2023 at 01:54 AM LVN A documented Resident (#50) had recent fall outside. CMA witnessed incident. resident did not hit head, had no injuries noted. neuros have been within normal limits for him. has had no complaint of pain. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's October 2023 Medication Administration Record revealed LVN A documented on 10/02/2023 she administered Resident #50's zolpidem 5mg at midnight, hydrocodone 7.5mg at 02:00 AM, and quetiapine 400mg at 01:19 AM. A record review of Resident #50's nursing progress note dated 02/18/2024 11:59 AM the Administrator documented, Witnessed (Resident #50) smoking in smoking patio during a non-smoking time. Approached (Resident #50) and he stated, 'you caught me.' Discussed the importance of smoking during supervised smoking times only to prevent any injuries. Discussed he is not allowed to keep smoking materials on his person and all smoking materials are to be turned in at the end of each smoke break. (Resident #50) voiced understanding and stated he does not have any other smoking materials on his person. Asked where he obtained cigarette and how he lit it, he again denied having any smoking materials on his person. He states it won't happen again. (Resident #50) does sign himself out on pass frequently. Explained to (Resident #50) if he purchases smoking materials when out on pass, two turn in smoking materials to charge nurse. he voiced understanding. Administrator, LNFA. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's nursing progress note dated 03/05/2024 at 12:35 AM LVN A documented Resident (#50) seen lowering himself to one knee outside on West. nurse from [NAME] witness resident lowering himself. nurse helped him back up. resident came back over to east. CNA from [NAME] came over to inform east nurse who went over looking for him. nurse on [NAME] informed nurse on east what occurred. resident without injury resident in room at this time. Further review revealed the note was also posted to the facility's 24-hour report. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A record review of Resident #50's March 2024 Medication Administration Record revealed LVN A documented on 03/05/2024 she administered Resident #50's zolpidem 5mg at midnight, hydrocodone 7.5mg at 02:00 AM, and quetiapine 500mg at 01:00 AM. A record review of Resident #50's nursing progress note dated 03/05/2024 06:50 PM LVN C documented, Resident (#50) did not wait for nurse on [NAME] side to escort for smoking break even after he was told not to be outside smoking on own will continue to assess. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's nursing progress note dated 03/18/2024 at 01:20 AM LVN A documented Resident (#50) reported to have fall outside at front of building, reported by CNA on [NAME] and another Resident. Resident then came back over to east on rollator and explained several times until he stated what occurred. Stated he was sitting on rollator, leaned over to put in code to get in front lobby area under carport, and rollator slipped out from behind him, he went down on one knee and caught himself with right arm on planter pot, had episode of dizziness, took a few deep breaths, got himself up and back on rollator. No injury noted, had on shoes. Went on down hall. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's March 2024 Medication Administration Record revealed LVN A documented on 03/18/2024 she administered Resident #50's zolpidem 5mg at midnight, hydrocodone 7.5mg at 02:00 AM, and quetiapine 500mg at 01:00 AM. A record review of Resident #50's nursing progress note dated 03/19/2024 at 02:49 AM LVN A documented (Resident #50) had recent fall outside of building. no injury noted. no complaint of pain. neuros within normal limits. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's March 2024 Medication Administration Record revealed LVN A documented on 03/19/2024 she administered Resident #50's zolpidem 5mg at midnight, hydrocodone 7.5mg at 02:00 AM, and quetiapine 500mg at 01:00 AM. A record review of Resident #50's nursing progress note dated 03/20/2024 at 11:19 PM LVN C documented had an assisted fall while walking through the doorway from smoking no injuries. Reported to (the physician group). Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's nursing progress note dated 03/25/2024 05:39 PM the Administrator documented, Administrator made aware resident may have smoking materials on his person. Administrator visited with Resident #50. States he does not have any cigarettes but did give Administrator his lighter. Re-educated Resident #50 on importance of safety, turning in all smoking materials to charge nurse or any manager, and not keeping smoking materials on his person or room while in facility. resident voiced understanding. Administrator LNFA. Further review revealed the note was also posted to the facility's 24-hour report. A record review on 03/30/2024 of the Texas Unified License Information Portal website for July 2023 to March 03/30/2024, accessed 03/30/2024, revealed no facility related report for Resident #50. 3. Resident #15 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A record review of Resident #15's admission record dated 03/26/2024 revealed an admitted [DATE] with diagnoses which included alcoholic cirrhosis of liver (a condition in which your liver is scarred and permanently damaged), viral Hepatitis C (a virus that attacks the liver and leads to inflammation), and alcohol abuse. A record review of Resident #15's admission MDS assessment, dated 02/02/2024, revealed Resident #15 was a [AGE] year-old male admitted for long term care and was assessed with a BIMS score of 15 out of a possible 15 which indicated no cognition impairment. Further review reveled resident #50 used a wheelchair and needed set up or clean up assistance .supervision or touching assistance with the wheelchair. A record review of Resident #15's care plan dated 03/26/2024, revealed, (Resident #15) enjoys drinking beer and may have one 12 0z. beer as desired one time a day per MD order .beer to be kept in medication room refrigerator .(Resident #15) must provide own beer .(Resident #15) is a smoker. (Resident #15) is at times non-compliant with facility policies and smoking policy. (Resident #15) refused to sign the facility smoking policy . instruct resident about the facility policy on smoking; locations, times, safety concerns . the resident requires supervision while smoking . the resident smoking supplies are stored at the nurses station A record review of Resident #15's Nursing - Smoking Safety Screen dated 01/30/2024, signed by the MDS Nurse, revealed Resident #15 could not safely use a lighter and needed supervision while smoking. A record review of Resident #15's physician's orders dated 03/27/2024 revealed resident #15 was prescribed the following medications: *cyclobenzaprine 10mg (a muscle relaxer) give every 8 hours, 12:00 AM, 08:00 AM, and 04:00 PM; *methadone 5mg (a narcotic used to treat opioid use) give 1 tablet .every 8 hours, 07:00 AM, 3:00 PM, and 11:00 PM; and *Tylenol with codeine#3 (used to relieve mild to moderate pain. Codeine belongs to a class of medications called opiate (narcotic) analgesics), and 1 12-ounce beer at 07:00 PM. A record review of resident #15's Nurse Practitioner notes revealed NP B documented on 03/02/2024 at 06:09 PM, . patient (Resident #15) is a chronic methadone user. Staff reports that the patient checks himself out a few times a week and wheels himself to the bar down the street or to the convenience store and buys beer and sits outside and drinks beer. Staff reports administration is aware Further review revealed the note was also posted to the facility's 24-hour report. A record review of resident #15's medical record revealed nursing progress notes as follows: On 12/21/2023 at 12:15 AM RN U documented, Resident on cement sidewalk proximal to employee after hours door near the bushes. he is left side lying in front of his wheelchair. It is drizzling rain. Per another male resident, it began to rain and resident rounding the corner too fast and slid out of the wheelchair. The witness stated that he did not hit his head on the sidewalk. Resident was out on pass at the time. Further review revealed the note was also posted to the facility's 24-hour report. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 12/23/2023 at 10:57 PM RN U documented, Resident had slipped out of wheelchair outside while out on pass Further review revealed the note was also posted to the facility's 24-hour report. On 12/24/2023 at 11:20 PM LVN A documented, Resident (#15) had slipped out of wheelchair outside while out on pass. No injuries, neuros within normal limits for him. Alert and verbal. Has no complaint of any pain from falling out of wheelchair. Further review revealed the note was also posted to the facility's 24-hour report. 02/18/2024 at 12:05 PM the Administrator documented, Witnessed (Resident #15) smoking during a non-smoking time in patio. Upon approaching (Resident #15), he immediately put out the cigarette in ashtray. Discussed the importance of following smoking policy and supervised smoking to prevent any injuries. (Resident #15) frequently attempting to change the subject / topic; redirected conversation and he voiced understanding. (Resident #15) frequently goes out on pass and discussed turning in all smoking materials to charge nurse should he purchase any smoking materials while out on pass. He voiced understanding. Administrator, LNFA. Further review revealed the note was also posted to the facility's 24-hour report. 03/05/2024 at 06:42 PM LVN C documented, Resident (#15) ask to have door unlocked so he could go outside I'll hit [sic] him know everyone is waiting on [NAME] nurse to take him that she will be here in a minute and he said no I can go outside whenever I want I said yes but not to smoke on your own he left and is smoking outside even after being told to wait for nurse from [NAME] side. Further review revealed the note was also posted to the facility's 24-hour report. 03/25/2024 at 06:28 PM the Administrator documented, Administrator made aware that (Resident #15) may have smoking materials on his person. Administrator, senior administrator, and RCS visited (Resident #15) in room. (Resident #15) initially denied having smoking materials. discussed concern for his safety and the safety of other residents. he was asked again if he had smoking materials at which time he produced 2 packs of cigarettes. he was asked if he had a lighter and he produced a lighter as well. read educated importance of turning in all smoking materials to the charge nurse or any manager. (Resident #15) does go out on pass and he was educated on turning in smoking material if he purchases and brings back smoking materials to the facility. Administrator, LNFA. Further review revealed the note was also posted to the facility's 24-hour report. A record review on 03/30/2024 of the Texas Unified License Information Portal website for July 2023 to March 03/30/2024, accessed 03/30/2024, revealed no facility related report for Resident #15. During an observation on 03/25/2024 at 02:24 PM revealed Resident #50 and resident #15 seated outside in the designated smoking patio. The facility's Activities Assistant was in control of a large yellow metal cabinet on wheels which contained the facility Residents smoking materials, for example, cigarettes, and lighters. Resident #50 and Resident #15 were observed seated at a patio table. Resident #50 and Resident #15 were observed to each reach into their pockets and produce cigarettes and personal lighters. Resident #50 proceeded to light and begin to smoke a cigarette. Resident #15 was observed to place a cigarette in his mouth but held his lighter in his hand. The Activities Assistant presented resident #50 with an additional 2 cigarettes and did not offer to light Resident #50's cigarette because it was already lit. The Activities Assistant presented Resident #15 with an additional 2 cigarettes and used her lighter to ignite resident #15's cigarette. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town and Country Nursing and Rehabilitation Center	625 N Main St Boerne, TX 78006

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 03/25/2024 at 02:40 PM the Activities Assistant stated Resident #50 had his lighter and cigarettes in his possession and did not light Resident #50's cigarette because it was already lit. The Activities Assistant stated she did light Resident #15's cigarette and gave him an additional 2 cigarettes. The Activities Director stated resident #50 and Resident #15 did have their cigarettes and lighters on their person and have a history of going out and purchasing their cigarettes and lighters. The activities director stated the practice of keeping cigarettes and lighters was against facility policy and would report the incident to the Activities Director. During an interview on 03/26/2024 at 04:55 PM LVN C stated Residents #50 and #15 were often smoking unsupervised. LVN C stated Residents #15 and #50 had a history of signing themselves out every evening around 6 to 7 PM and would return around 11PM to midnight. LVN C stated Residents #15 and #50 had a history of smelling like beer because they had an order for beer. LVN C stated she had often signed resident #50's and resident #15's medication administration record for the order to administer the beer even though the facility kept no beer for the residents, we don't have beer here .they sign themselves out and maybe buy beer .I don't know what they do when they sign themselves out. LVN C stated she had verbally told the leadership of the resident's routine but could not elaborate details of the reports. LVN C stated she had not documented any incident reports or reports to the physicians. During an interview on 03/28/2024 at 03:00 PM LVN C stated for Residents #15 and #50 she often signed the medication administration record for the order to administer the beer without administering the beer. LVN C she did not report Residents #15 and #50 might be drinking off the premises and if they smell like beer it is because they have an order for beer. During an interview on 03/31/2024 at 02:43 PM LVN A stated she worked the 10PM to 6AM shift on the hall for Residents #50 and #15. LVN A stated Residents #50 and #15 had a history of signing themselves out and leaving the facility on the shift before she arrived. LVN A stated Residents #50 and #15 would return back to the facility usually around 11PM to midnight. LVN A stated Residents #50 and #15 would sometimes return to the facility smelling like alcohol and then would be administered their scheduled quetiapine; zolpidem; and hydrocodone. LVN A stated Residents #50 and #15 had a history of falling around these times, from midnight to 2AM. LVN A stated she had documented the episodes of falls with the suspicion of Residents #50 and #15 drinking alcohol while away from the facility. 4. Resident #47 A record review of Resident #47's admission record revealed an initial admitted [DATE] with diagnoses which included cirrhosis of the liver (degenerative disease of the liver resulting in scarring and liver failure), major depressive disorder, cognitive communication deficit (difficulty with communication that has an underly cause in a cognitive deficit), unsteadiness of feet, anxiety disorder, and age-related physical debility (physical weakness). A record review of Resident #47's annual MDS assessment dated [DATE] revealed Resident #47 had a BIMS of 15 out of 15 indicating intact cognition. A record review of Resident #47's care plan, undated, revealed the following: [Resident #47] has liver disease r/t cirrhosis with interventions that included Give medications as ordered, date initiated 12/18/2018. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A record review of TULIP on 03/27/2024 revealed an intake on 01/11/2024, reported by an anonymous complainant, revealed My second concern is a situation where a resident, [Resident #47] is reported for having empty liquor bottles in her room and is know [sic]. To be pocketing her Percocet and trading them with a visitor for the liquor. There were no intakes reported by the facility from December 2023 to present day involving Resident #47. A record review of Resident #47's nursing note, dated 02/03/2024 at 09:50 PM and authored by LVN AI, revealed, Dayshift CNA notified nurses resident was on the floor after falling. Oncoming nurse entered room to find resident lying on her back sideways across bed. CNA notified nurse patient was assisted back into bed. Resident was assisted with proper repositioning on bed. Appears groggy and eyes with glossy appearance. Disoriented. Laughing when asked what happened and how she fell . CNA answered she slipped on her shoes. Resident stated, yeah I sure did slip on my shoes. Speach [sic] slurred. Strong smell of alcohol. Off going nurse in room for verification of this. Bed low, call light in reach. Resident educated on fall precautions and importance of not getting OOB by herself. Encouraged her to call for any assistance needed. Also encouraged use of RW with ambulation. [DON] was notified of unwitnessed fall and patient current symptoms/condition. Attempted to call on call NP/MD for [MD AH] but not able to reach on call. 72 hour neuro checks initiated. A record review of Resident #47's Doctor's Progress Note, dated 02/08/2024 and signed by MD AH, revealed, [Resident #47 had a fall secondary to being inebriated. They state that the family member of another resident is trading [NAME] and alcohol for her percocets. They have tried to stop this. They are aware of the situation and are looking into it . They have searched her room and are trying to get rid of her alcohol. She is allowed to have some wine at night but not to have [NAME] being the hard alcohol and get inebriated. A record review of Resident #47's nursing note, dated 03/20/2024 at 01:15 PM and authored by LVN D, revealed, Several pills found under and next to residents wheelchair, some pills wrapped in Kleenex appearing slightly dissolved. Pills with identifying numbers verified with pills in card of Percocet. [Doctor's group] called and message left requesting a return call. All supervisors notified. During an interview on 03/28/24 at 09:39 AM, Confidential Staff Me [TRUNCATED]

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564 Based on observation, interview, and record review the facility's interdisciplinary team failed to review and revise the care plan after each assessment, including both the comprehensive and quarterly review assessments for 3 of 32 residents (Resident #18) reviewed for revised care plans in that: 1. The facility failed to ensure Resident #18's use of dentures was care planned. 2. The facility failed to ensure Resident #8's care plan was updated after an attempted elopement. These failures could place residents at risk for not receiving appropriate interventions to meet their current and changing needs. The findings included: 1. Record review of Resident #18's face sheet, dated 03/29/2024, reflected a [AGE] year-old resident initially admitted to the facility on [DATE] with diagnosis that included schizoaffective disorder (a combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder), parkinsonism (disorder of the central nervous system that affects movement, often including tremors), and hypothyroidism (A condition in which the thyroid gland doesn't produce enough thyroid hormone). Record review revealed Resident #18's MDS Assessment, dated 1/15/2024, reflected no information relating to the status of Resident #18's dentures. Record review of Resident #18's care plan, dated 03/29/2024, reflected no information relating to the resident's use of dentures, the status of the dentures, how frequently they should be cleaned, or what staff should do to assist the resident with her dentures. Observation on 03/25/2024 at 1:39 PM, during an interview with Resident #18, revealed the resident had a loose-fitting upper denture that rattled in her mouth as she spoke. 2. Record review of Resident #8's admission record revealed an initial admitted [DATE] with diagnoses which included dementia (loss of thinking, remembering, and reasoning skills), Alzheimer's (brain disorder that gets worse over time), major depressive disorder, anxiety, cognitive communication deficit, dependence on wheelchair, and altered mental status. Record review of Resident #8's annual MDS assessment dated [DATE] revealed Resident #8 had a BIMS of 08 out of 15 indicating moderate mental cognition impairment. Record review of Resident #8's care plan, undated, revealed, [Resident #8] is at moderate risk for elopement risk/wanderer [related to] Alzheimer's diagnosis and medications that could lend to increased confusion, initiated on 07/01/2019 and revised on 02/06/2020. No intervention has been added since 08/15/2019. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of a nursing note on 03/07/2024 at 10:01 PM, authored by Nurse AG, revealed [Resident #8] remained agitated and verbally/physically aggressive with staff this shift. Made multiple attempts at exiting building through emergency exits. Resident opened emergency exit next to the beauty salon and attempted to leave, yelled, cussed, and screamed at staff when staff redirected and brought her back to the nurse's station. Resident began attempting to exit through side door, before being assisted back to her room and set up with a TV show of her choice. no further attempts to leave building were made. Yelling, cussing, and screaming continued through the shift. During an interview on 03/29/24 at 04:44 PM, LVN M revealed she used the care plans to see what interventions are needed to follow for falls and elopement. She revealed Resident #8 was not exit seeking and was unaware of any previous incidents where she exhibited exit seeking behavior. During an interview on 03/29/24 at 05:11 PM, the DON revealed the social worker updated the elopements/wandering behavior in care plans, however, the DON has had to do this while the facility did not have a social worker. The DON revealed she was not aware of exit seeking behavior of Resident #8 on 03/07/24 and the care plan should've been updated due to this incident. Record review of the facility's policy Elopements and Wandering Residents, dated 11/21/22, reflected The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards or risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Record review of the facility's policy Comprehensive Care Plans, dated 10/24/22, reflected The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. 48366

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47564 Based on interviews, and record reviews the facility failed to ensure residents who are unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; for 1 of 24 residents (Resident #12) reviewed for assistance with showers. The facility failed to provide Resident #12 a shower for 7 days . This failure could place residents at risk for demoralized self-esteem and risk for infections. The findings included: A record review of resident #12's admission record dated 03/25/2024, revealed an admitted [DATE] with diagnoses which included paraplegia (paralysis of all or part of your trunk, legs), acquired absence of left leg below the knee, and major depression. A record review of resident#12's annual MDS assessment dated [DATE] revealed resident #12 was a [AGE] year-old male admitted for long term care, assessed with a BIMS score of 13 which indicated intact cognition. Further review revealed resident #12 was assessed as substantial / maximal assistance - helper does more than half the effort. helper lifts or holds trunk or limbs and provides more than half the effort for showers. A record review of resident #12's care plan dated 03/25/2024 revealed, (Resident #12) is at risk for impaired skin integrity related to: bladder incontinence, decrease skin elasticity, diabetes .history of pressure ulcers, impaired mobility . provide timely incontinent care; provide and or encourage good skin care keeping skin clean, conditioned, reducing excessive moisture .(Resident #12) has an activities of daily life self-care performance deficit related to paraplegia . bathing showering; requires physical help in part of activity with extensive assistance times one staff for bathing shower A record review of resident #12's shower log revealed he last received a shower from CNA AA on 03/18/2024 at 09:15 PM. During an interview on 03/25/2024 at 02:50 PM Resident #12 stated he was neglected for showers. Resident #12 stated he had not been showered for 2 weeks and was frustrated no one cared. Resident #12 stated he was due a shower twice a week on Tuesdays and Saturdays in the evenings before bed. During interview on 03/25/2024 at 03:30 PM LVN M stated she had her own personal shower schedule for her residents who receive showers on the 0:00 AM to 02:00 PM shift. LVN M stated resident #12 was scheduled to receive showers on Tuesdays and Thursdays during the 02:00 PM to 10:00 PM shift. LVN M stated the 02:00 PM to 10:00 PM shift nurse was LVN C. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/25/2024 at 04:07 PM LVN C stated she was the 02:00 PM to 10:00 PM nurse for Resident #12 and he was scheduled to receive assistance with showers on Tuesdays and Thursday evenings. LVN C stated she did not review if the CNA's documented residents' showers. LVN C could not review residents CNA shower documentation because she did not know where to find the documentation. During an interview on 03/25/2024 at 04:25 PM CNA AA stated she did provide showers for Resident #12 but sometimes she did not document, and many times he refused, and she did not work some Tuesdays and Thursdays, she stated she recalled she showered him, 03/18/2024. During an interview on 03/25/2024 at 06:00 PM the administrator received a report from the surveyor, resident #12 alleged he had not been bathed in 2 weeks. The Administrator stated she would report the allegation of neglect to the state agency and initiate an investigation. During an interview on 03/30/2024 at 08:30 AM the DON stated Resident #12's record for ADL's revealed no documentation for showers and resident #12 claimed he had not received assistance with showers. The DON stated he accepted assistance with a shower on 03/26/2024 in the evening. The DON stated the facility in-serviced the staff for Abuse, neglect, and exploitation prevention and ADL documentation. A record review of the facility's Activities of Daily Living policy dated 05/26/23, revealed, the facility will, based on the residence comprehensive assessment and consistent with the residents needs and choices, assure residents abilities in ADL do not deteriorate unless deterioration is unavoidable. care and services will be provided for the following activities of daily living: bathing, dressing, grooming, and oral care . A record review of the facility's Abuse, Neglect, and Exploitation policy dated 08/15/22, revealed, 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 . identification of abuse, neglect and exploitation . the facility will have written procedures to assist staff in identifying the different types of abuse- mental /verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. this includes staff to resident abuse and certain resident to resident altercations. possible indicators of abuse include, but are not limited to: . physical marks such as bruises or patterned appearances such as a handprint, built a ring mark on a resident body, physical injury of a resident, of unknown source .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564 Based on observation, interview, and record review, the facility failed to provide resident preferences for individual activities and independent activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 2 of 8 residents (Resident #48 and Resident #62) reviewed for activity preference, in that: The facility failed to ensure Resident #48, and Resident #62 received activities to meet their interests. This failure could place residents at risk for not having activities to meet their interests or needs and a decline in their physical, mental, and psychosocial well-being. The findings included: 1.Record review of Resident #48's face sheet, dated 3/29/2024, reflected Resident #48 was a [AGE] year-old female resident who was initially admitted to the facility on [DATE] with diagnosis of paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), and generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities). Record review of Resident #48's quarterly MDS assessment, dated 02/09/2024, reflected Resident #48 had clear speech and was understood by staff. The MDS revealed Resident #48 was able to understand others. The MDS revealed Resident #48 had a BIMS score of 15, which indicated no cognitive impairment. The MDS revealed Resident #48 had no behaviors that affected others and had no behaviors of wandering. Record review of Resident #48's comprehensive care plan, dated 03/29/2024, reflected Resident #48 enjoyed activities such as painting, drawing, board games, puzzles, and pet therapy, and that she requires a variety of activity types and locations to maintain interests. Resident #48's care plan further reflected that she was able to sign herself out on pass when she pleased. Interview on 3/29/2024 at 11:15 AM, Resident #48 stated there were not many activities for her to attend, as most of them were tailored toward an older population. Resident #48 stated she preferred to do arts and crafts and to go outside and sit with the cats on the back fenced in patio area. Resident #48 went on to say that they rarely do arts and crafts and are regularly told they are not able to sit on the back patio due to the door being locked and nurses stating they did not have time to unlock the door or to supervise the residents on the fenced in patio. Resident #48 stated she was lonely and did not have much to do, and sitting on the patio with the cats was something that brought her more joy than anything else and had been told by nursing staff that it was unlikely residents would be allowed to sit on the patio without supervision. Observation of back patio area on 3/25/2024 at 11:05 AM revealed a fenced in patio area with an approximately 8-foot-tall privacy fence, preventing residents from exiting the patio area. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 3/25/2024 at 11:05 AM, the Activities Director stated that residents can only sit outside during smoking break times, and if they do not want to come outside at the same time as smoking break occurs, they generally cannot come outside as the door to the patio is locked and nursing staff and activities staff do not have time to open the door for residents throughout the day. 2.Record review of Resident #62's face sheet, dated 03/29/2024, reflected Resident #62 was a [AGE] year-old female resident who was initially admitted to the facility on [DATE] with diagnosis of spina bifida (a birth defect in which a developing baby's spinal cord fails to develop properly), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), and anxiety disorder (severe, ongoing anxiety that interferes with daily activities). Record review of Resident #62's face sheet, dated 01/08/2024, reflected Resident #62 had clear speech and was understood by staff. The Quarterly MDS Assessment, dated 2/9/2024, revealed Resident #62 was able to understand others. The MDS revealed Resident #62 had no behaviors that affected others and had no behaviors of wandering. Record review of Resident #62's comprehensive care plan, dated 03/29/2024, reflected Resident #62 enjoyed activities such as arts and crafts, listening to music, special events, watching tv/movies, going outdoors, visiting with family, painting, and socializing. Interview on 3/26/2024 at 2:46 AM, Resident #62 stated that there are not many activities that people her or Resident #48's age are interested in, and that they have asked for more activities but have not received any. Interview on 3/31/2024 at 7:00 PM, the Social Worker stated that he had not had a chance to implement many new activity ideas since he began working at the facility on 03/07/2024 and had not had time. A policy on resident activities was requested on 3/29/2024 at 12:08 PM and was not provided upon exit.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	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** 47564 48366 Based on observations, interviews, and record reviews the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 4 of 24 Residents (Residents #15, #47, #50, and #82) reviewed for safety, monitoring, and supervision. 1. The facility failed to monitor and supervise Resident #50's multiple incidents of drinking beer and receiving quetiapine (used to treat the symptoms of mental illness that caused disturbed or unusual thinking), Zolpidem (used to treat difficulty falling asleep or staying asleep; a class of medications called sedative-hypnotics) and hydrocodone (a narcotic analgesic agent for the treatment of moderate to moderately severe pain) with subsequent falls, possession of cigarettes and a personal lighter while assessed as a smoker who needed supervision. 2. The facility failed to monitor and supervise Resident #15's multiple incidents of drinking beer and receiving methadone with subsequent falls, possession of cigarettes and a personal lighter while assessed as an unsafe smoker who needed supervision. 3. The facility failed to monitor and supervise Resident #47's multiple incidents of Resident #47 allegedly drinking unprescribed alcohol and having extra Percocet's on hand. 4. The facility failed to ensure Resident #82 was safe in the facility by allowing her to have toxic hair dye without Doctor's orders or supervision. An Immediate Jeopardy (IJ) was identified on 03/29/2024. While the IJ was removed on 03/31/2024, the facility remained out of compliance at a scope of pattern with risk for harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective actions. This failure could place residents at risk for serious harm, accidents, or major injury. The findings included: 1. Resident #50 A record review on 03/30/2024 of the Texas Unified License Information Portal website for July 2023 to March 03/30/2024, accessed 03/30/2024, revealed no facility related report for Resident #50. A record review of Resident #50's admission record dated 03/27/2024 revealed an admitted [DATE] with diagnoses which included schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood), alcohol abuse, ataxia (Loss of coordination of voluntary muscle movements), nicotine dependence, dementia (A group of symptoms that affects memory, thinking and interferes with daily life) and malignant neoplasm of skin of nose (a cancer that can spread). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A record review of Resident #50's admission MDS assessment, dated 01/17/2024, revealed Resident #50 was a [AGE] year-old male admitted for long term care and was assessed with a BIMS score of 15 out of a possible 15 which indicated no cognition impairment. Further review reveled resident #50 used a walker and needed set up or clean up assistance .supervision or touching assistance with ADL's. A record review of Resident #50's care plan dated 03/26/2024, revealed, (Resident #50) enjoys drinking beer and may have one 12 0z. beer as desired one time a day per MD order (Resident #50) is suspected of drinking while off facility premises when he signs himself out to go out on pass. Patent education unsuccessful Date Initiated: 02/09/2021 Revision on: 08/19/2023 .Administer beer as per MD orders Date Initiated: 02/09/2021; Beer to be kept in medication room refrigerator. Date Initiated: 02/09/2021; Resident must supply own beer Date Initiated: 02/09/2021 . further review revealed (Resident #50) is a smoker. (Resident #50) refused to sign the facility smoking policy. Educated resident of facility policy, still refused to sign (Resident #50) is non-compliant with facility policies, and smoking policies Date Initiated: 12/26/2018 Revision on: 05/10/2023 . The resident requires SUPERVISION while smoking. Date Initiated: 05/10/2023 . The resident's smoking supplies are stored in secure area behind the nurses station; Date Initiated: 12/26/2018; Revision on: 05/21/2021 . (Resident #50) has impaired cognitive function and impaired thought processes r/t Dementia Date Initiated: 03/21/2019 A record review of Resident #50's Nursing - Smoking Safety Screen dated 01/17/2024, signed by LVN R, revealed resident #50 needed supervision while smoking. A record review of Resident #50's physician's orders dated 03/27/2024 revealed resident #50 was prescribed quetiapine 500mg oral tablets by mouth at bedtime, 01:00 AM, for schizophrenia disorder; zolpidem 5mg by mouth at bedtime, 01:00 AM, for insomnia; and hydrocodone - acetaminophen 7.5mg/325mg by mouth 4 times a day (02:00 AM, 08:00 AM, 02:00 PM, and 08:00 PM, for pain in knees . Further review revealed resident #50 was also prescribed 1 12-ounce beer daily at 07:00 PM. A record review of resident #50's doctors progress note dated 08/15/2023 revealed Dr. S documented resident 50's HPI (History of Present Illness), [AGE] year-old white male at facility for long term care, seen today for regulatory physician visit, and follow up of multiple complex medical issues. He has a past medical history of EtOH (alcohol) dependence, weakness with falls, COPD, . tobacco use disorder . he has a history of surreptitious (secret) EtOH (alcohol) use .assessment and plan .EtOH abuse: ongoing chronic intermittent issue. Is allowed a small agreed upon amount of beer A record review of Resident #50's medical record revealed nursing progress notes and medication administration documentation as follows: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	08/18/2023 at 05:38 AM LVN Z documented Resident (#50) pulled bathroom light, aids reported patient was on the floor, in between bathroom and bed, facing up. Patient had a strong odor of alcohol. Nurse asked Resident if he has been drinking alcohol, patient answers yes, free beer, when nurse question where he received it from he did not answer and only states it was free beer patient vitals were taken upon arrival blood pressure 98/67, 96.8 temp (temperature), R (respirations) 18, 02% 95, patient refused full assessment, nurse was able to do a quick assessment, no skin tear, no redness noted to head, back, arms or legs. Patient denies pain, patient denies hitting his head, patient denies range of motion assessment, patient denies help too bed, CNA moved his [NAME] to his side and he was able to get up on his own. Patient denies neuro checks and further assessment. Resident was given his 12 AM, 1:00 AM, and 2:00 AM meds; at that time nurse did not notice any alcohol odor on him. The patient was hanging out in the front of the building and the back patio area with other residents this evening. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's August 2023 Medication Administration Record revealed LVN Z documented on 08/18/2023 she administered Resident #50's zolpidem 5mg at midnight, hydrocodone 7.5mg at 02:00 AM, and quetiapine 400mg at 01:18 AM. 08/20/2023 at 02:07 AM LVN Y documented, Resident (#50) was found on the floor by the CNA. Resident (#50) awake and responsive. He was on the floor close to the restroom with walker by his feet. Resident unable to state what happened or how he fell . He kept repeating I'm OK Resident did report he was drinking outside. He had been back for less than an hour when found on floor. Vital signs within normal limits. No injury noted. No complaints of pain voiced. Resident (#50) was assisted up to his feet and he was able to use walker but needed staff to hold him up. He made it to the bed where he immediately fell asleep and started snoring. [NAME] and call bell within reach. Door left open to keep a lookout for him. No other complaints at this time. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's August 2023 Medication Administration Record revealed LVN Y documented on 08/20/2023 she administered Resident #50's zolpidem 5mg at midnight, hydrocodone 7.5mg at 02:00 AM, and quetiapine 400mg at 01:01 AM. 09/02/2023 at 02:30 AM LVN A documented, Resident finally in bed. Slurs words. Resident does not smell like alcohol but behaving the same on days he is inebriated. Resident already had night meds and is drowsy. Blood pressure earlier tonight around 12:00 AM was 140/92. Blood pressure lower at this time. Will sometimes get up from laying position and has blood pressure drop and will have fall where he sits down. Gets up by himself. Assisted tonight. Still no injury noted. neuros within normal limits for him. Has range of movement in all extremities. No complaint of pain. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's September 2023 Medication Administration Record revealed LVN A documented on 09/02/2023 she administered Resident #50's zolpidem 5mg at midnight, hydrocodone 7.5mg at 02:00 AM, and quetiapine 400mg at 12:52 AM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	09/12/2023 at 02:39 PM the Activities Director T documented, Resident (#50) was sitting on the patio at 1:30 PM (staff) let resident know it was not smoke break time yet. Resident replied angrily 'I am allowed to sit out here.' I walked out to the patio at 1:45, Resident asked if (staff) had told me to come. I saw a lighter tightly held in his right hand and he had a cigar (unlit) hidden behind the ashtray. Resident did not move the cigar or lighter until (staff) came out at 2:00 PM for smoke break, he then hid them quickly and accepted two more cigars from her. Further review revealed the note was also posted to the facility's 24-hour report. 10/01/2023 at 12:56 AM LVN A documented, Resident (#50) had recent fall outside and hit face. Has not complained of pain so far tonight. Gets scheduled pain med at night. Able to move all extremities. Uses rollator, ambulates. Had X-ray done recently of right ankle. No fractures, injury. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's October 2023 Medication Administration Record revealed LVN A documented on 10/01/2023 she administered Resident #50's zolpidem 5mg at midnight, hydrocodone 7.5mg at 02:00 AM, and quetiapine 400mg at 01:16 AM. 10/02/2023 at 01:54 AM LVN A documented Resident (#50) had recent fall outside. CMA witnessed incident. resident did not hit head, had no injuries noted. neuros have been within normal limits for him. has had no complaint of pain. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's October 2023 Medication Administration Record revealed LVN A documented on 10/02/2023 she administered Resident #50's zolpidem 5mg at midnight, hydrocodone 7.5mg at 02:00 AM, and quetiapine 400mg at 01:19 AM. 02/18/2024 11:59 AM the Administrator documented, Witnessed (Resident #50) smoking in smoking patio during a non-smoking time. Approached (Resident #50) and he stated, 'you caught me.' Discussed the importance of smoking during supervised smoking times only to prevent any injuries. Discussed he is not allowed to keep smoking materials on his person and all smoking materials are to be turned in at the end of each smoke break. (Resident #50) voiced understanding and stated he does not have any other smoking materials on his person. Asked where he obtained cigarette and how he lit it, he again denied having any smoking materials on his person. He states it won't happen again. (Resident #50) does sign himself out on pass frequently. Explained to (Resident #50) if he purchases smoking materials when out on pass, two turn in smoking materials to charge nurse. he voiced understanding. Administrator, LNFA. Further review revealed the note was also posted to the facility's 24-hour report. 03/05/2024 at 12:35 AM LVN A documented Resident (#50) seen lowering himself to one knee outside on West. nurse from [NAME] witness resident lowering himself. nurse helped him back up. resident came back over to east. CNA from [NAME] came over to inform east nurse who went over looking for him. nurse on [NAME] informed nurse on east what occurred. resident without injury resident in room at this time. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's March 2024 Medication Administration Record revealed LVN A documented on 03/05/2024 she administered Resident #50's zolpidem 5mg at midnight, hydrocodone 7.5mg at 02:00 AM, and quetiapine 500mg at 01:00 AM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	03/05/2024 06:50 PM LVN C documented, Resident (#50) did not wait for nurse on [NAME] side to escort for smoking break even after he was told not to be outside smoking on own will continue to assess. Further review revealed the note was also posted to the facility's 24-hour report. 03/18/2024 at 01:20 AM LVN A documented Resident (#50) reported to have fall outside at front of building, reported by CNA on [NAME] and another Resident. Resident then came back over to east on rollator and explained several times until he stated what occurred. Stated he was sitting on rollator, leaned over to put in code to get in front lobby area under carport, and rollator slipped out from behind him, he went down on one knee and caught himself with right arm on planter pot, had episode of dizziness, took a few deep breaths, got himself up and back on rollator. No injury noted, had on shoes. Went on down hall. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's March 2024 Medication Administration Record revealed LVN A documented on 03/18/2024 she administered Resident #50's zolpidem 5mg at midnight, hydrocodone 7.5mg at 02:00 AM, and quetiapine 500mg at 01:00 AM. 03/19/2024 at 02:49 AM LVN A documented (Resident #50) had recent fall outside of building. no injury noted. no complaint of pain. neuros within normal limits. Further review revealed the note was also posted to the facility's 24-hour report. A record review of Resident #50's March 2024 Medication Administration Record revealed LVN A documented on 03/19/2024 she administered Resident #50's zolpidem 5mg at midnight, hydrocodone 7.5mg at 02:00 AM, and quetiapine 500mg at 01:00 AM. 03/20/2024 at 11:19 PM LVN C documented had an assisted fall while walking through the doorway from smoking no injuries. Reported to (the physician group). Further review revealed the note was also posted to the facility's 24-hour report. 03/25/2024 05:39 PM the Administrator documented, Administrator made aware resident may have smoking materials on his person. Administrator visited with Resident #50. States he does not have any cigarettes but did give Administrator his lighter. Re-educated Resident #50 on importance of safety, turning in all smoking materials to charge nurse or any manager, and not keeping smoking materials on his person or room while in facility. resident voiced understanding. Administrator LNFA. Further review revealed the note was also posted to the facility's 24-hour report. 2. Resident #15 A record review on 03/30/2024 of the Texas Unified License Information Portal website for July 2023 to March 03/30/2024, accessed 03/30/2024, revealed no facility related report for Resident #15. A record review of Resident #15's admission record dated 03/26/2024 revealed an admitted [DATE] with diagnoses which included alcoholic cirrhosis of liver (a condition in which your liver is scarred and permanently damaged), viral Hepatitis C (a virus that attacks the liver and leads to inflammation), and alcohol abuse. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A record review of Resident #15's admission MDS assessment, dated 02/02/2024, revealed Resident #15 was a [AGE] year-old male admitted for long term care and was assessed with a BIMS score of 15 out of a possible 15 which indicated no cognition impairment. Further review reveled resident #50 used a wheelchair and needed set up or clean up assistance .supervision or touching assistance with the wheelchair. A record review of Resident #15's care plan dated 03/26/2024, revealed, (Resident #15) enjoys drinking beer and may have one 12 0z. beer as desired one time a day per MD order .beer to be kept in medication room refrigerator .(Resident #15) must provide own beer .(Resident #15) is a smoker. (Resident #15) is at times non-compliant with facility policies and smoking policy. (Resident #15) refused to sign the facility smoking policy . instruct resident about the facility policy on smoking; locations, times, safety concerns . the resident requires supervision while smoking . the resident smoking supplies are stored at the nurses station A record review of Resident #15's Nursing - Smoking Safety Screen dated 01/30/2024, signed by the MDS Nurse, revealed resident #15 could not safely use a lighter and needed supervision while smoking. A record review of Resident #15's physician's orders dated 03/27/2024 revealed resident #15 was prescribed cyclobenzaprine 10mg (a muscle relaxer) give every 8 hours, 12:00 AM, 08:00 AM, and 04:00 PM; methadone 5mg (a narcotic used to treat opioid use) give 1 tablet .every 8 hours, 07:00 AM, 3:00 PM, and 11:00 PM; Tylenol with codeine#3 (used to relieve mild to moderate pain. Codeine belongs to a class of medications called opiate (narcotic) analgesics), and 1 12-ounce beer at 07:00 PM. A record review of resident #15's Nurse Practitioner notes revealed NP B documented on 03/02/2024 at 06:09 PM, . patient (Resident #15) is a chronic methadone user. Staff reports that the patient checks himself out a few times a week and wheels himself to the bar down the street or to the convenience store and buys beer and sits outside and drinks beer. Staff reports administration is aware Further review revealed the note was also posted to the facility's 24-hour report. A record review of resident #15's medical record revealed nursing progress notes as follows: On 12/21/2023 at 12:15 AM RN U documented, Resident on cement sidewalk proximal to employee after hours door near the bushes. he is left side lying in front of his wheelchair. It is drizzling rain. Per another male resident, it began to rain and resident rounding the corner too fast and slid out of the wheelchair. The witness stated that he did not hit his head on the sidewalk. Resident was out on pass at the time. Further review revealed the note was also posted to the facility's 24-hour report. On 12/23/2023 at 10:57 PM RN U documented, Resident had slipped out of wheelchair outside while out on pass Further review revealed the note was also posted to the facility's 24-hour report. On 12/24/2023 at 11:20 PM LVN A documented, Resident (#15) had slipped out of wheelchair outside while out on pass. No injuries, neuros within normal limits for him. Alert and verbal. Has no complaint of any pain from falling out of wheelchair. Further review revealed the note was also posted to the facility's 24-hour report. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	02/18/2024 at 12:05 PM the Administrator documented, Witnessed (Resident #15) smoking during a non-smoking time in patio. Upon approaching (Resident #15), he immediately put out the cigarette in ashtray. Discussed the importance of following smoking policy and supervised smoking to prevent any injuries. (Resident #15) frequently attempting to change the subject / topic; redirected conversation and he voiced understanding. (Resident #15) frequently goes out on pass and discussed turning in all smoking materials to charge nurse should he purchase any smoking materials while out on pass. He voiced understanding. Administrator, LNFA. Further review revealed the note was also posted to the facility's 24-hour report. 03/05/2024 at 06:42 PM LVN C documented, Resident (#15) ask to have door unlocked so he could go outside I'll hit him know everyone is waiting on [NAME] nurse to take him that she will be here in a minute and he said no I can go outside whenever I want I said yes but not to smoke on your own he left and is smoking outside even after being told to wait for nurse from [NAME] side. Further review revealed the note was also posted to the facility's 24-hour report. 03/25/2024 at 06:28 PM the Administrator documented, Administrator made aware that (Resident #15) may have smoking materials on his person. Administrator, senior administrator, and RCS visited (Resident #15) in room. (Resident #15) initially denied having smoking materials. discussed concern for his safety and the safety of other residents. he was asked again if he had smoking materials at which time he produced 2 packs of cigarettes. he was asked if he had a lighter and he produced a lighter as well. read educated importance of turning in all smoking materials to the charge nurse or any manager. (Resident #15) does go out on pass and he was educated on turning in smoking material if he purchases and brings back smoking materials to the facility. Administrator, LNFA. Further review revealed the note was also posted to the facility's 24-hour report. 1. and 2. Residents #50 and #15 During an observation on 03/25/2024 at 02:24 PM revealed Resident #50 and resident #15 seated outside in the designated smoking patio. The facility's Activities Assistant was in control of a large yellow metal cabinet on wheels which contained the facility Residents smoking materials, for example, cigarettes, and lighters. Resident #50 and Resident #15 were observed seated at a patio table. Resident #50 and Resident #15 were observed to each reach into their pockets and produce cigarettes and personal lighters. Resident #50 proceeded to light and begin to smoke a cigarette. Resident #15 was observed to place a cigarette in his mouth but held his lighter in his hand. The Activities Assistant presented resident #50 with an additional 2 cigarettes and did not offer to light Resident #50's cigarette because it was already lit. The Activities Assistant presented Resident #15 with an additional 2 cigarettes and used her lighter to ignite resident #15's cigarette. During an interview on 03/25/2024 at 02:40 PM the Activities Assistant V stated Resident #50 had his lighter and cigarettes in his possession and did not light Resident #50's cigarette because it was already lit. The Activities Assistant stated she did light Resident #15's cigarette and gave him an additional 2 cigarettes. The Activities Assistant V stated resident #50 and Resident #15 did have their cigarettes and lighters on their person and have a history of going out and purchasing their cigarettes and lighters. The Activities Assistant V stated the practice of keeping cigarettes and lighters was against facility policy and would report the incident to the Activities Director. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 03/26/2024 at 04:55 PM LVN C stated Residents #50 and #15 were often smoking unsupervised. LVN C stated Residents #15 and #50 had a history of signing themselves out every evening around 6 to 7 PM and would return around 11PM to midnight. LVN C stated Residents #15 and #50 had a history of smelling like beer because they had an order for beer. LVN C stated she had often signed resident #50's and resident #15's medication administration record for the order to administer the beer even though the facility kept no beer for the residents, we don't have beer here .they sign themselves out and maybe buy beer .I don't know what they do when they sign themselves out. LVN C stated she had verbally told the leadership of the resident's routine but could not elaborate details of the reports. LVN C stated she had not documented any incident reports or reports to the physicians. During an interview on 03/28/2024 at 03:00 PM LVN C stated for Residents #15 and #50 she often signed the medication administration record for the order to administer the beer without administering the beer. LVN C she did not report Residents #15 and #50 might be drinking off the premises and if they smell like beer it is because they have an order for beer. During an interview on 03/31/2024 at 02:43 PM LVN A stated she worked the 10PM to 6AM shift on the hall for Residents #50 and #15. LVN A stated Residents #50 and #15 had a history of signing themselves out and leaving the facility on the shift before she arrived. LVN A stated Residents #50 and #15 would return back to the facility usually around 11PM to midnight. LVN A stated Residents #50 and #15 would sometimes return to the facility smelling like alcohol and then would be administered their scheduled quetiapine; zolpidem; and hydrocodone. LVN A stated Residents #50 and #15 had a history of falling around these times, from midnight to 2AM. LVN A stated she had documented the episodes of falls with the suspicion of Residents #50 and #15 drinking alcohol while away from the facility. Interviews by leadership for residents #15, and #50: During an interview on 03/28/2024 at 10:48 AM, NP B stated she worked for the Medical Director and had been calling upon the facility since August 2023. NP B stated Residents #15 and #50 had a history of signing out at 6:00 PM and returning at midnight and falling. NP B stated, prior to February 2024, she had not received report that residents had returned from being out on pass and had fallen while smelling like beer. NP B stated she spoke to the Administrator and the Medical Director and said the Administrator and the DON knew of the allegation of alcohol abuse off property as evidenced by the progress notes and care plans. During an interview on 03/28/24 at 11:14 PM the DON stated the incidents for Residents #15 and #50 were documented as falls and not connected to the use of alcohol while out on pass and the few incidents where nurses documented alcohol were in August and September 2023 when she first started and did not understand Resident #15 and #50's routines. The DON stated she was unaware the facility had no beer to administer to residents #15 and #50. The DON stated she was unaware Nurses were signing the MAR as if they were administering the beer without administering the Beer. The DON stated she interviewed the Nurses who had documented as such, and they reported to her they believed they were documenting the residents were receiving beer while out on pass. The DON stated she was not informed by NP B or any of her nursing staff the suspicion Residents were drinking alcohol. The DON stated the notes regarding unsupervised smoking and possession of lighters were reviewed by the Administrator and herself. The DON stated the Administrator wrote some of those progress notes. The DON stated she had expectations the Administrator would have reported those incidents to the state agency and investigated those incidents for safety reasons. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	3. Resident #47 A record review of Resident #47's admission record revealed an initial admitted [DATE] with diagnoses which included cirrhosis of the liver (degenerative disease of the liver resulting in scarring and liver failure), major depressive disorder, cognitive communication deficit (difficulty with communication that has an underly cause in a cognitive deficit), unsteadiness of feet, anxiety disorder, and age-related physical debility (physical weakness). A record review of Resident #47's annual MDS assessment dated [DATE] revealed Resident #47 had a BIMS of 15 out of 15 indicating intact cognition. A record review of Resident #47's care plan, undated, revealed the following: [Resident #47] has liver disease r/t cirrhosis with interventions that included Give medications as ordered, date initiated 12/18/2018. A record review of Resident #47's Order Summary report revealed no orders for alcohol consumption and Percocet Tablet 10-325 MG (oxycodone-acetaminophen) Give 1 tablet by mouth every 6 hours as needed for pain **Administer medication with a full glass of water**. A record review of TULIP on 03/27/2024 revealed an intake on 01/11/2024, reported by an anonymous complainant, revealed My second concern is a situation where a resident #47 is reported for having empty liquor bottles in her room and is known. To be pocketing her Percocet and trading them with a visitor for the liquor. There were no intakes in TULIP reported by the facility from December 2023 to present day involving Resident #47. A record review of Resident #47's nursing note, dated 02/03/2024 at 09:50 PM and authored by LVN AI, revealed, Dayshift CNA notified nurses resident was on the floor after falling. Oncoming nurse entered room to find resident lying on her back sideways across bed. CNA notified nurse patient was assisted back into bed. Resident was assisted with proper repositioning on bed. Appears groggy and eyes with glossy appearance. Disoriented. Laughing when asked what happened and how she fell . CNA answered she slipped on her shoes. Resident stated, yeah I sure did slip on my shoes. Speech slurred. Strong smell of alcohol. Off going nurse in room for verification of this. Bed low, call light in reach. Resident educated on fall precautions and importance of not getting OOB by herself. Encouraged her to call for any assistance needed. Also encouraged use of RW with ambulation. [DON] was notified of unwitnessed fall and patient current symptoms/condition. Attempted to call on call NP/MD for [MD AH] but not able to reach on call. 72-hour neuro checks initiated. A record review of Resident #47's Doctor's Progress Note, dated 02/08/2024 and signed by MD AH, revealed, [Resident #47 had a fall secondary to being inebriated. They state that the family member of another resident is trading [NAME] and alcohol for her percocets. They have tried to stop this. They are aware of the situation and are looking into it . They have searched her room and are trying to get rid of her alcohol. She is allowed to have some wine at night but not to have [NAME] being the hard alcohol and get inebriated. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A record review of Resident #47's nursing note, dated 03/20/2024 at 01:15 PM and authored by LVN D, revealed, Several pills found under and next to residents wheelchair, some pills wrapped in Kleenex appearing slightly dissolved. Pills with identifying numbers verified with pills in card of Percocet. [Doctor's group] called and message left requesting a return call. All supervisors notified. During an interview on 03/28/24 at 09:39 AM, Confidential Staff Member AF revealed Resident #47 had an incident where she dropped percocets in a public area. This was reported to her supervisors. She further revealed she made Resident #47 take her medications nurse's desk so the medications dissolve by the time she goes to her room. During an interview on 03/28/24 at 10:48 AM, NP B revealed she was unaware of what family is providing [NAME] to Resident #47. NP B further revealed this incident could have potential for death due to polypharmacy and possible consequences could include sedation, falls, and injuries. 4. Resident #82 A record review of Resident #82's admission record revealed an initial admitted [DATE] with diagnoses which included Alzheimer's disease (degenerative brain disease that causes a gradual decline in memory, thinking, and reasoning skills), dementia (loss of cognitive functioning that interferes with daily life and activities), amnesia (loss of memory), and muscle wasting and atrophy. A record review of Resident #82's annual MDS assessment dated [DATE] revealed Resident #82 had a BIMS of 11 out of 15 indicating moderate mental cognition impairment. A record review of Resident #82's care plan, undated, revealed the following: [Resident #82] has an ADL self-care performance deficit r/t Weakness with interventions that included BATHING/SHOWERING: [Resident #82] requires extensive assistance by (1) staff with bathing/showering [Resident #82] orders items online and has them delivered to facility often. She will refuse to let staff assess what she has ordered. Redirection unsuccessful with intervention of Encourage (Resident #82) to let staff assess items ordered online for safety. Respect her right to refuse, date initiated 03/25/24. During an observation on 03/25/24 at 10:20 AM, there were hair dye components of a [TRUNCATED]

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** 41937 Based on observations, interviews, and record reviews the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 24 residents reviewed for medication storage. 1. The facility failed to store Resident #52's medications which were kept at her bedside which resulted in an incident on 11/22/2023, when she was hospitalized and diagnosed with overdose related to self-medication with Diphenhydramine (an antihistamines; used for relief from symptoms related to hay fever, upper respiratory allergy, or cold symptoms) and hydrocodone (a narcotic analgesic agent for the treatment of moderate to moderately severe pain). An Immediate Jeopardy (IJ) was identified on 03/29/2024. While the IJ was removed on 03/31/2024, the facility remained out of compliance at a scope of pattern with risk for harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective actions. This failure could place residents at risk for serious harm accidents. The findings included: Resident #52. A record review of Resident #52's admission record revealed an initial admitted [DATE] with diagnoses which included depression, cirrhosis of the liver (permanent scarring that damages your liver and interfere with its functioning), altered mental status, and need for assistance with personal care. A record review of Resident #52's annual MDS assessment dated [DATE] revealed Resident #2 had a BIMS of 06 out of 15 indicating severe mental cognition impairment. A record review of Resident #52's care plan, undated, revealed the following: [Resident #52] is resistive to care at times. Refuses certain medications often . with an intervention Educate resident/family/caregivers of the possible outcome(s) of not complying with treatment or care., initiated 05/30/2023. [Resident #52] has liver disease [related to] cirrhosis with an intervention Give medications as ordered, initiated 10/04/2022. [Resident #52] uses anti-anxiety medications [related to] Anxiety with an intervention Monitor the resident for safety. The resident is taking ANTI-ANXIETY meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia ., initiated 10/04/2022. (continued on next page)

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A record review of Resident #52's hospital documents, dated 02/19/24, revealed Resident #52 was admitted [DATE] with chief complaint of loss of consciousness. The hospital documents reflected EMS was called and on their arrival, there was note of a large bottle of Benadryl as well as Norco. There was some concern for polypharmacy. The toxicology report on 02/16/2024 at 05:47 PM revealed urine opiates screen was positive. The hospital documents further revealed likely altered mental status secondary to medication effect. A record review or Resident #52's Medication Administration Record for February, dated 03/28/24, revealed Resident #52 did not take Norco Tablet 7.5-325 MG (Give 1 tablet by mouth every 6 hours as needed for pain. Ensure resident drinks full glass of water after medication. Do not exceed 3 grams of acetaminophen in 24 hours) from 02/13/24 to 02/19/24. Acetaminophen-Codeine Tablet 300-30 MG (Give 1 tablet by mouth every 6 hours as needed for Pain. Do not exceed 3Gm of [acetaminophen] in 24-hour period) was last given on 02/15/24 at 06:00 AM and at 02:27 PM. During an interview on 03/27/24 at 05:30 PM, Resident #52 revealed she did not remember why she was in the hospital on 02/16/24. Resident #52 did not remember if she had taken any medications before being hospitalized . Resident #52 revealed a family member brought in the medications but would not disclose who brought them in. She further revealed maybe she was taking Tylenol PM because she was self-medicating. She further revealed she did not know she had to let anyone know what she gets from outside of the facility. She further revealed no staff came in to inspect what she kept in her room. During an interview on 03/28/24 at 12:26 PM, the DON revealed she had asked Resident #52 where she got the medications that were at her bedside on 02/16/2024, but Resident #52 did not want to identify who brought the medications to her. The DON further revealed the facility educated Resident #52's RP to check with the nursing station before bringing anything to the resident. During an interview on 03/28/24 at 01:58 PM, Resident #52's RP revealed he was surprised by the 02/16/24 incident that led the hospitalization of Resident #52. He was told Resident #52 had bottle of Norco. The RP further revealed he did not know he could not bring in some OTC medications like TUMS. He did not know where Resident #52 was receiving the other OTC medications that were at her bedside. The RP was made aware to go through the nursing station when bringing anything to the resident. During an interview on 03/31/24 at 06:49 PM, MD AJ revealed she was aware Resident #52 had medications at her bed side last month. She revealed this would cause Resident #52 to be at risk of overdosing and she could have been given discharge orders due to this incident. She further revealed overdosing could cause hospitalization s. She added having OTC medications like Tylenol could cause liver problems if too much was taken. She further added there was a possibility of death if there was an over intake of opiates. During an interview on 03/28/24 at 12:26 PM the DON stated she and the department heads, including the Administrator, every weekday morning reviewed the previous days documents for all residents to include incident reports, grievance reports, 24-hour reports and all progress notes to include physician and nurse practitioner notes. During an interview on 03/28/24 at 12:38 PM the Administrator was asked if she was aware of resident #52's incident when she was discovered with AMS and pills at the bedside the Administrator stated she was. The administrator was asked if she could share some details about Resident #52; the Administrator stated she did not know much about Resident #52. (continued on next page)

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 03/28/2024 at 02:00 PM, the DON stated she had reported to the Administrator Resident #52's incident with altered mental status and need for hospitalization . A record review of an anonymous email to the corporate organization for this facility, provided by Confidential Staff member AF and dated 08/07/2023, revealed, The reason I am writing is because I no longer feel I or any of my other direct care coworkers can safely and confidently provide the care and services our special resident deserve . Our company has allowed agency but due to the cost they have begun cutting back on caregivers . the extent of cutting back is exceeding to the point of promoting unsafe and hazardous practices . I have expressed my concerns to management, I have written letters signed by other staff, I have reached as far as I can to try and resolve this issue with no results . Management is aware of this issue and I have personally witnessed them cover things up to try to consolidate the results of an unreported incident to an already open incident . We have reported unsupervised smoking and consumption of alcohol to management multiple times due to intoxication resulting in falls and cigarette burns to residents who fall asleep smoking. A plan was put into place and an alarm was placed on the doorway to alert staff if someone is going out, however the alarm is constantly disarmed therefore allowing incidents to continue happening. I cannot help but feel as though management does not care . Please help me. I want my residents to be safe, feel safe, and trust they are always being cared for by people who truly care. I don't know what else to do. I do want this complaint to remain anonymous due to fear of retaliation. A record review of the facility's Resident Admission Agreement, revised 10/14/2021, revealed The resident has the right to retain and use personal possessions . unless doing so would infringe upon the rights, health, or safety of other residents. It further revealed prohibited items include smoking or tobacco products, lighters, other smoking paraphernalia or illegal substances. Additions and deletions to the inventory shall be brought to the attention of the facility's administration so that records remain current. The Facility may terminate this Agreement by discharging the Resident in accordance with state and federal law. A record review of the facility's Medication and Disposal policy dated 10/01/19, revealed, 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 assessed and deemed appropriate for the judgment of the facilities interdisciplinary resident assessment team. Procedure: a written order for the bedside storage of medication is present in the residence medical record. bedside storage of medications is indicated on the resident medication administration record and in the care plan for the appropriate medications. 4 residents who self-administer medications the following conditions are met for bedside storage to occur; the manner of storage prevents access by other residents. lockable drawers or cabinets are required only if unlock storage is deemed inappropriate. facility management should have a copy of the key in addition to the resident. the medications provided to the resident for bedside storage are kept in containers dispensed by the pharmacy or in the original container if a non-prescription medication. the bedside medication record is reviewed on each nursing shift, and the administration information is transferred to the medication administration record kept at the nurse's station. notation of each self-administered dose is made by placing a check mark in the appropriate space and noting in the nursing comments the initials of the nurse who obtained the information from the resident. the resident is instructed in the proper use of bedside medications, including what the medication is for, how it is to be used, how often it is to be used . the completion of this instruction is documented in the residence medical record (continued on next page)

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A record review of the facility's Abuse, Neglect, and Exploitation policy dated 08/15/22, revealed, 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 . identification of abuse, neglect and exploitation . the facility will have written procedures to assist staff in identifying the different types of abuse- mental /verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. this includes staff to resident abuse and certain resident to resident altercations. possible indicators of abuse include, but are not limited to: . physical marks such as bruises or patterned appearances such as a handprint, built a ring mark on a resident body, physical injury of a resident, of unknown source . The administrator was given the IJ template and notified of the IJ(Immediate Jeopardy) on 3/29/24 and a POR was requested. The following Plan of Removal submitted by the facility was accepted on 03/30/2024. plan of removal For Those Affected: On 3/29/24, the Licensed Nurse assessed residents # 15 related to consumption of alcohol and Tylenol with Codeine and Methadone. No ill effects noted. Care plan updated 3/30/24 to reflect his behavior with non-compliance with smoking and assumed alcohol consumption while out on pass. Refuses nurse assessment at times. An order was received on 3/27/24, to call the physician if returns from on pass impaired. On 3/29/24, the Licensed Nurse assessed resident #50 related to alcohol consumption and administered Seroquel, Ambien, and Hydrocodone. Not ill effects noted. Care plan updated 3/30/24 to reflect his behavior with non-compliance with smoking and assumed alcohol consumption while out on pass. Refuses nurse assessment at times. On 3/29124, the License Nurse assessed resident #52 related to Altered Mental Status with suspected overmedication. No ill effects were noted. Care plan updated 3/30/24 to reflect to note history of non-compliance re OTC medications. Interventions in place to daily monitoring compliance with not keeping medications at bedside. Interventions included: Resident #52 and RP were re-educated on importance of not having medications at bedside; RP will provide any medications he purchases for resident #52 to the licensed nurse. Staff to monitor daily to ensure no medications are found at bedside. Facility wide monitoring started 3-30-2024 to monitor for any non-compliance for any medications at bedside for all residents. Identify Others Affected: Those with orders allowing out on pass are identified. Those who smoke are identified. Those that have orders for alcohol consumption are identified. (continued on next page)

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Those that self- medicate are identified. Those with Changes in Condition Actions Taken: The Director of Nursing or designee began reeducation for all staff on the following: o Abuse and Neglect o Recognition of Change of Condition including those who are impaired to call physician upon their return to include suspected alcohol consumption. This was completed 3-29- 24 & 3-30-24. o Self-Administration of Medications. No residents currently at facility self-administer medications. o Smoking Policy including Paraphernalia o Policy for Resident Personal Possessions Re-education initiated 3/29/24 and completed on 3/30/24 with all staff. Those that are PRN, Agency and/ or out on FMLA/ LOA will have the education completed prior to accepting assignment. Beginning 3/29/24 and ongoing, newly hired and agency staff will receive this training during orientation prior to providing care to the residents. The training will include the above-stated educational components. On 3/29/24, an Ad Hoc QAPI meeting was held with the Medical Director, facility Administrator, Director of Nursing, and Regional Clinical Specialist to review the plan of removal. Safe Smoking assessments were conducted By ADON'S on 3/30/2024 for all smokers. All paraphernalia must be surrendered by all smokers to the staff upon return from their smoking break and secured on designated cart. If resident assessed as impaired (inebriated), a change of condition will be done, and MD will be notified for further instructions on giving or holding medications. The physician on-call services are available 24/7 and/or Medical Director (or designee). All Licensed Nurses re-educated on resident with orders with alcohol consumption have revisions to reflect amount of alcohol consumed. This was conducted on 3/29/24. Order revision conducted on 3/29/24 to require additional documentation if alcohol is administered. Monitoring: Beginning 3/29/24 and going, The DON/designee will: (continued on next page)

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Monitor that residents with intact cognition are allowed to sign in and out on pass. That residents who smoke do in a designated smoke area and time. Those with orders to go out on pass were re-education to check back with facility upon return and are asked by the Licensed Nurse that they return their smoking paraphernalia. Those that return from out on pass and determined to be impaired, have assessment completed and that the Physician is notified regarding their condition. Staff re-education completed on 3- 29-2024 & 3-30-2024. Required actions such as notifications to MD (or designee), RP, Administrator, DON. Those that Self Administer are doing as physician ordered. Monitoring will be completed per nurse managers Monday thru Friday and by Weekend Supervisor/Designee on weekends to ensure no medications at bed side. When staff administer medications, facility practice is that nurse will stay with resident to ensure medications are swallowed. Media alert sent 3/30/24 to families that all medications brought into facility must be turned into the nurse for proper storage and administration by licensed staff. Plan of Removal Verification For Those Affected: On 3/29/24, the Licensed Nurse assessed residents # 15 related to consumption of alcohol and Tylenol with Codeine and Methadone. No ill effects noted. Care plan updated 3/30/24 to reflect his behavior with non-compliance with smoking and assumed alcohol consumption while out on pass. Refuses nurse assessment at times. Record review of Resident #15's progress note dated 3/29/2024 and written at 8:38 PM by ADON 1 reflected, Resident assessment completed: Resident is alert and oriented, BIMS=15. Resident propels self in w/c. Resident is frequently signing self out on pass and leaving from the facility alone. MD made aware and states resident is safe to go out on pass per self. Resident re-educated to sign RELEASE OF RESPONSIBILITY FOR LEAVE OF ABSENCE form prior to leaving facility and to check back in with facility staff upon return. Record review of Resident #15's progress note, dated 3/29/2024 and written at 9:33 PM by the DON reflected, Call placed to MD and verified order to remain in place for resident to be allowed to be administered (1) 12 oz beer during 2-10 shift, unless resident has gone out on pass or received alcohol beverages. Resident is aware of this order and aware when he goes out on pass, if he appears cognitively or physically impaired, the charge nurse will hold his medication per MD order and notify the MD, DON and administrator. Resident is aware the facility can assist resident with purchasing the alcoholic beverages and the facility will maintain control of these alcohol beverages and will administer them to the resident per MD order. Resident verbalized understanding and agrees with above plan of care. (continued on next page)

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #15's care plan, dated reflected, [Resident 15] has a behavior problem related to non-compliance with facility policies. [Resident 15] is non-complaint with assumed alcohol consumption while out on pass and refuses nursing to assess upon return at times with date initiated of 3/30/2024 and interventions including, Administer medications as ordered. Monitor/document for side effects and effectiveness.; Anticipate and meet the resident's needs.; Educate [Resident 15] on importance of following facility policies.; If reasonable, discuss The resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident.; If resident appears cognitively or physically impaired after they return from Out on pass, the charge nurse must complete an assessment and change of condition, and immediately notify the MD, RP, DON and Administrator.; Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed., all with a date initiated of 3/30/2024. Record review of Resident #15's care plan, dated reflected, [Resident 15] has a behavior problem related to non-compliance with facility policies. [Resident 15] is non-complaint with assumed alcohol consumption while out on pass and refuses nursing to assess upon return at times. With intervention, If resident appears cognitively or physically impaired after they return from Out on pass, the charge nurse must complete an assessment and change of condition, and immediately notify the MD, RP, DON and Administrator. With a care plan revision and interventions dated 3/30/2024. Interview on 3/31/2024 at 4:10, the DON stated that if a resident declines an assessment, they document, notify the Physician, RP, DON, and Administrator. An order was received on 3/27/24, to call the physician if returns from on pass impaired. Record review of Resident #15's orders revealed an order with a start date of 3/29/2024 reading, If resident appears cognitively or physically impaired after they return from Out on pass, the charge nurse must complete an assessment and change of condition, and immediately notify the MD, RP, DON and Administrator. Ordered by the Medical Director. Record review of Resident #50's orders revealed an order with a start date of 3/29/2024 reading, If resident appears cognitively or physically impaired after they return from Out on pass, the charge nurse must complete an assessment and change of condition, and immediately notify the MD, RP, DON and Administrator. Ordered by the MD. Interview on 3/31/2024 at 4:08 PM, the DON stated that the expectation is that the nursing staff will call the physician as soon as the impairment is recognized. On 3/29/24, the Licensed Nurse assessed resident #50 related to alcohol consumption and administered Seroquel, Ambien, and Hydrocodone. Not ill effects noted. Care plan updated 3/30/24 to reflect his behavior with non-compliance with smoking and assumed alcohol consumption while out on pass. Refuses nurse assessment at times. (continued on next page)

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #50's progress note dated 3/29/2024 and written at 8:39 PM by ADON 1 reflected, Resident assessment completed: Resident is alert and oriented, BIMS=15. Resident is ambulatory with walker. Resident is frequently signing self out on pass and leaving from the facility alone. MD made aware and states resident is safe to go out on pass per self. Resident re-educated to sign RELEASE OF RESPONSIBILITY FOR LEAVE OF ABSENCE form prior to leaving facility and to check back in with facility staff upon return. Record review of Resident #50's progress note, dated 3/29/2024 and written at 9:33 PM by the DON reflected, Call placed to MD and verified order to remain in place for resident to be allowed to be administered (1) 12 oz beer during 2-10 shift, unless resident has gone out on pass or received alcohol beverages. Resident is aware of this order and aware when he goes out on pass, if he appears cognitively or physically impaired, the charge nurse will hold his medication per MD order and notify the MD, DON and administrator. Resident is aware the facility can assist resident with purchasing the alcoholic beverages and the facility will maintain control of these alcohol beverages and will administer them to the resident per MD order. Resident verbalized understanding and agrees with above plan of care. Record review of Resident #50's care plan reflected a problem dated 3/30/2024, [Resident #50] has a behavior problem related to non-compliance with facility policies. [Resident #50] is non-complaint with assumed alcohol consumption while out on pass and refuses nursing to assess upon return at times., with interventions including, If resident appears cognitively or physically impaired after they return from Out on pass, the charge nurse must complete an assessment and change of condition, and immediately notify the MD, RP, DON and Administrator. With a care plan revision and intervention date of 3/30/2024. On 3/29124, the License Nurse assessed resident #52 related to Altered Mental Status with suspected overmedication. No ill effects were noted. Care plan updated 3/30/24 to reflect to note history of non-compliance re OTC medications. Interventions in place to daily monitoring compliance with not keeping medications at bedside. Interventions included: Resident #52 and RP were re-educated on importance of not having medications at bedside; RP will provide any medications he purchases for resident #52 to the licensed nurse. Staff to monitor daily to ensure no medications are found at bedside. Record review of Resident #52's progress notes revealed a note written on 3/29/2024 and written at 7:29 PM by ADON 2 revealed, Resident assessment completed; Resident alert, able to voice needs/concerns to staff. VS- 121/77, 75, 17, 98.1, O2 98% RA. Resident denies any pain or discomfort at this time. Able to move all extremities without difficulty and follow commands. BIMS assessment completed, scored 10. This nurse asked resident if she remembered the recent care meeting regarding having OTC medications at bedside, resident stated yes and that she has been compliant and currently has no OTC medications at bedside. Resident laying in bed playing solitaire on cell phone prior to and after assessment. Call light within reach. Will continue with current POC. Record review of Resident #52's care plan revealed a problem of, [Resident #52] has a history of non-compliance regarding facility policies regarding OTC medications. [Resident #52] was found with OTC medication bottles in her room, putting [Resident #52] at risk for polypharmacy and medical complications related to excessive intake of OTC with interventions including, [Resident #52] and RP educated on importance of not having medications at bedside.; RP will provide any medications he purchases for [Resident #52] to the nurse; Staff to monitor to ensure no medications are found at bedside with care plan revision date and intervention dates of 3/30/2024. (continued on next page)

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview 3/31/2024 at 4:11 PM, the DON stated that the nurses and nurse management team (DON, ADON, MDS Nurses, and Charge Nurses) will ensure with a form that is being filled out daily for each resident room that there are no prohibited items such as over-the-counter medication, cigarettes, lighters, or any paraphernalia that can be a danger to residents. Facility wide monitoring started 3-30-2024 to monitor for any non-compliance for any medications at bedside for all residents. Record review of document titled, Monitoring F689 revealed a checklist by room number with a requirement to check off and initial that no paraphernalia that could be a danger to residents was observed in the room. Interview on 3/31/2024 at 4:13 PM, the DON stated that the nurse management team to include the DON, ADON, MDS Nurse, and Charge Nurses will monitor by completing a daily form that includes each resident's room to ensure there are no prohibited items such as over-the-counter medication, cigarettes, lighters, or any paraphernalia that can be a danger to residents. The DON further stated that they will complete this monitoring form daily for 30 days, 4 times a week for the following 14 days, and 2 times a week for the 14 days following that. Observation on 3/31/2024 at 5:15 PM revealed the DON inspecting rooms [ROOM NUMBER] for unsafe items. Identify Others Affected: Those with orders allowing out on pass are identified. Interview on 3/31/2024 5:34 PM, the DON stated that the residents listed on the document provided were permitted to go out on pass as ordered. Record review revealed the following residents had orders to be able to be allowed to go out on pass: Resident #48 Resident #15 Resident #50 Resident #21 Resident #18 Resident #62 Resident #92 Those who smoke are identified. (continued on next page)

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A record review of the POR revealed 15 residents were identified as residents who smoke; 1. Resident #50 2. Resident #15 3. Resident #2 4. Resident #62 5. Resident #12 a. During an interview on 03/29/2024 at 04:40 PM resident #12 stated she was educated on smoking safety with supervision and only during the designated smoking times six times a day. 6. Resident #41 7. Resident #49 8. Resident #92 9. Resident #7 10. Resident #31 11. Resident #45 12. Resident #66 13. Resident #13 14. Resident #150 15. Resident #11 Those that have orders for alcohol consumption are identified. Record review revealed Resident #15 and Resident #50 had orders for alcohol consumption. Those that self- medicate are identified. Record review revealed no resident self-medicate. Interview on 3/31/2024 at 4:56 PM, the DON stated that no residents self-administer medications. Those with Changes in Condition (continued on next page)

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 03/31/2024 at 04:25 the DON stated all the census had a potential for a change of condition for which all the staff had received in-services for nurses to recognize changes of condition, document, complete the sbar, notify the physician, and notify the don, the representative, the progress notes are auto to the 24-hr report which are reviewed the next morning during the department head meetings which in include the don and the administrator. Actions Taken: The Director of Nursing or designee began reeducation for all staff on the following: o Abuse and Neglect o Recognition of Change of Condition including those who are impaired to call physician upon their return to include suspected alcohol consumption. This was completed 3-29- 24 & 3-30-24. o Self-Administration of Medications. No residents currently at facility self-administer medications. o Smoking Policy including Paraphernalia o Policy for Resident Personal Possessions Re-education initiated 3/29/24 and completed on 3/30/24 with all staff. Those that are PRN, Agency and/ or out on FMLA/ LOA will have the education completed prior to accepting assignment. A record review of the facility's employee roster dated, 03/31/2024 revealed 105 employees. 66% of employees, 69 of the 105, were interviewed to confirm receiving in-services for IJ F689. A record review of the facility's employee roster dated, 03/31/2024 revealed of the 105 employees, 34 were nurses. A sample of 23 nurses, 10 on the 6 am to 2 pm shift, 10 on the 2 pm to 10 pm shift, and 3 (of 3) on the 10 pm to 6 am shift, were interviewed to confirm receiving in-services for IJ F689. A record review of the facility's employee roster dated, 03/31/2024 revealed of the 105 employees 35 were CNAs. A sample of 24 CNAs, 11 on the 6 am to 2 pm shift, 7 on the 2 pm to 10 pm shift, and 6 on the 10 pm to 6 am shift, were interviewed to confirm receiving in-services for IJ F689. Record review of document titled In-service training report, dated 3/28/2024, with the topic Reportable Incidents, ANE Prevention, and Reporting revealed 99 of 105 staff signed off as having completed the in-service. Record review of document titled In-service training report, dated 3/28/2024, with the topic Change in condition revealed 99 of 105 staff signed off as having completed the in-service. Record review of document titled In-service training report, dated 3/29/2024, with the topic Medication Administration revealed 99 of 105 staff signed off as having completed the in-service. (continued on next page)

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of document titled In-service training report, dated 3/29/2024, with the topic Personal Belongings revealed 99 of 105 staff signed off as having completed the in-service. Record review of document titled In-service training report, dated 3/29/2024 and 3/30/2024, with the topic Resident's going out on pass revealed 99 of 105 staff signed off as having completed the in-service. Record review of document titled In-service training report, dated 3/28/2024, with the topic Smoking Policy revealed 99 of 105 staff signed off as having completed the in-service. Record review of document titled In-service training report, dated 3/30/2024, with the topic Alcohol revealed 99 of 105 staff signed off as having completed the in-service. Interview on 3/31/2024 at 12:51 PM, LVN F stated they primarily work from 2 pm until 10 pm, trainings consisted of information relating to residents coming back from pass and doing assessments to ensure they are not incapacitated in any way, and if they are incapacitated or impaired the nurses must do a change in condition and call the physician. She stated they also went over smoking, resident personal items, abuse and neglect, and reporting any abuse and neglect. Interview on 3/31/2024 at 12:55 PM, CNA G stated they primarily work from 6 am until 2 pm, revealed they were in-serviced for reporting abuse and neglect to the administrator, as well as smoking, ensuring residents do not have any dangerous possessions such as lighters, cigarettes, and

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564 Based on observations, interviews and record reviews, the facility failed to assist residents in obtaining routine dental services and assist the resident with making appointment for 2 of 8 (Residents #18 and #81) residents reviewed for dental services in that: 1. The facility failed to assist Resident #18 in obtaining appropriate dental services after Resident #18's upper dentures became loose and were recommended to be replaced by the dentist. 2. The facility failed to assist Resident #81 in obtaining appropriate dental services after Resident #81 and Resident #81's family requested it due to lack of natural teeth per her annual MDS assessment dated [DATE]. This deficient practice could affect residents who had dentures and place them at-risk by contributing to mouth pain, difficulty eating and weight loss. The findings were: 1. Record review of Resident #18's face sheet, dated 03/29/2024, reflected a [AGE] year-old resident initially admitted to the facility on [DATE] with diagnosis that included schizoaffective disorder (a combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder), parkinsonism (disorder of the central nervous system that affects movement, often including tremors), and hypothyroidism (A condition in which the thyroid gland doesn't produce enough thyroid hormone). Record review revealed Resident #18's MDS Assessment, dated 1/15/2024, reflected no information relating to the status of Resident #18's dentures. Record review of Resident #18's weight record, undated, revealed the resident's weight has maintained with no more than a 3% loss in one month for the last year. Record review of the Resident #18's physician orders, dated 3/29/2024, reflected Resident #18 was placed on a regular texture, no added salt diet on 09/29/2022. Record review of Resident #18's dental visit record, dated 9/19/2022, reflected Resident #18 visited the dentist for an initial exam on 9/19/2022. The Fit of Dentures section reveals, Upper: Loose and Lower: WNL. The Treatment notes section revealed, in part, [Resident 18] reports issues with looseness and desiring implants. Upper denture has looseness, rocks and is not retentive .Discussed that new denture would be necessary for better fit .Lower denture is slightly loose but is adequate and at the end describes that Recommending fabrication of upper full denture. Observation on 03/25/2024, during an interview with Resident #18, revealed the resident had a loose-fitting upper denture that rattled in her mouth as she spoke. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/27/2024 at 10:46 AM, Resident #18's family member stated that she has asked about her mother's dentures, and she has not been communicated with relating to replacing the top denture. Resident #18's family member stated she was considering taking her to a private dentist so she would not have to rely on the facility for the resident's dental care as it has not been occurring. Resident #18's family member stated her dentures have fallen out before, and it can sometimes be difficult for Resident #18 to eat. Resident #18's family member stated that she feels Resident #18's dentures have not been taken care of because there has not been a social worker who consistently assisted residents with obtaining dental services. Interview on 03/28/2024 at 12:46 PM, the DON revealed Resident #18's representative had been communicated with previously relating to her dentures. She stated she was not aware of the status in replacing her dentures. The DON stated that she would provide documentation of any instances since 9/2023 that the resident has seen a dentist. Record review of email from the dental provider to the DON, undated, reflected that Resident #18's original documentation sent to the physician for indication of necessity for services was sent on 09/26/2022, and were sent again on 03/28/2023, and 06/22/2023. Review of the Resident #18's clinical record reviewed there was no documentation provided to indicate that the resident has seen a dentist since 09/19/2022, or that any more attempts were made to have the dentures replaced by the facility since this visit and subsequent requests. 2. Record review of Resident #81's admission record revealed an initial admitted [DATE] with diagnoses which included depression. Record review of Resident #81's annual MDS assessment, dated 01/29/2024, revealed Resident #81 had a BIMS of 11 out of 15 indicating moderate mental cognition impairment. It further reflected no information relating to the status of Resident #81's dentures and Resident #81 had no natural teeth or tooth fragment (s) Record review of Resident #81's clinical record revealed the care plan and physician orders did not address dental services. Record Review of Resident #81's weight history revealed no weight loss. During an interview on 03/24/24 at 11:55 AM, Resident #81 revealed she had not received any dental services for a year. She showed she was missing teeth and needed dentures. During an interview on 03/26/24 at 01:32 PM, Resident #81's Responsible Party revealed Resident #81 had been without dentures for about a year and had requested help with this from the facility multiple times because this affected Resident #81's ability to eat. Record review of email from the dental provider to the DON, undated, reflected that Resident #81's original documentation sent to the physician for indication of necessity for services was sent on 07/19/2023, and were sent again on 11/01/2023. There was no documentation provided to indicate that the resident has seen a dentist in the past year, or that any more attempts were made to have the dentures replaced by the facility since this visit and subsequent requests. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/31/2024 at 5:45 PM, the Social Worker stated they began their position on 03/07/2024 and has not put anything in place as of yet and the dentist has visited but they were not sure if Resident #18 and Resident #81 were seen or the last time she was seen. Record review of facility policy titled, Dental Services, dated 10/24/2022, reflected, Routine Dental Services' means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures, e.g., taking impressions for dentures and fitting dentures and For residents with lost or damaged dentures, the facility will refer the resident for dental services within three days. 48366

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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. 48366 Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen, in that: 1. Sanitizing buckets were not stored away from food products on 03/24/24. 2. Personal beverages were in a part of the kitchen work area on 03/24/24. 3. The juice machine was not clean on 03/24/24. 4. A couple of milk jugs were opened and not dated on 03/24/24. 5. There was a prepared salad in the refrigerator that was not discarded on the discard date of 03/20/2024. 6. There was a package of cheese stored in the freezer that was open and exposed to the inner freezer environment on 03/24/24. 7. There was not a discard date for cooked eggs that was stored in the freezer with only one date: 3-23 on the package. 8. The handwashing sink did not provide hot running water on 03/24/24. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: Observation during the initial kitchen tour on 03/24/24 at 08:23 AM revealed the following: 1. In the kitchen work area, 2 sanitizing buckets were near 3 boxes of Smuckers jelly, 1 box of ranch packets, 1 box of honey mustard packets, 1 box of tartar sauce packets, 1 mayo sauce packets. 1 ketchup sauce packets. 2. Personal beverages (1 yoohoo chocolate drink, 1 yeti, 1 other thermos beverage) were in a work area. 3. The juice machine dispenser had 2 nozzles, 1 for water and 1 for juice. The juice machine nozzle interiors appeared to have a dried dark red substance inside. both nozzles (one for water and one for juice) were in liquids. Juice was in purple/red-ish fluid with suspended substance in liquids. 4. There were two 2 gallon opened milk jugs that were undated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. There was a prepared salad in the refrigerator that was dated 03/17/2024 with a discard date of 03/20/2024. 6. There was a package of cheese in the freezer that was open and exposed to the inner freezer environment. 7. There was not a discard date for cooked eggs in the freezer with only one date: 3-23 on the package. 8. The handwashing sink water temperature was cold to touch and never reached a warm temperature on 03/24/24. During interview and observation, on 03/24/24 at 08:37 AM, Cook/Dietary Aide AB revealed there were personal beverages in the kitchen work area that should not be in the working areas just in case they spilled and contaminated foods. She further revealed sanitizing buckets should not be near food products in case they tipped over and contaminated these food products. Cook/Dietary Aide AB took the water temperature, and it was 76 F. Dietary Aide AC was washing her hands and revealed the warm water at the hand washing sink did not seem to be working and was not getting as hot as it used to. She revealed cleaned hands, including washing them with warm water, were important when doing food service. Cook/Dietary Aide AB stated the juice machine was dirty and needed to be cleaned, packages used to store foods needed to be sealed, there needed to be a date for when milk was opened, and there needed to be discard dates on foods stored in the refrigerator and freezer. During an interview on 03/27/24 at 11:00 AM, the Dietary Manager revealed sanitizing buckets should not be near food products and prepared food products that are stored should be labeled with the date it was made and the date it needed to be discarded. She further revealed the juice machine needed to be cleaned and the staff were to follow their cleaning schedules to ensure this. During an interview on 03/27/24 at 03:41 PM, the RD revealed food products should not be near sanitizing buckets. The Dietary Manager and RD revealed water for hand washing should be warm to touch and the water temperature was fixed yesterday because it was running colder than normal earlier this week. They both revealed packaged food products needed to be sealed appropriately and labeled correctly, including having a discard date. Record review of the facility's policy General Kitchen Sanitation, dated 10/01/2018, reflected, 6. Clean non-food contact surface of equipment at intervals as necessary to keep them free of dust, dirt, and food particles and otherwise in a clean and sanitary condition and 14. Store toxic chemicals away from food products . Record review of the facility's policy Food Storage, dated 06/01/2019, reflected the following: 1. Dry storage rooms i. Do not use or store cleaning materials or other chemicals where they might contaminate foods. Label and store them in their original containers when possible. Store in a locked area away from any products. Refrigerators d. Date, label, and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage, and e. Use all leftovers within 72 hours. Discard items that are over 72 hours old. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Freezers e. Store frozen foods in moisture-proof wrap or containers that are labeled and dated. Record Review of the facility's policy Hand Hygiene, dated 10/24/22, reflected, 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, 3-305.11, revealed: Preventing Contamination from the Premises - Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, Paragraph 5-202.12(A) states that a handwashing sink must be capable of delivering running water that is at least 29.4 C (85 F). An inadequate flow or temperature of water may lead to poor handwashing practices by food employees. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, Paragraph 6-305.11 stated . Personal belongings can contaminate food, food equipment, and food-contact surfaces. Proper storage facilities are required for articles .