STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455800	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lev Attown Park	8820 Town Park Dr Houston, TX 77036

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review the facility failed to protect the personal and medical records of residents reviewed for privacy and confidentiality in that: On 06/11/25 MA B was not at her medication cart when her computer screen was showing numerous profiles on the computer screen of resident's pictures. This failure placed residents at risk of breach in confidentiality of medical information. Findings: Observation on 06/11/25 at 10:43AM revealed MA B left her computer open with resident records easily accessible showing their photo and names. In an interview on 06/11/25 at 10:44AM MA B said she had forgotten to lock her computer when she walked away from it to go to the medication room to check for a medication. MA B said she should not have done that because it placed the resident at risk for their medical records being exposed to the public. MA B said this was a HIPAA violation. MA B said she had received in-service on protecting the residents' medical records and that she did not mean to leave her computer unlocked. In an interview on 06/11/25 at 3:15PM the Administrator regarding HIPPA said the staff needed to always protect resident medical records. The Administrator said when a staff did not always protect a resident's medical record, it placed the resident at risk of their privacy being invaded. Record review of the facility policy on Confidentiality of Personal and Medical Records copyright 2022 reflected in part: .This facility honors the resident's right to secure and confidential personal and medical records. This includes the right to confidentiality of all information contained in a resident's record regardless of the form of storage or location of the record . keep confidential is defined as safeguarding the content of information including written documentation, video. Audio, or other computer stored information from unauthorized disclosures without the consent of the individual and/or the individual surrogate or representative .

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet a resident's medical, mental, and psychosocial needs for 3 (Resident #17, Resident #31, Resident #48) of 5 residents reviewed for comprehensive care plans. - Resident #17 was not care-planned for exit-seeking when she was documented in her progress notes as pushing on the exit door by her room as a behavior. - Resident #31 did not have a comprehensive care plan in place with interventions to address oxygen use or anticoagulant use. -Resident #48 did not have a comprehensive care plan to address his advanced directive status of DNR This deficient practice could place residents at risk of their behaviors and needs being monitored and cared for at the facility. Findings included: Record review of Resident #17's face sheet dated 06/11/2025, reflected she was a [AGE] year-old female originally admitted on [DATE]. Her medical diagnoses included basal cell carcinoma of the skin (skin cancer), schizophrenia (a mood disorder characterized by hallucinations, delusions, and disorganized thinking and behavior), insomnia, and pain. Record review of Resident #17's Comprehensive MDS dated [DATE], reflected Resident #17 had a BIMS score of 9 out of 15 which suggested she had moderate cognitive impairment related to memory and thinking skills. She required moderate assistance with toileting, dressing, footwear, and personal hygiene. Resident #17 was coded as having no impairments to her upper and lower extremities. Record review of Resident #17's care plan last revised 04/28/2025, reflected she was care-planned for impaired cognitive function/dementia or impaired thought processes related to dementia, with interventions including administering medications as ordered and monitoring/documenting for side effects and effectiveness and cueing, reorienting and supervising as needed. There was no care plan for Resident #17's behavior of pushing on the door. A later record review of Resident #17's care plan last revised 06/11/2025 after surveyor intervention, Resident #17 was care-planned for being a wanderer related to being disoriented to place, with interventions including assessing for fall risk, distracting resident from wandering by offering pleasant diversions, structured activities, food, conversation and television and monitoring Resident #17 for fatigue and weight loss. Record review of Resident #17's Order Summary Report, reflected she had an active order for Lorazepam (generic name of Ativan) Oral Tablet 1 MG, give 1 tablet by mouth three times a day related to Schizophrenia and to hold for excessive sedation with a start date of 06/06/2025. Record review of Resident #17's elopement evaluation on 4/2/2025, reflected she was documented as posing no risk for elopement. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #17's progress notes, reflected she made attempts to push on the door at the exit near her room on 5/1/2025, 5/7/2025, 6/2/2025, 6/3/2025, and 6/9/2025. Record review of Resident #17's medication consent form, reflected she was prescribed Ativan for anxiety and agitation on 6/6/2025. Observation and interview with Resident #17 on 06/10/2025 at 9:33am, revealed Resident #17 was in her room sitting on her bed and was holding her head with both hands and talking to herself. She appeared well-groomed and agitated. When asked how she was doing, Resident #17 said thank you and waved the surveyor off. When the surveyor walked past her bedroom, Resident #17 was heard talking progressively louder, Stop looking at me! Later observations of Resident #17 on 6/12/2025 at 10:59am, revealed she was walking around the facility away from the door and at 4:28pm, Resident #17 was in her room in bed. Observation on 6/11/2025 at 2:29pm, revealed LVN K pushed on the exit door on Resident #17's hallway, and the alarm rang for 15 seconds before the door fully opened. He turned off the alarm with a key which fit into the alarm box at the top of the doorframe. The door was observed with no damages or concerns. In an interview with MDS Nurse LVN F on 6/11/2025 at 1:20pm, she said she was not aware of Resident #17 and that she would care-plan the behavior of pushing on the door and document Resident #17's wandering behavior on her assessments. LVN F said that Resident #17 could get out the door or fall if she left. LVN F said nurses used the care plan to see how to provide care to the residents. In an interview with LVN M on 6/11/2025 at 2:29pm, she said Resident #17 would walk with her wheelchair and push it into the door. When the alarm would turn on, Resident #17 would get irritated but was easily redirected away from the door. Resident #17 would move away from the door when the alarm turned on. LVN M had in-services on elopement and resident behaviors such as redirection at the facility. In an interview on 6/11/2025 at 2:38pm, the DON said that Resident #17 would not be considered exit-seeking per se, but that she made attempts to push on the doors but would get scared and was easily redirected from the situation. In a later interview with the DON and Administrator on 06/11/2025 at 4:34pm, the Administrator said they were evaluating where they could move Resident #17 so she could be away from the door. The Administrator said the purpose of care plans was to document needs and try to meet them for residents, and that Resident #17's behavior of pushing on the door might need to be documented. The Administrator said Resident #17 had no exit-seeking behavior or the facility would have to find another building for her as they did not have a secured unit. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with RN G on 6/11/2025 at 2:55pm, she said that Resident #17 had attempted to push on the door every few days but Resident #17 had not exited or left the building. After each attempt, RN G would give Resident #17 a PRN dose of anxiety medication. Resident #17's NP was notified of her behavior. Resident #17 never told RN G why she attempted to leave but would talk to herself. The facility had working alarms, and RN G and CNAs on the hall watched and redirected her. When Resident #17 would push on the door, RN G called Resident #17's Psychiatric NP, documented it in Resident #17's progress notes, and told the next shift's nurses and aides to continue monitoring. RN G had elopement and resident behavioral training. RN G said Resident #17's behavior should be in her care plan, but she would need to check. Behaviors should be in the care plan so a resident's condition was documented, and nurses could be aware. In an interview with the Unit Manager LVN N on 6/11/25 at 3:24pm, she said Resident #17 liked to go to the door but never left the building. LVN N was not aware why Resident #17 would go near the door. Resident #17's NP checked on her and would ask if her medications were effective. She said care plans highlighted resident's care, how they were, medications and behaviors. In an interview with NP B on 6/13/2025 at 8:16am, he said that he was Resident #17's Psych NP. NP B said the facility staff called him frequently for her behaviors, including trying to exit. NP B said medications did not treat a specific behavior but were used to treat Resident #17's condition in general. He recently changed her medication to help with her behaviors such as restlessness, anxiety, talking to herself, and getting her to put on her gown and talk to NP B. Resident #31 Record review of Resident #31's facility admission record dated 6/11/25 revealed that Resident #31 had an original admission date of 8/14/2015 and re-admission date of 2/9/25. Resident #31 was a [AGE] year-old male with diagnoses that included Ileus unspecified (a condition where the intestines don't move food and waste along as they should, but there's no physical blockage like a tumor or scar tissue) and Hydronephrosis with renal and ureteral calculous obstruction (the swelling of a kidney due to a blockage in the ureter (the tube carrying urine from the kidney to the bladder) caused by a kidney stone (calculus). Record review of Resident #31's Quarterly MDS dated [DATE], revealed a BIMS score of 12 out of 15 indicating a moderate cognitive impairment. Resident #31 was documented to require substantial/maximum assistance from staff for ADLs. He required supervision or touching assistance with eating and oral hygiene. He had an indwelling urinary catheter and was always incontinent with bowels. Section N-Medications indicated he used anticoagulants. Section O-Special Treatments indicated Resident #31 used oxygen. Record review of Resident #31's undated care plan, revealed there were no care plans with interventions to address anticoagulant or oxygen use. Record review of Resident #31s physician orders for May 2025 revealed an order for oxygen at 2 liters/min via nasal cannula PRN with a start date of 9/25/24. Record review of Resident #31's physician orders for May 25 revealed a physician order for Xarelto oral tablet 20 mg. Give 1 tab by mouth in the evening. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 6/10/25 at 10:10 AM with Resident #31, revealed the resident appeared to be clean, and had no odors, or visible signs of injury. He said that he felt very pleased with his care at the facility and had no concerns. In an interview on 6/11/25 at 9:24 AM with the Administrator, she said care plans for anticoagulants and oxygen should be in place for Resident #31 and the MDS coordinator was responsible for updating. A negative impact could be resident needs not being addressed. In an interview on 6/11/25 at 1:29 PM with LVN F/MDS Coordinator she confirmed that there were no comprehensive care plans to address anticoagulants or oxygen use for Resident #31 and there should have been. Care plans were important because nurses looked at them to provide care for residents. She added the responsibility lied with the IDT. In an interview on 6/11/25 at 2:37 PM with the DON, she said that Resident #31's oxygen and anticoagulants status should have been care planned. She said that without the care plan he could have bled out or needed oxygen and the care plans were used to provide care. She said that MDS Coordinator was responsible for updating the care plans. Resident #48 Record review of Resident #48's facility admission record dated 6/11/25 revealed that Resident #48 had an original admission date of 3/2/21 and re-admission date of 5/1/25. Resident #48 was a [AGE] year-old male with diagnoses that included lobar pneumonia (a type of pneumonia where a large portion or entire lobe of one or both lungs becomes inflamed and consolidated, meaning it fills with inflammatory fluid and/or pus) and Parkinson's Disease without Dyskinesia without fluctuations (a specific presentation of Parkinson's disease where patients do not experience involuntary movements (dyskinesia) or noticeable changes in the severity of their symptoms over time (fluctuations). Record review of Resident #48's Quarterly MDS dated [DATE], revealed a BIMS score of 8 out of 15 indicating a moderate cognitive impairment. Resident #48 was documented to require partial to moderate assistance to substantial/maximum assistance from staff for ADLs. He required set-up to or clean-up assistance with eating. He was always incontinent with bladder and bowel. Record review of Resident #48's undated care plan revealed there was no care plan to address his advanced Directive choice of DNR. Record review of Resident #48's physician orders dated 5/2025 revealed a physician order for DNR with OOH DNR signed 5/8/25. Record review of Resident #48's DNR dated 5/7/25 revealed that he elected for DNR status. Observation on 6/10/25 at 10:03 AM of Resident #48, revealed he appeared to be asleep, very frail, as he laid on his bed. In an interview on 6/11/25 at 9:24 AM with the Administrator, she said a care plan to address DNR for Resident #48 should be there to address the needs of the resident and the MDS coordinator was responsible for updating care plans. A negative impact could be resident needs not being addressed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 6/11/25 at 1:29 PM with LVN F/MDS Coordinator she confirmed that there were no comprehensive care plans to address DNR status for Resident #48 and there should have been. She said the care plan would be added on 6/11/25. In an interview on 6/11/25 at 2:37 PM with the DON, she said that the care plan for Resident # 48's DNR status should have been updated. She said that without the care plan he could have been given CPR (lifesaving interventions) if the DNR status was not care planned. Record review of the facility's policy on Comprehensive Care Plans copyrighted 2025 read in part, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality .3.The comprehensive care plan will describe, at a minimum . The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .f. Resident specific interventions that reflect the resident's needs and preferences . Record review of the facility's policy on Elopements and Wandering Residents copyrighted 2022 read in part, The facility is equipped with door locks/alarms to help avoid elopements . Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team .Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff .

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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** Based on observation, interview, and record review the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to provide necessary services to maintain good grooming and personal hygiene for 1 (Resident #21) of 6 residents reviewed for activities of daily living in that: -The NF failed to remove unwanted facial hair from Resident #21's chin area and above the resident's top lip. This failure placed resident at risk for psychological embarrassment, sadness, and decrease in quality of life. Findings: Record review of Resident #21's face sheet dated 06/12/25 revealed a [AGE] year-old female admitted to the facility initially on 12/02/2013 and again on 07/17/23. The resident's diagnoses included the following: Alzheimer's Disease (a disease that destroys memory and other important memory function), muscle weakness, Parkinson's disease (disorder that affects the brain that can cause tremor, slowness of movement, limb stiffness, and gait and balance problems), need for assistance with personal care, lack of coordination, and dementia (loss of memory and thinking skills). Record review of Resident #21's quarterly MDS dated [DATE] reflected a BIMS score of 13 indicating that resident cognition was intact. Further review section GG-Functional abilities reflected the resident required supervision or touching assistance with personal hygiene. Record review of Resident #21's Comprehensive Care Plan revised 08/15/24 revealed the resident was care planned for ADL self-care performance deficit r/t dementia (loss of memory and thinking skills) with an intervention that included resident was independent with personal hygiene and oral care. Further review revealed that resident was being care planned for the potential for impaired thought process r/t impaired decision making, dementia, Alzheimer's that included an intervention to cue (serve as a signal or a hint when to do something) for, reorient and supervise as needed. Observation on 06/10/25 at 8:58AM revealed Resident #21 was sitting up on the side of her bed dressed in street clothing. The resident had just finished eating breakfast. Further observation was made of the resident having a moderate amount of hair growing out of her chin appearing to be approximately a half inch long in some areas. The resident had hair growing above her top lip. Interview on 06/10/25 at 8:58AM Resident #21 said she would like the hair removed from above her lip as well as her chin. The resident said the staff had removed her unwanted facial hair before with a razor but did not know when the last time it had been done. The resident said she was unable to shave the unwanted facial hair because of her hands shook sometimes. Observation on 06/11/25 at 8:57AM revealed Resident #21 was sitting on side of bed with facial hair on her chin and above her top lip. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/12/25 at 12:58PM the DON said the CNAs and nurses were responsible for keeping the residents groomed. The DON said it was the responsibility of the nurse to ensure the CNAs were keeping the residents groomed by shaving unwanted facial hair on residents . The DON said it was important to keep the residents groomed for their dignity and hygiene. The DON said if that was not being done, it placed the resident at risk of not feeling good about themselves, experiencing sadness, and feeling of self-consciousness. Observation on 06/12/25 at 1:09AM revealed Resident #21 was in her room sitting up on the side of her bed eating her lunch. The resident no longer had the facial hair on her chin and above her top lip. Interview on 06/12/25 at 1:15PM CNA C said the removal of any unwanted facial was provided with resident showers. CNA C said when the resident was not groomed it could make the resident feel bad or unhappy. Interview on 06/12/25 at 5:09PM Resident #21 said she felt better after the facial hair had been removed. The resident said when she had hair on her face it made her feel unclean. Record review of the facility's policy on Promoting/Maintaining Resident Dignity with copyright of 2022 reflected in part: .It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each residents individuality .All staff members are involved in promoting care to residents to promote and maintain resident dignity and respect residents rights .Groom and dress residents according to resident preference .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure resident who is incontinent of bladder receives appropriate treatment and service to prevent urinary tract infections for 1 (Resident #42) of 6 residents reviewed for incontinent care in that: -CNA D placed Resident #42s Foley bag on the bed during Foley catheter care. This failure placed resident at risk for urinary tract infection, unwanted antibiotic therapy, and decrease in quality of life. Findings: Record review of Resident #42's face sheet dated 06/11/25 revealed an [AGE] year-old female admitted to the facility initially on 04/09/20 and again on 01/02/25. The resident's diagnoses included urinary tract infection, dementia (memory loss), acute kidney failure (when the kidneys suddenly cannot filter waste from the blood), severe sepsis (a life-threatening complication of an infection), and neuralgia (pain resulting from damaged or irritated nerves). Record review of Resident #42's quarterly MDS dated [DATE] reflected a BIMS score of 7 indicating that resident cognition was severely impaired. Record review of section H-Bladder/Bowel reflected the resident had an indwelling Foley catheter. Record review of Resident #42's Physician's Order Summary Report for the month of June 2025 reflected the following order: -Dated 01/02/25 16Fr/10cc urethral indwelling urinary catheter (a tube that carries urine from the bladder to the outside of the body and held in place by a balloon inflated inside of the bladder). Dx stage 4 (a severe and deep wound that extends through multiple layers of skin and tissue, potentially exposing muscle, tendon, or the bone) sacral (triangular bone at the base of the spine)with closed drainage system (when the catheter is retained in the bladder by an inflated balloon and the drainage of urine is totally dependent on gravity). Record review of Resident #42's Comprehensive Care Plan updated 05/27/25 reflected the resident was care planned for bladder incontinence that included an intervention to clean peri-area with each incontinent episode, hand washing before and after delivery of care. Observation on 06/11/25 at 1:46PM of Foley catheter care for Resident #42 by CNA D and CNA E revealed the resident's Foley catheter bag was inside a privacy bag and the resident had a stat-loc on her left thigh securing the Foley tubing. During the observation, CNA D took the residents Foley bag that was hanging on the left side of bed below the resident's bladder, and placed the Foley bag on the bed and began to provide Foley catheter care. When done providing care, CNA D placed the Foley bag back on the left side of bed below the resident's bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/11/25 at 2:09PM CNA D said she had received an in-service on Foley catheter. CNA D said she should not have placed the resident's Foley bag on the bed during Foley catheter care due to the risk of urine flowing back in the resident's bladder, placing the resident at risk for urinary tract infections. Interview on 06/11/25 at 2:20PM the facility's Infection Control Preventionist said when the staff provided Foley catheter care, the Foley bag should not be placed on the resident's bed but hung below the resident's bladder on the side of the bed to prevent the back flow of urine in the resident's bladder that could cause a urinary tract infection. Record review of the facility policy on Catheter care copyright date August 2024 reflected in part: .Ensure drainage bag is located below the level of the bladder to discourage back flow of urine . Record review of the facility policy on Quality of Care with a copyright 2022 reflected the in part: .Based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the resident's choices .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who are fed by enteral means receive the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 (Resident #29) of 7 residents for the administration of medication via gastrostomy in that: -LVN A did not check for gastrostomy placement, per the facility policy, prior to administering Resident #29's medication on 06/10/25. This failure placed resident at risk for aspiration, unwanted hospitalization, and decrease in quality of life. Findings: Record review of Resident #29's face sheet dated 06/13/25 reveled an [AGE] year-old female admitted to the facility on [DATE] and again on 08/16/23. The resident's diagnoses included the following: dysphagia (difficulty swallowing), protein calorie malnutrition, cerebral infraction (condition where the brain tissue dies due to lack of blood supply), Alzheimer's Disease (memory loss), gastro-esophageal reflux disease (digestive disease in which the stomach acid or bile irritates the food pipe lining), gastrostomy (a surgically placed tube through the abdominal wall into the stomach, providing a route for delivering nutrition, medications, and fluids directly into the digestive system when a person cannot eat or drink adequately by mouth), and adult failure to thrive. Record review of Resident #29's quarterly MDS dated [DATE] reflected a BIMS score of 3 indicating the resident's cognition was severely impaired. Section K-Swallowing/Nutritional of the MDS reflected the resident had a feeding tube. Record review of Resident #29's Physician's Order Summary for the Month of June 2026 included the following orders: -Dated 08/13/24 Enteral Feed Isosource 1.5 (calorie dense completed nutrition formula with fiber for increase calorie needs) at 25ml/hr continuous with 25ml/hr water flush q 24 hours. -Dated 10/04/24 Hyoscyamine 0.125mg one tablet via G-tube every 4 hours for excessive secretions. -Dated 10/16/24 Sucralfate 1 gm via G-tube three times a day for gastric protection. Record review of Resident #29's Comprehensive Care Plan with an admission date 08/16/23 reflected the resident was care planned for PEG tube (same as G-tube) for nutrition r/t dysphagia and malnutrition. The interventions included to observe, document, report PRN any s/sx of: aspiration (accidental breathing in of food or fluids in a person's airway and eventually the lungs), fever, abdominal pain, distention (expansion of an organ or structure due to internal pressure), infection at tube site, SOB, tube dislodged .tube dysfunction of malfunction. (continued on next page)

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	455800	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lev Attown Park	8820 Town Park Dr Houston, TX 77036

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/10/25 at 12:45PM of medication pass for Resident #29 by LVN A revealed LVN A entered the room without a stethoscope (a device used to listen to the internal sounds of the body) to administer medications hyoscyamine 0.125mg and medication sucralfate 1 gm via G-tube TID. Prior to administering the medications, LVN A did not check for gastrostomy tube placement or observe the G-tube site. LVN A used a syringe to check the G-tube for residual (the volume of food, liquid, or material that remains in the stomach at a particular time during or between enteral nutrition feedings). The resident did not have any residual from the G-tube. LVN A did push the air from the syringe she used to check for residual with no audible sounds heard (sound perceived by the human ear). LVN A proceeded by flushing the G-tube with 30ml of water followed by administering the medication that was mixed in 5 ml of water. After LVN A finished administering the medication, she then flushed the G-tube with 30 ml of water. Interview on 06/12/25 at 11:57AM LVN A said she worked the morning shift from 6AM-2PM full time. LVN A said she was told by the DON that if she checked the residual of a resident with gastrostomy tube feedings, she did not have to check for placement and just return the residual contents back to the resident. LVN A said in the past, she was taught to check for the placement of a gastrostomy tube by listening with her stethoscope. LVN A said by not checking for gastrostomy placement placed the resident at risk for aspiration. Interview on 06/12/25 at 12:58PM the DON said the staff checked for placement of a gastrotomy tube by aspirating for any gastric contents using a syringe. The DON said if the resident yielded any gastric contents when aspirating the nurse would hear a swishing sound to ensure proper placement and that the nurse did not have to listen with a stethoscope. The DON said that method of checking for gastrostomy placement was changed by the corporate team she thought in 2023. The DON said if placement was not confirmed, it placed the resident at risk for aspirations. The DON was asked for the facility policy on the care of gastrostomy tube when administering medications via gastrotomy tube. Interview on 06/12/25 at 1:15PM LVN K said he worked the 6AM-2PM full time. LVN K said prior to administering medications or feeding through a gastrostomy tube, he always checked for placement by using a stethoscope to listen and an irrigation syringe checking resident residual (gastric contents). LVN K said if the resident did not have a residual, he would then listen with the stethoscope to check placement. Observation on 06/12/25 at 3:00PM of Resident #29 resting in bed quietly with eyes closed receiving continuous gastrostomy feedings with Head of bed elevated. Resident respirations were even and unlabored with no distress observed. Record review of the facility policy on Medication Administration via Enteral Tube copyright 2024 reflected in part: .It is the policy of the facility to ensure the safe and effective administration of medications via enteral feeding tubes by utilizing best practice guidelines .Enteral tube placement must be verified prior to administering any fluids or medication. (See Flushing a Feeding Tube policy) . Record review of facility policy on Flushing a Feeding Tube copyright 2024 reflected in part: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Prior to flushing the feeding tube, administration of medication or providing tube feedings, the nurse verifies the proper placement by noting the length of the tube or performing a measure of the pH (measures the density of hydrogen ions {important component in acid-base chemistry in a substance) of gastric secretions, if performed in the facility. See Verifying Placement of Feeding Tube Policy. Record review of the facility policy on Verifying Placement of Feeding Tube copyright 2021 reflected in part: .For gastrostomy tubes, check that the enteral retention device is properly approximated to the abdominal wall by gently tugging on the tube and taking note of the marking on the tube .Measure length of tube and record the length. Check and record the length of the tube prior to feedings as per facility policy .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals to meet the needs of each resident for 2 (Med Carts A and B) of 3 medication carts reviewed for pharmacy services. 1. Med Cart A had 3 blister packs of Tramadol 50 mg tablets totaling 68 tablets with an expiration date of 05/20/2025 for Resident #53. 2. Med Cart B had 1 blister pack with 9 tablets of Hyoscyamine Sulfate .125 mg tablets totaling 1 tablet and 1 blister pack of Haloperidol 1 mg oral tablet totaling 1 tablet with an expiration date of 05/25/2025 for Resident #68. This deficient practice could place residents at risk for not receiving the intended therapeutic benefit of their medications. Findings included: 1. Observation of Med Cart A and interview with RN G on 6/12/2025 at 4:28pm, revealed there were 3 blister packs of Tramadol 50 mg tabs (medication given to treat mild to moderate chronic pain), with instructions to take 1 tablet by mouth every 6 hours as needed. The packs had 29 tablets, 25 tablets and 14 tablets, respectively. The packs had the same expiration date of 05/20/2025. RN G said that nurses checked the carts for expired medications when they worked on them, and RN G missed this medication. RN G said having this expired medication presented no harm to Resident #53 because she had Tylenol PRN if she needed her medication. RN G removed the blister packs and took them to the medication storage room. Record review of Resident #53's face sheet dated 06/12/2025, reflected she was a [AGE] year-old female originally admitted on [DATE] and last re-admitted on [DATE]. Her medical diagnoses included cellulitis (infection of the skin tissue), Type 2 diabetes mellitus (high blood sugar), hyperlipidemia (high levels of fat in the blood), paranoid schizophrenia (a mental health condition making it hard for someone to tell what is real and what isn't, characterized by hallucinations, delusions and disorganized thinking), muscle weakness, history of stroke, and hypertension (high blood pressure). Record review of Resident #53's Order Summary Report, reflected she had an order for Tramadol HCl Oral Tablet 50 MG to be given by mouth every 6 hours as needed for pain with a start date of 8/19/2023 and was discontinued with no end date documented. Resident #53 had a new order for Tramadol HCl Oral Tablet 50 MG with a start date of 06/05/2025. Record review of Resident #53's MAR for May and June 2025, reflected Tramadol was not administered for May 2025 nor for 06/01/2025 to 06/12/2025. Resident #53 had documented pain levels of 0 for May and June 2025. Resident #53's Tramadol 50 mg had an order date of 08/19/2023 and a D/C date of 06/04/2025. Resident #53 had another order for Tramadol 50 mg with an order date of 06/05/2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Controlled Drug Administration Record Tablet for Resident #53's Tramadol 50 mg tab, reflected it had the same RX number as the blister packs. The record showed the last time Resident #53 took Tramadol was on 11/17/2024. 2. Observation of Med Cart B and interview with LVN H on 6/12/2025 at 4:49pm, revealed there was 1 blister pack containing 9 tablets of Hyoscyamine Sulfate oral 0.125 mg sublingual (administered under the tongue) tablet, with instructions to take 1 tablet by mouth every 8 hours as needed for secretion (medication given to produce more saliva) and another blister pack containing 1 tablet of Haloperidol 1 mg oral tablet with instructions to take 1 by mouth or under the tongue every 6 hours as needed for confusion, agitation or nausea/vomiting. Both blister packs had expiration dates of 05/25/2025. LVN H said that nurses should double-check the cart along with Unit Managers on a weekly basis, and that a negative outcome of residents possibly taking expired medication would be an adverse reaction or residents not getting the intended effect from expired medications. LVN H said those medications came from Resident #68's hospice and that LVN H did not think Resident #68 took those medications anymore. LVN H had in-services on checking for medication dates and medication administration. Record review of Resident #68's face sheet dated 06/12/2025, reflected she was a [AGE] year-old female originally admitted on [DATE]. Her medical diagnoses included Schizophrenia, Major Depressive Disorder, Anxiety Disorder, and pain. Record review of Resident #68's Order Summary Report, reflected she had an order for Haloperidol Oral Tablet 1 MG to be given as 1 tablet sublingually every 6 hours as needed for Agitation, with a start date of 02/26/2025 and was discontinued with no end date documented and a current order for Hyoscyamine Sulfate oral Tablet 0.125mg for 1 tablet to be given every 8 hours as needed for increased secretions, with a start date of 02/26/2025. Record review of Resident #68's MAR for May and June 2025, reflected she was not administered Haloperidol nor the Hyoscyamine for the months of May and June 2025. In an interview with the DON and Administrator on 06/12/2025 at 5:18pm, the DON said that Resident #68's Haloperidol came from her other facility and that Resident #68 did not take Haloperidol anymore because she did not have any behaviors warranting it. The DON said that nurses and unit managers were to check carts. The Unit Manager and DON were to make sure nurses were doing what they should. If residents took expired medications, they could have adverse reactions. The facility had medication training and in-services two weeks ago which covered medication management. Record review of the facility's policy on Medication Administration copyrighted in 2022 read in part, Medications are administered by licensed nurses or other staff who are legally authorized to do so . 12. Identify expiration date. If expired, notify nurse manager.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an infection program designed to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections for 2 (Resident #29, Resident #42) of 7 residents and two staff members reviewed for infection control in that: -CNA KK was observed on 06/10/24 coming out of Resident # 42's room with a folded sheet placing the sheet back on the clean cart. -CNA D and Restorative Aide CNA E did not wear a disposable gown when providing Foley catheter for Resident #42 who was on enhanced barrier precautions. -CNA D and CNA E was not familair with EBP. -Resident #29's bathroom there was a gray wash pan sitting on side of the commode on the floor and a urinal sitting on top of the sink countertop not labeled or bag. -LVN P was observed on 06/10/25 coming out of room with a packet of used disposable wipes placing them on her medication cart. -Resident #29 and Resident #42 did not have EBP infection control signage on their door. The failures placed residents at risk for cross contamination and infections. Findings: Resident #29 Record review of Resident #29's face sheet dated 06/13/25 reveled an [AGE] year-old female admitted to the facility on [DATE] and again on 08/16/23. The resident's diagnoses included the following: dysphagia (difficulty swallowing), protein calorie malnutrition, cerebral infraction (condition where the brain tissue dies due to lack of blood supply), Alzheimer's Disease (memory loss), gastro-esophageal reflux disease (digestive disease in which the stomach acid or bile irritates the food pipe lining), gastrostomy (a surgically placed tube through the abdominal wall into the stomach, providing a route for delivering nutrition, medications, and fluids directly into the digestive system when a person cannot eat or drink adequately by mouth), and adult failure to thrive. Record review of Resident #29's quarterly MDS dated [DATE] reflected a BIMS score of 3 indicating the resident's cognition was severely impaired. Section K-Swallowing/Nutritional of the MDS reflected the resident had a feeding tube. Record review of Resident #29's care plan did not reflect care plan for EBP Record review of Resident #29's Physician's Order Summary for the Month of June 2026 included the following orders: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dated 08/13/24 Enteral Feed Isosource 1.5 (calorie dense completed nutrition formula with fiber for increase calorie needs) at 25ml/hr continuous with 25ml/hr water flush q 24 hours. Observation on 06/10/25 at 8:57AM of Resident #29 having no EBP sigange on door. Resident #42 Record review of Resident #42's face sheet dated 06/11/25 revealed an [AGE] year-old female admitted to the facility initially on 04/09/20 and again on 01/02/25. The resident's diagnoses included urinary tract infection, dementia (memory loss), acute kidney failure (when the kidneys suddenly cannot filter waste from the blood), severe sepsis (a life-threatening complication of an infection), and neuralgia (pain resulting from damaged or irritated nerves). Record review of Resident #42's quarterly MDS dated [DATE] reflected a BIMS score of 7 indicating the resident's cognition was severely impaired. Record review section H-Bladder/Bowel reflected the resident had an indwelling Foley catheter. Record review of Resident #42's Physician's Order Summary Report for the month of June 2025 reflected the following order: -Dated 01/02/25 16Fr/10cc urethral indwelling urinary catheter (a tube that carries urine from the bladder to the outside of the body and held in place by a balloon inflated inside of the bladder). Dx stage 4 sacral wound with closed drainage system (when the catheter is retained in the bladder by an inflated balloon and the drainage of urine is totally dependent on gravity). Record review of Resident care plan did not reflect a care plan for EBP. Observation on 06/10/25 at 8:57AM Resident #42 was awake in bed resting on an air mattress. Resident #42 had an indwelling Foley catheter that was inside of a privacy bag. Further observation was made of the resident not having an EBP infection control sign on the room door. Further observation in resident bathroom revealed a gray wash basin sitting on the floor on the left side of the commode and there was a urinal sitting on the sink counter. The wash basin and urinal were not labeled and not inside of a plastic bag. Observation was made on 06/10/25 at 12:30PM revealed the wash basin was still sitting on the floor and urinal on bathroom rail. Observation on 06/10/25 at 9:50AM revealed CNA KK coming out of a room with a white flat folded sheet in her hand. CNA KK placed the sheet back on the clean linen cart. Interview on 06/10/25 at 9:50AM CNA KK said it was okay to place the sheet on the clean linen cart as long she bagged the linen. The CNA then retracted her comment and said it was not okay to come out of a resident room with linen and place it back on the clean linen cart because it was cross contamination. CNA KK said she had just finished providing incontinent care. Interview on 06/10/25 at 10:06AM LVN N said once linens went into a resident's room, the staff was not to bring the linen back out and place them on the clean linen cart even if the linen was not used. LVN N said that was cross contamination and infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/10/25 at 2:19PM the DON said the staff were not supposed to bring linen out of a room and place it back on the clean linen cart due to cross contamination and infection control. Observation on 06/11/25 at 9:08AM revealed in Resident #42's bathroom, the gray wash basin was still on the floor by the commode along with the urinal hanging on the rail. None of the items were bagged or labeled. Interview on 06/11/25 at 9:12AM LVN I said he was working as a CNA and was assigned to Resident #42. After LVN I observed the gray wash basin on the floor and the urinal hanging on railing not dated or bagged, LVN I said all residents' wash basins, urinals, etc. were supposed to be labeled and bagged for infection control. LVN I began to remove the wash basin and urinal from the room. Interview on 06/11/15 at 9:13AM LVN P said she was the nurse for residents #42. LVN P said all resident care items should be labeled and bagged for infection control. LVN P said the CNAs were supposed to label resident care items and bag them. LVN P said because she was the nurse, she was responsible for ensuring that the CNAs were carrying out those tasks. Observation on 06/11/25 at 10:13AM revealed LVN P coming out of Resident #42's room with a pack of disposable wipes in her hand walking up the hallway and placing them on a cart. Interview on 06/11/25 at 10:14AM LVN P said she had just finished providing incontinent care for Resident #42. LVN P said Resident #42 had a bowel movement. LVN P said she placed the disposable wipes pack on her medication cart. LVN P said it was not okay to place the wipes on her cart. LVN P said she did that to have what she needed when providing care for the residents because disposable wipes were not always accessible due to central supply sometimes not stocking the nurses station with disposable wipes. LVN P did not respond when asked if there was a lack of disposable wipes at the facility. Observation on 06/11/25 at 10:38AM with LVN P of the facility supply room revealed the supply room was observed having 24 boxes of disposable wipes (with a count of 64 wipes in each packet). Interview on 06/11/25 at 10:40AM the facility Central Supply Manager said she stocked each nurse's station with disposable wipes each shift and as needed. Observation on 06/11/25 on at 10:50AM with LVN P revealed the nurse station being stocked with disposable wipes. Interview on 06/11/25 at 10:55AM LVN P said she didn't want to take the time to get the disposable wipes out of the medication room behind the nurse station and therefore chose to put the used wipes on her cart. LVN P said taking resident care items from a room and placing them on her medication cart was wrong due to cross contamination and infection control. LVN P said she had received in-service on infection control. LVN P said it would not happen again. Observation on 06/11/25 at 1:46PM of Foley catheter care for Resident #42 by CNA D with the assistance of Restorative Aide CNA E revealed the resident did not have a EBP infection control signage on the room door. During the observation, CNA D and Restorative Aide CNA E did not wear full PPE that consisted of disposable gown and gloves (just washed their hands and placed on gloves). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/11/25 at 2:09PM CNA D said she was not familiar with EBP as it related to infection control. CNA D said her last infection control in-service was at the beginning of the month and did consist of cross contamination. Interview on 06/11/25 at 2:11PM Restorative Aide CNA E said he was not familiar with EBP and that his last in-service on infection control was last month he believed. Interview on 06/11/25 at 2:16PM LVN P said she was not familiar with EBP. Interview on 06/11/25 at 2:20PM the facility Infection Control Preventionist said she had been working as the facility's Infection Control Nurse Preventionist since 2023. The Infection Control Nurse said she was familiar with infection control EBP. She said EBP was to prevent infections such as MDRO and that if the infection was colonized (the presence of bacteria on the body surface like the skin, mouth, intestines, or airway without causing the disease in the person). the staff just needed to wear gloves but if the infection was not colonized, the staff needed to be donned((put on) in both gloves and disposable gowns when performing direct care for the resident(s). Further interview with the Infection Control Preventionist revealed a resident's wash pan and urinal needed to be labeled with the resident's name, stored inside of a plastic bag, and kept in the resident's bathroom to prevent cross contamination. The Infection Control Preventionist said when the staff took items into a resident's room to care for a resident, that item should stay in the resident's room to prevent cross contamination and infections. The Infection Control Preventionist said she was going to place EBP infection control signs on all rooms doors of residents' that had wounds, Foley catheters, trach (tracheostomy-surgical procedure to create an opening in the neck directly into the windpipe to facilitate breathing), gastrostomy ((feeding tube inserted through the abdominal wall directly into the stomach), colostomy (surgical procedure that creates an opening in the abdomen, connecting the colon to the outer side of the body to allow stool to pass) , etc. and provide in-service to the staff about EBP and infection control. Interview on 06/11/25 at 2:34PM the DON said she learned on 06/11/25 about EBP and signage needing to be on all doors or residents that had wounds, IV's, colostomy bag, G-tubes, trachs, etc. The DON said when she read the information regarding EBP, she was under the impression it was for MDRO's and issues dealing with colonize vs not colonized infections. The DON said she was also an Infection Control Preventionist. Interview on 06/11/25 at 2:37PM the Administrator said after reviewing CMS recommendations on EBP, she realize that the facility had misread their recommendations on EBP thinking it meant for colonized and MDRO infections. The Administrator said the facility had begun a 100 % audit on all residents with Foley catheters, wounds, trach, colostomy, G-tubes, IV's, infection control as it related to EBP, PPE, and infection control signage on doors. The Administrator said the facility had initiated a PIP on the incident and spoke with the facility Medical Director regarding EBP and infection control. The Administrator said no staff would be allowed to work until in-serviced had be done with staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/12/25 at 12:05PM Restorative Aide CNA E said he worked the 7AM-3AM full time and had been in-serviced on infection control/EBP. Restorative Aide CNA E said when providing direct care for a resident such as incontinent care, he had to wear a disposable gown and gloves, making sure the resident had an EBP sign on the door and PPE by the doorway or on the doorway. CNA E said residents that needed to be on EBP were residents with wounds, Foley catheters, trachs (surgical procedure that creates an opening in the neck and windpipe to allow breathing), gastrostomy feedings, and IV's (administering fluids, medications, nutrients through a vein. Interview on 06/11/25 at 12:09PM with LVN M who worked at the facility on the 6AM-2PM shift revealed she had received an in-service on infection control/EBP to wear disposable gowns and gloves when providing direct care for residents with infections, wounds, Foley catheters, gastrostomy, colostomy, receiving dialysis, and trachs. Interview on 06/12/25 at 12:11PM LVN N Unit Manager said she worked at the facility full time Monday-Friday form 9AM-5PM. LVN N said she had received in-service on infection control, and EBP to don with gloves and disposable gowns when providing direct care for residents with Foley catheters, wounds, gastrostomy tubes, colostomies, and intravenous, or any other artificial openings. LVN N said the EBP signage had to be on the resident's door with PPE being available. Intervention on 06/12/25 at 12:39PM via phone with LVN W said he worked on the 10PM-6AM and had received in-service on infection control as it related to EBP. LVN W said any resident with an artificial opening (G-tubes, colostomy), wounds, indwelling Foley catheters, etc. LVN W said the staff had to wear disposable gowns and gloves when providing direct care for the resident. LVN W said the infection control sign had to be placed on the resident(s) door with PPE available. Interview on 06/11/25 at 12:45PM via phone LVN Z said they worked the night shift form 10PM-6AM PRN. LVN Z said he had been in-serviced on EBP for residents with any wounds or artificial openings to ensure that the EBP signage were on their doors with PPE being accessible. LVN Z said he had to wear disposable gowns and gloves when providing direct care to protect themselves as a well as the resident. Interview on 06/12/25 at 12:47PM via phone LVN TT said she worked the night shift form 10PM-6AM full time. LVN TT said she had been in-serviced on making sure infection control signage was on resident doors with wounds, gastrotomy tubing, trachs, Foley catheters and to wear disposable gowns and gloves when providing care. LVN TT said PPE had to placed by the resident's door. LVN TT said the reason this was done was to protect the resident and the staff providing care for the resident. Interview on 06/12/25 at 5:03PM with LVN I said he worked at the facility full time from 2PM-10PM and had received in-service on EBP and PPE. Interview on 06/12/25 at 5:05PM with CNA RR who worked the 2PM-10PM shift. CNA RR said she had received in-service on EBP and PPE. Record review of the facility policy on Infection Control copyright 2022 reflected in part: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455800	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lev Attown Park	8820 Town Park Dr Houston, TX 77036

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.All staff are to assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Therefore, all staff adhere to standard precautions to prevent the spread of infection to residents, staff and visitors . Record review of the facility policy on Enhanced Barrier Precautions dated August 2022 reflected in part: .Enhanced barrier precautions (EBP's) are utilized to prevent the spread of multi-drug resistance organisms to residents .EBP's are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization .EBP's remain in place for the duration of the resident's stay or until resolution of the wound or indwelling medical devices regardless of MDRO colonization .Signs are posted in the door or wall outside the resident room indication the type of precautions and PPE required .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure the facility was adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for one resident (Resident #48) of 10 residents reviewed for resident call system in that: The facility failed to ensure Resident #48's call light was in working order. This failure could place residents at risk of being unable to obtain assistance for activities of daily living or in the event of an emergency. Findings included: Record review of Resident #48's facility admission record dated 6/11/25 revealed that Resident #48 had an original admission date of 3/2/21 and re-admission date of 5/1/25. Resident #48 was a [AGE] year-old male with diagnoses that included lobar pneumonia (a type of pneumonia where a large portion or entire lobe of one or both lungs becomes inflamed and consolidated, meaning it fills with inflammatory fluid and/or pus) and Parkinson's Disease without Dyskinesia without fluctuations (a specific presentation of Parkinson's disease where patients do not experience involuntary movements (dyskinesia) or noticeable changes in the severity of their symptoms over time (fluctuations). Record review of Resident #48's Quarterly MDS dated [DATE], revealed a BIMS score of 8 out of 15 indicating a moderate cognitive impairment. Resident #48 was documented to require partial to moderate assistance to substantial/maximum assistance from staff for ADLs. He required set-up to or clean-up assistance with eating. He was always incontinent with bladder and bowel. Record review of Resident #48's care plan revealed a care plan to address ADL self-care performance deficit r/t decreased mobility and unsteady gait Date Initiated: 6/1/21. Revision on: 4/10/2024 with a target date of 6/30/25. Interventions included requiring 2 staff to transfer and to encourage the resident to use bell to call for assistance. Observation and interview on 6/11/25 at 8:35 AM revealed Resident #48's sitting up in his bed eating breakfast. He said that the staff had not answered his call light for the past week. The surveyor requested Resident #48 to press his call light and when he pressed the call light the light outside the room failed to turn on. Resident #48 said that it made him feel scared when he pressed the call light, and no one responded because he needed help. Observation and interview on 6/11/25 at 8:37 AM revealed the surveyor found and asked CNA O to please check Resident #48's call light. CNA O and LVN P came into the room and checked the call light.The call-lights for both beds were unplugged and re-inserted and then the call-light worked. LVN P said that she placed a work order about the call-light immediately with the Maintenance Director. She said that a functional call light was important because the call light was the resident's way to communicate their needs, she also monitored the halls constantly and it was everyone's responsibility to monitor call-lights to make sure resident needs were addressed. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 6/11/25 at 8:48 AM with the Maintenance Director, revealed he said that the call light was very important because the residents needed help and all staff were responsible to make sure the resident needs were met. The surveyor observed the Maintenance Director when he gave the new cords for the call light to be replaced to CNA O and he said he would dispose of the faulty cords. In an interview on 6/11/25 at 8:55 AM with LVN A/Charge Nurse, she said that safety was number one and making sure the resident needs were met. She said the monitoring and reporting of needed repairs were all staff responsibilities. She said they communicated through an email system in the facility any work orders that needed to be addressed and the email reached all management. In an interview on 6/11/25 at 9:24 AM with the Administrator, she said that she was aware of Resident #48's call light and said that the call-light was repaired immediately. She said that she was also conducting a 100 percent audit on all call-lights. She said that all staff were responsible for monitoring call-lights and communicating needed repairs and ambassadors checked call lights daily. She added call lights were important to address and assist with help and a negative outcome could have been if the resident had fallen and required assistance. In an interview on 6/11/25 at 10:28 AM with the Infection Control Preventionist-LVN/Unit Manager she acknowledged that she was an ambassador for the residents and checked the call lights daily and that Resident #48's call light not working for approximately the last week was untrue because she always checked the call lights for safety and said all staff were responsible for checking call lights. An interview on 6/11/25 at 2:37 PM with the DON, revealed the DON said that if a resident's call light was not functional, the resident would not be capable of calling for help when needed and they could get hurt if they could not call. She said all staff were responsible for monitoring call-lights. Review of the facility's undated policy and procedure entitled Call Lights: Accessibility and Timely Response, read in part . The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response . Ensure the call system alerts staff members directly or goes to a centralized staff work area. .