STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455806	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terrace at Denison	1300 Memorial Dr Denison, TX 75020

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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 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 Based on observation, interview and record review the facility failed to ensure residents had the right to a safe, clean, comfortable and homelike environment for secure unit dining room, main dining room and for 14 of 27 residents (Resident #2, Resident #39, Resident #12, Resident #13, Resident #14, Resident #17, Resident #22, Resident #25, Resident #28, Resident #34, Resident #35, Resident #43, Resident #47, Resident #48) reviewed for environment and resident rights, in that, The facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior and did not ensure resident rooms were clean, sanitary and free of food debris and drink spills to prevent ants, gnats and flies. There were ants, gnats, flies in resident rooms and resulted in 102 ant bites on Resident #2's upper middle chest, over the right breast, right side of the neck, right shoulder, right arm, and right elbow. An IJ was identified on 08/08/24. The IJ template was provided on 08/08/24 at 4:11 PM. While the IJ was removed on 08/12/24, the facility remained out of compliance at a scope of pattern and severity level of potential for more than minimal harm because all staff had not been trained on clean, sanitary, and homelike environment. These failures placed residents at risk of living in an unsanitary and unhomelike environment. Findings included: 1. Review of Resident #2's face sheet, dated 08/07/24, revealed she was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included Hypertension (high blood pressure), diabetes mellitus, Acute and chronic respiratory failure with hypoxia (a condition in which the body or a region of the body is deprived of adequate oxygen supply at the tissue level), Quadriplegia (paralysis of all four limbs), Cognitive communication deficit, aphasia following cerebral infarction (type of ischemic stroke resulting from a blockage in the blood vessels supplying blood to the brain), chronic pain, and adult failure to thrive. Review of Resident #2's MDS quarterly assessment, dated 04/28/24 revealed Resident#2's BIMS score of 00 indicating severe cognitive impairment. Resident #2 had a feeding tube with over 51% or more received through tube feeding. (continued on next page)

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

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

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #2's care plan, dated 03/29/23, and updated 08/08/24, reflected the following Problems: Resident #2 has scattered insect bites (ant bites) on her right neck, right shoulder, right arm, and right breast. Goal: Resident #2 insect bites will heal without complications over the next 90 days. Approach: Monitor for s/s of infection and report findings to MD. Treatment as ordered. Record review of Resident #2's weekly skin assessment, dated 07/29/2024, revealed Resident #2's skin was intact. Record review of Resident #2's skin assessment, dated 07/30/2024, revealed Resident #2 had redness, bites/welts on the right shoulder, and right arm. Record review of Resident #2's physician order dated 07/30/2024 revealed Resident #2 had an order for, Kenalog cream apply to right of neck and right forearm three time a day till healed. Record review of Resident #2's nursing progress note, dated 07/30/2024 at 06:00 p.m., revealed a note reflecting Resident #2 . Approximately 06:00 pm walked into resident's room to administer medication via G tube (gastrostomy tube is a tube that is surgically inserted through the abdominal wall and into the stomach to provide an alternative way to deliver nutrition, fluids, and medications directly to the stomach) and noted ants on resident R arm/elbow, and right side of her face. Removed ants as quickly as possible, assessing resident and noted resident to have reddened welts to R elbow, and bend of AC (Antecubital - the area on the front side of the upper part between the arm and forearm) and to the right side of her neck. Notified Doctor (Resident primary doctor) new order received to apply Kenalog three time a day. Resident moved to another bed in another room. Notified DON. Notified resident representative . Vital signs: Blood pressure: 118/75, Heart rate, Temperature: 98.2 F, Respiratory rate: 20. Record review of Resident #2's nursing progress note dated 07/31/2024 at 01:00 am., revealed a note stating Resident #2 currently in bed resting no signs and symptoms of pain or discomfort noticed, small bites to right inner elbow, no edema (swelling caused by too much fluid trapped in the body's tissues) noted to the areas. Record review of Resident #2's nursing progress note, dated 08/01/2024 at 09:00 a.m., revealed a note reflecting Resident #2 . new order Benadryl 25 mg via peg tube bid for 7 days . Record review of Resident #2's nursing progress note, dated 08/7/2024 at 10:00 a.m., revealed a note reflecting Resident #2 . day 7/7 Benadryl r/t insect bites Record review of Resident #2's Doctor orders revealed Resident #2 had an order dated 06/01/2024 for Tylenol-Codeine #3 (Acetaminophen with codeine, pain medication) one tablet every four hours as needed for pain via G-tube feeding. Record review of Resident #2's MAR revealed Resident #2 received Tylenol-Codeine #3 (prescription drug used to relieve mild to moderately severe pain that is not well-controlled with over-the-counter medication) one tablet on 07/31/24 at 08:00 a.m., 08/01/24 at 08:00 a.m., and 08/02/2024 at 08:00 a.m. via G-tube feeding, with the note of pain level 6/10, and pain reassessment after medication revealed effectiveness. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 08/06/2024 at 09:13 AM of Resident #2's room revealed Resident #2's bed was located next to the window. Resident#2 was up in the wheelchair and connected to G-tube feeding. Ant bites were visible on Resident#2's right side of her neck, and right arm around the anti-cubital fossa (the area on the anterior side of the upper part between the arm and forearm). Observation revealed the ants bites were either clear fluid filled raised areas and/or scabbed raised areas in the affected area. Resident #2's G tube had feeding formula spots on the floor, and the on the G tube pump pole, and electric wire. Observation and Interview with the ADON on 08/06/24 at 4:13 PM revealed skin assessment with ADON on Resident #2. Resident had multiple healing ant bites on her right arm, upper chest, neck and face. ADON stated when she came in that night (07/30/24) after the incident it broke her heart to think of Resident #2 lying there, not being able to speak, not being able to call out for help. She stated the ants were crawling on the resident and crawling in the bed linens. She stated the ants were everywhere. Observation on 08/07/2024 at 10:07 am of Resident #2's Skin assessment by LVN B with the help of CNA I revealed : 8 ant bites at the middle chest by the neck; 9 ant bites over the right breast; 15 ant bites on the right side of resident neck; 25 ant bites on the right shoulder; 30 ant bites in top of the right arm in front of the elbow; 15 ant bites on the resident's right elbow. Observation and interview revealed Resident # 2 sustained a total of 102 ant bites. Resident #2's G tube feeding formula pole was next to resident's bed with drip spots on the floor, and on the G tube pump support, pole, and power cord. Interview on 08/07/2024 at 10:16 AM with LVN B revealed Resident #2's equipment looked like it needed cleaning from the G Tube formula drip stain, and it was the responsibility of everyone to clean the formula drips stain, CNAs, nurses, and housekeeper. She stated was going to clean it right way. Interview on 08/07/2024 at 10:18 AM with CNA I revealed Resident #2's equipment needed good cleaning and did not know whose responsibility it was to do it. She stated she mentioned it to the housekeeper few days ago, but the housekeeper replied that it was the nurses' responsibility to clean residents' equipment. Telephone Interview on 08/07/2024 at 11:13 am over the phone with Resident #2's family member revealed she saw ants in the resident room on 07/21/24. Interview revealed she asked a facility staff member to clean the dirty floor and clean up the G-Tube formula drip stains on the floor. The family member stated the facility did not do anything on 07/21/24. The family member stated on 07/26/24, she saw ants in the resident room. Interview revealed she asked a housekeeping staff member to clean up the floor and the floor mat to remove the G Tube formula drip stains. The family member stated housekeeping did not clean the floor. The family member stated she moved the resident bed , kneeled to clean up the floor and floor mat on 07/26/24. Interview with the family member revealed she visited the resident on the day of the incident, 07/30/24 for about 30 minutes. She stated she did not uncover the resident to look at the resident. The family member stated she saw G Tube feeding formula drip stains on the floor and feeding tube equipment each time she visited the resident. Interview revealed she did not inform the Administrator about the ants, the dirty floor and dirty resident equipment. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview over the phone on 08/07/2024 at 1:22 pm with agency LVN M revealed she saw G Tube formula drip stains on the floor and G Tube equipment. She stated it was not her responsibility to clean the floor and equipment. Interview revealed she did not know whose responsibility it was to clean the floor and resident equipment. Agency LVN M stated at around 6:00PM on 07/30/24, she went to Resident #2's room to administer scheduled medications to Resident #2. Interview revealed she noted ants crawling on the right side of Resident #2's face. She uncovered the resident and there were ants crawling on Resident #2's right arm and right leg. Agency LVN M stated she saw ant bites around Resident #2's neck and arm. Agency LVN M stated she saw black big ants and black small ants crawling on the resident and ants crawling in the linens. She stated she removed the top linens off the resident. Agency LVN M stated she used her hands to remove the ants that were crawling on the resident. Agency LVN M stated she called CNA H to help her. Interview on 08/08/2024 at 2:45 PM with the Administrator revealed the G-tube feeding formula spill spots on the resident's linen, floor, and the pump pole was a food source for ant and gnats, and the facility reeducated the staff to clean the area and keep G tube feeding residents' rooms free of any G tube feeding formula dripping spots. An interview with LVN B on 08/09/24 at 01:20 p.m., revealed, she stated on 07/31/2024 at 08:00 am she noticed Resident #2 grimacing and grinding her teeth. She said she assessed her pain, called Resident #2's primary doctor and got orders for Benadryl 25 mg via G-Tube feeding to ease the skin irritation related to ant bites, apply Kenalog to the affected area three times a day, and continuous with pain medication order Acetaminophen with codeine one tablet via G tube feeding every four hours as needed for pain. An interview with Resident #2's primary doctor on 08/09/24 at 01:35 PM, revealed, he stated he was notified of Resident #2's ant bites incident on July 30, 2024, and ordered Kenalog cream to apply to the affected area three times a day to ease the skin irritation from the ant bites. He stated the Nurse Practitioner assessed Resident #2 the next day after the incident (07/31/2024) of ant bites. He stated he saw Resident #2 on 08/01/24 and noted small red ant bites on Resident #2's right shoulder, right arm, and elbow. 2.Review of Resident #39's undated face sheet reflected a [AGE] year-old female with and admitted [DATE] and a re-admitted [DATE]. Diagnoses included dehydration, dysphagia (difficulty swallowing), cerebral vascular accident (stroke), contractures, and unspecified severe protein-calorie malnutrition. Review of Resident #39's quarterly MDS assessment, dated 04/26/24, reflected Resident #39 had BIMS score of 0 which indicated she was severely cognitively impaired. She was totally depended on all ADLs and always incontinent of bowel and bladder and she received 51% or more of total calories through a feeding tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach). Record review of Resident #39's care plan with a revision date of 07/01/24 reflected, .[Resident #39] require PEG feeding . (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation and interview on 08/07/24 at 11:32 AM revealed three ants were in Resident #39's window blinds and 1 brown/black ant on window seal crawling. Resident #39 was connected to g-tube feeding while lying in her bed next to window where brown/ black ants were located. LVN A was notified by surveyor about the brown/black ants in Resident #39's room. LVN A moved Resident #39's bed away from the window. Resident #39's g-tube pole had drops of feeding on the middle of pole and along the bottom of the pole and stand along with 4 to 5 drops of feeding to the right of the g-tube pole on the floor next to resident's bed. Interview with LVN A revealed the g-tube feeding pole did have drops of feeding on the g-tube pole and it needed to cleaned along with the floor. LVN A stated she would move Resident #39 to another room due to ants in the resident window. Observation on 08/08/24 at 10:43 AM revealed Resident #39 was in the new room. She was lying in bed and her g-tube pole had drops of feeding on the pole and on the bottom of the g-tube pole. 3) Review of Resident #28's face sheet undated reflected Resident #28 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Bipolar disorder, Dysphagia (Swallowing disorder), Cognitive Communication deficit, Chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), Respiratory Failure, Schizoaffective disorder (mental health condition combining symptoms of schizophrenia and mood disorders), diabetes and heart failure. Review of Resident #28's Quarterly MDS assessment dated [DATE] reflected Resident #28 had a BIMS score of 12 indicating he was moderately cognitively impaired. Observation and interview on 08/06/24 at 9:26 AM revealed Resident # 28 was in his room lying across his bed dressed. Resident #28 was surrounded by clutter. There were numerous gnats noted swarming around his chest of drawers and bedside table. There was a dirty sheet wadded up on the floor with brown substance. Resident #28 stated he had spilt some of his coffee on the floor. Resident #28's room smelled of urine. There was a milk crate with dirty clothes. Interview on 08/06/24 at 9:32AM with Contract Housekeeping Supervisor S revealed housekeeping had Resident # 28's room on their high priority cleaning schedule. She stated he hoarded a lot of paper and other stuff. She stated they clean the Resident #28's room twice a day and deep cleaned it once a week. She stated she knew there were gnats in his room. Observation on 08/06/24 at 10:52 AM of Resident #28's room revealed there was a strong smell of urine and a swarm of small flying insects on the resident's privacy curtain, on his bedside table, his dresser top and on his bed. There was a swarm of flying insects on soiled linens tangled and lying on the floor. There were over 25 small flying insects on Resident #28's bedside table with sticky residue and crumbs of food and debris. Observation of Resident #28's bathroom revealed his toilet had a yellow liquid that smelled strongly of urine. Interview on 08/06/24 at 10:54 AM with LVN A revealed she was aware of the state of Resident #28's room and that he commonly clogged the toilet and hoarded food and trash in his room. Observation on 08/08/24 at 9:17 AM in Resident #28's room revealed there was soiled linen wrapped and lying on the floor with 5 small flying insects on top. There were large crumbs of food on his bed spread with two flies on top. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 08/09/24 at 2:22 PM of Resident #28's room revealed he was still in the same room and there was a sticky residue on the bedside table with 18 small flying insects on the bedside table. Observation on 08/11/24 at 2:25 PM of Resident #28's room revealed he had been moved to a different room. Resident #28 was not in his room, and it had a bed that was placed away from the wall and window with a privacy curtain, night stand, bedside table with mini soda's, instant coffee and a loveseat on the wall next to the entry door. Observation of the floor under Resident #28's loveseat revealed food crumbs and paper trash. Interview on 08/11/2024 at 2:30 PM with CNA X, revealed it was her first day at the facility and she worked for a staffing agency. She stated she had been in-serviced on pests and cleaning of resident rooms and knew there was a binder they put any pest sightings or housekeeping concerns in. She stated that she observed what looked to be food residue on Resident #28's bed spread, a live fly on the bed spread, and that it did not look like the floor under the loveseat had been swept,- there were food crumbs and small paper trash. She stated she had not looked at the windowsills of the resident's room yet and planned to at the end of her shift. 4. Review of Resident #25's face sheet dated 08/08/24 reflected Resident #25 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Diabetes, Chronic Obstructive Pulmonary Disease (lung disease causing restricted airflow and breathing problems), Dysphagia (Swallowing disorder), Hemiplegia (Paralysis) on left side, End Stage Renal Disease, Seizure Disorder, Heart Failure and Legal Blindness. Review of Resident #25's quarterly MDS assessment dated [DATE] reflected Resident #25 had a BIMS score of 15 indicating he was cognitively intact. It reflected Resident #25 required substantial/maximal assistance with toileting. Review of Resident #25's Comprehensive Care Plan last updated 06/24/24 reflected Resident #25 was at risk for falling R/T (related to) impaired mobility and impaired vision. Has left bka (below knee amputation) with prothetic. Intervention included Assure the floor is free of glare, liquids, foreign objects. Observation and interview on 08/06/24 at 12:01 PM revealed Resident #25's room had a yellowish stain on the floor from the closet and inside closet there was wetness on closet floor with Resident #25's clothing on floor. There was a strong odor in the resident room and 2 flies on bedside table and landed on his bed while Resident #25 was sitting in the middle of the bed. There was bubbling paint on the wall between window and the closet. There was bubbling paint on walls between closet and bathroom door for Resident #25. Resident #25's bed was next to window and window seal had particles and small dead black bugs on the window sill Resident #25 revealed he was blind and could not see if there were any ants in his room. He stated he had flies and gnats in his room and knew they were there because the flies landed on him and his face. He stated he knew there had been a leak recently in his room from the closet but did not know what they had done. Observation on 08/06/24 at 12:04 PM of Resident #25's bathroom revealed sink was dripping into a plastic cup with spoon in it and his toilet had yellowish/brownish stains in the toilet with floor having yellowish/brownish stains around the toilet on the floor. Resident #25's bathroom floor was sticky with stains and wetness covering the floor. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 08/08/24 at 9:40 AM revealed Resident #25's room had food debris noted on the floor, empty cracker wrapper on the floor and empty medication cup on the floor. 5. Review of Resident #17's face sheet undated reflected Resident #17 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Emphysema (a lung condition that causes shortness of breath), Psychotic disorder, Neuropathy (nerve damage that causes weakness, numbness and pain, usually in your hands and feet), Stroke, Hemiplegia (Paralysis on right side), heart failure and schizoaffective disorder. Review of Resident #17's quarterly MDS assessment dated [DATE] reflected Resident #17 had a BIMS score of 13 indicating he was cognitively intact. Resident #17 required supervision with ADLs. Resident #17 was continent with bowel and bladder. Observation on 08/06/24 at 11:54 AM revealed Resident #17's window was cracked open with windowsill next to his bed full of debris, dead black bugs, and crumbs. His bathroom had blackish stains on floor near toilet and around the toilet bowl. The wall in the bathroom had bubbling paint and was wet. Bathroom cabinet door was sitting on floor leaned against the wall below the toilet roll. Bathroom cabinet had no door with toilet seat lid sitting under the bathroom sink with yellowish/brownish stains along with black particles and bugs covering the toilet seat lid. Observation on 08/06/24 at 11:53 AM revealed Resident #13 shared a room with Resident #17 and was lying in his bed. Interview on 08/06/24 at 2:20 PM with Resident #17 revealed housekeeping did not clean his room including his bathroom on the weekends at all. He stated he had flies and gnats in his room. Interview on 08/07/24 at 2:31 PM with Contract Housekeeping Supervisor S revealed, Resident #28 stored and hoarded alot of stuff in his room and spilt drinks in his room. She stated Resident #17's bathroom had spills due to Resident #17 urinated on floor. She stated both Resident #17 and #28's rooms were required to be cleaned twice daily including bathrooms. She stated these rooms were to be cleaned first and then come back later in the day to follow up to look for spills, debris and clean. She stated Resident #17's bathroom floor was black and stained. She stated she spoke to Maintenance Director about a month ago about Resident #17's toilet seat lid needing to be replaced and bathroom cabinet door was off needing to be replaced. She stated she did not clean the toilet lid since it was off needing to be replaced by Maintenance. She stated she noticed the yellowish stain on Resident #25's bedroom floor near the closet about 2 weeks ago and it required more deeper cleaning. She stated they would have to have resident move out of room in order to clean up the floor of Resident #25. She stated the toilet stains required stronger cleaning supplies to get rid of stained inside toilet. She stated Resident #28's room had flies and gnats in his room since he hoarded food and other items in his room. She stated she had noticed the flies in Resident #17's room. She stated she would have to bring the mop and bucket to clean the secure unit common area and dining room floors in the secure units. She stated she had not cleaned the common areas of the secure unit yet. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. Observation on 08/06/2024 at 11:25 AM of the outside of the secure unit (hall 200) and hall 100 revealed there was a flattened cardboard box approximately 2 feet wide by 4 feet long with one corner touching the foundation wall underneath the window of the secured unit's living room windows with improperly stored unused electrical equipment. Observation revealed a trail of ants crawled along the length of the foundation of Hall 100 to the secured unit foundation and up and along the window frame of the secured unit living room windows which were cracked open up to a half of an inch wide and a trail of ants crawled into inside of the window frame into the secure unit common area. Observation of a crepe [NAME] tree approximately 6 feet from the secure unit and Hall 100 revealed numerous ants of different types crawled around the perimeter of the tree and crawled up the trunk of the tree. Observation on 08/06/24 at 11:36 AM revealed the first window in the common area of the secure unit had ants coming in through one window. Ants were noted on inside of the window of secure unit common area and on the bottom of window and top of window near latch. Six residents were sitting in the common area. There was a brownish stain below this window in the common area. Observation on 08/06/24 at 11:40 AM of the Maintenance Director revealed he picked up the unused electrical equipment and there were hundreds of ants that crawled all over on the flattened cardboard box. He picked up the flattened cardboard box turning it on the side and shook off the ants and walked away with the flattened cardboard box. Interview on 08/06/2024 at 11:41 AM with the Maintenance Director revealed he stated the ants were sugar ants, they did not bite and were nothing to worry about. He stated they were not able to prevent ants or them coming into the building. The Maintenance Director stated Pest Control Company N came to the facility regularly and had already come out to spray for the ants. Observation and interview with the Maintenance Director in the secure unit living room revealed there were ants entering through the cracks in the window frame and the Maintenance Director stated he did not need to look because he was going to spray them and would see them when he sprayed. Observation of the main dining room on 08/06/2024 at 1:55 PM revealed all the dining room tables had various amounts of food crumbs, smears, and drink residue on their surfaces and there were 2 flies in the dining room. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In confidential group interview on 08/06/2024 at 2:00 PM with 9 residents revealed their biggest concern regarded housekeeping which they had brought up in previous meetings with the Activity Director. Another resident stated that the gnats and flies were another concern and that the gnats really bothered her when they fly around her face or landed on her. Resident in the group stated that the flies bothered her a lot and that housekeeping had not wiped down the dining room tables after lunch, which was about 2 hours ago, and there was still food residue and crumbs and sticky drink residue on the tables. All of the residents stated there were numerous flies and gnats throughout the facility, in the common areas, and sometimes in their rooms but they had not observed ants. One resident stated that it seemed like the cleaning wasn't done on the weekend at all. Another resident agreed with the resident and stated that he observed a housekeeper clean his toilet with a rag and then wipe down his sink with the same rag. A resident stated the housekeeper did not understand English when he tried to tell her that it was unsanitary, and he complained to staff. Resident stated that he had someone help him make a sign in Spanish which told the housekeeper not to use the same rag used on the toilet in the sink and a staff member came and showed the housekeeper how to clean his bathroom properly but the door was closed and he did not see what they showed her-so he kept the sign up to be on the safe side. All residents in the confidential group meeting stated they felt that the lack of housekeeping quality and frequency bothered them greatly because it felt gross when things were dirty. Interview on 08/07/24 at 8:25 AM with Maintenance Director revealed he would attempt to contact the main number to get hold of Pest Control Service Tech P for surveyor. He stated Pest Control Company N was not scheduled to come out to the facility. Interview on 08/07/24 at 10:13 AM with Pest control Service Tech P revealed on 07/31/24 when he came to the facility Resident #28's room had stickiness and spilled soda on the floors. He did not see any ants in rooms but it was reported to him that ants had been seen in the room. He stated the risk to the residents for pests was the ants can bite if threatened. He stated the fire ants bite. He stated any type of ants can bite if threatened. He stated he was not made aware of ants being found in the facility yesterday (08/06/24). He stated he came out for his monthly visit on 08/03/24 and treated the kitchen drain for gnats. He stated the facility needed to treat the source of the gnats/flies to address the pests. He stated the gnats and flies have been an ongoing issue and he tried to knock it down. He stated the facility was not on a program for small flies. He stated the ongoing issues with lack of sanitation and cleanliness make it difficult to address the pests especially when going into resident rooms that had pest activity revealing food debris, food stickiness and drink spills. He stated he was aware of Resident #28's room having ants and gnat activity. He stated the ants were attracted to food and water sources. He was not aware of any ants in resident room currently and the facility had not notified him of ants coming inside. He treated on 07/31/24 and 08/03/24 but did not see any ants at this time. Interview on 08/07/24 at 4:35 PM with Pest Control Company O Service Tech revealed he did rounds with the Executive Director on 08/07/24. He stated in Resident #44's room he found about 6 fire ants near the window. He stated he treated Resident #44's window with sealant for the cracks inside and outside of resident rooms where he found trails of ants on the foundation. He stated he spot treated resident rooms and treated the outside of the facility for ants. He stated ants can bite. He stated he did not treat for gnats today. He stated he did not find ant activity in Resident #39's room. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the grievance summaries revealed an undated document titled June Grievances that stated rooms were not being cleaned on the weekends and were not being cleaned thoroughly under beds and behind furniture. Grievance Summary revealed an incident dated 07/23/2024 and reported date 08/06/2024 revealed resident council had a grievance of rooms not cleaned on the weekends with no other details under the sections for resolved date, resolved note, summary of investigation, summary of findings, or summary of action taken. Record review of the resident council meeting notes dated 06/28/2024 revealed an issue of weekend housekeeping slacking. 7. Review of Resident #14's face sheet undated reflected Resident #14 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Cerebral palsy, protein-calorie malnutrition, Heart failure, and Dysphagia. Review of Resident #14's quarterly MDS assessment dated [DATE] reflected Resident #14's cognition was severely impaired and had a feeding tube. Resident #14 was dependent for all ADLs. Review of Resident #14's Comprehensive Care Plan with problem start date of 03/09/24 and revised on 08/09/24 reflected Resident #14 requires feeding tube R/T (related to) recurrent aspiration pneumonia. Observation on 08/08/24 at 10:45 AM revealed Resident #14's g-tube pole had drops of feeding and stained on bottom of g-tube pole while Resident #14 was connected via g-tube. Interview on 08/08/24 at 10:48 AM with the ADON revealed Resident #39 and #14's g-tube poles and floor should be free of spills from the feeding. She stated both residents were total dependent. She stated she expected nursing to clean the g-tube poles and floor when feeding spilled on it. She stated the g-tube poles not being cleaned placed residents at risk of attracting pests. She stated housekeeping should be cleaning the floor daily to ensure g-tube feeding not on floor. 8. Review of Resident #47's quarterly MDS assessment dated [DATE] reflected Resident #47 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of heart failure, hypertension, Kidney Failure and Parkinson's Disease, Resident #47 had a BIMS score of 12 indicating she was moderately cognitively impaired. Resident #47 required partial/moderate assistance with most ADLs. Review of Resident #48's quarterly MDS assessment dated [DATE] reflected Resident #48 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of hypertension, diabetes and seizure disorder. Resident #48 had a BIMS score of 13 indicating she was cognitively intact. Resident #48 required supervision with ADLs. Interview with Resident #47 and Resident #48 on 08/06/24 at 2:20 PM revealed Resident #47 stated that she and Resident #48 were roommates, and their sink was clogged for at least a month, and they were not able to use the sink. Resident #4 [TRUNCATED]

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 49427 Based on record review and interview the facility failed to implement their written policies and procedures to prohibit and prevent abuse, neglect and exploitation for 7 of the 10 employees (Activity Director, LVN AA, CNA BB, LVN DD, CNA EE, CNA FF, CNA GG) reviewed for background screenings. The facility failed to screen, through the Employee Misconduct Registry (EMR)/Nurse Aide Registry (NAR), 7 employees, which included: the Activity Director, LVN AA, CNA BB, LVN DD, CNA EE, CNA FF, CNA GG. This failure could place residents at risk of care by staff who have been reported for misconduct such as abuse, neglect, or exploitation. Findings Included: Record review of facility's Abuse, Neglect, Exploitation, or Mistreatment prohibition policy titled Leadership Policies and Procedures Section III Organizational Ethics, dated 2019, reflected: Component I: Screening 1. Pre-employment background screening is mandated for all facility employees: A. Facility state-specific Background Investigation Policy is available through the facility's regional HR consultant. B. The facility may not employ any individual that has been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. C. The facility may not employ any individual that has a finding entered into the State nurse aide registry concerning abuse, neglect exploitation, mistreatment of residents or misappropriation of property. D. The facility may not employ any individual that has a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents and/ or misappropriation of resident' s property. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Record review of the Activity Director's employee file revealed a hire date of 02/28/2023 and no record of an annual EMR/NAR check. 2. Record review of LVN AA's employee file revealed a hire date of 03/02/2001 and no record of an annual EMR/NAR check. 3. Record review of CNA BB's employee file revealed a hire date of 11/11/2014 and no record of an annual EMR/NAR check. 4. Record review of LVN DD's employee file revealed a hire date of 12/28/2022 and no record of an annual EMR check. 5. Record review of CNA EE's employee file revealed a hire date of 03/15/2023 and no record of an annual EMR/NAR check. 6. Record review of CNA FF's employee file revealed a hire date of 05/11/2023 and no record of an annual EMR/NAR check. 7. Record review of CNA GG's employee file revealed a hire date of 06/22/2024 and no record of an annual EMR/NAR check. In an interview on 08/09/2024 at 2:20 PM with Human Resources, she stated she started working at facility in July 2024 and was still in training. She did not know what an EMR or NAR was and stated that she did not know the requirements on annual checks or who was responsible to conduct the checks. She stated she thought the Administrator ran the background checks and EMR/NAR when employees were hired and thought the corporation for the facility ran monthly checks on all employee licenses and arrests. She stated that screening was important because they needed to ensure those who had arrests or license bars were identified because it impacted resident care and safety. Interview on 08/12/2024 at 3:00 PM with Human Resources revealed she was unable to find the EMR/NAR checks prior to 08/12/2024 for the Activity Director, LVN AA, CNA BB, LVN DD, CNA EE, CNA FF, CNA GG The facility completed the EMR/NAR checks on 08/12/2024 and there were no bars to employment or license restrictions. Interview on 08/12/2024 at 3:47 PM with the Interim Administrator revealed she expected EMR/NAR checks were conducted before an employee is hired and then annually. She stated that the Human Resources at the facility was responsible to ensure the checks were completed annually. She stated that it was important to run the EMR/NAR checks annually to prevent residents from being abused and screen out employees that have abuse charges or other restrictions to their license or record. Record review of the facility's bars of employment policy titled Texas Bars of Employment related to Criminal Record, dated January 2015, reflected: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Important Information: Nurse Aide Registry and Employee Misconduct Registry . At the time of hire and annually thereafter, Facility must verify that all certified nurse aides are listed in the nurse aid registry. Furthermore, the Facility must at the time of hire and annually thereafter ensure that all staff are not designated in the nurse aide registry or employee misconduct registry as having a finding of abuse, neglect, mistreatment or misappropriation . Facility must conduct nurse aide and misconduct registry checks annually as described above.

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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** 34918 Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for two of 17 (Residents #41 and Resident #39) reviewed for comprehensive care plans. 1. The facility failed to include in the care plan with an onset date of 05/29/24, Resident #41's ADLs functional limitations, Bowel incontinence and foley catheter and interventions necessary for care. 2. The facility failed to include in the care plan last revised on 07/16/24 Resident #39's contractures to bilateral hands with interventions required to prevent further decline. These failures could affect residents by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings include: Record review of Resident #41's quarterly MDS assessment, dated 06/12/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. She had a BIMS score of 11, which indicated her cognition was moderately impaired. Resident #41 required substantial/maximum assist with toileting, had an indwelling catheter and was always incontinent of bowel, and shower/bathe dependent. Resident #41 had diagnoses which included neurogenic bladder (loss of bladder control due to brain, spinal cord, or nerve problems), diabetic mellites, dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), and depression. Record review of Resident #41's care plan, with an onset date of 05/29/24, reflected she did not have a care plan for activities of daily living, bowel incontinence, urinary indwelling foley catheter care. Observation/Interview of Resident #41 on 08/08/24 at 02:50 p.m. revealed the resident was lying in bed covered with blanket her face and hands were clean. Resident #41 stated only getting bed bath due to her inability to set on the shower chair. Resident #41 stated was okay with getting a bed bath and liked to have it three times a week. Resident #41 stated CNA K was the last one to give her a bed bath before she stopped working with her more than a week ago. Resident#41 stated they only cleaned her from here pointing to her face, neck, and hands. (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 08/09/24 at 09:58 a.m. with the MDS Coordinator, she was asked if Resident #41 had care plans interventions for her ADLs abilities, her bowel incontinence and her foley catheter. After looking, she stated no, none were care planned. The MDS Coordinator stated she was responsible for the care plans. She stated failing to have current and accurate care plans could potentially affect resident care. She stated staff would not know the interventions for the resident, and it could diminish the residents' care. She stated she was not sure how the above areas were missed, but stated she would correct them today. 2. Record review of Resident #39's undated face sheet reflected a [AGE] year-old female with and admitted [DATE] and a re-admitted [DATE]. Diagnoses included dehydration, dysphagia(difficulty swallowing), cerebral vascular accident (stroke), contractures, and unspecified severe protein-calorie malnutrition. Record review of Resident #39's quarterly MDS assessment, dated 04/26/24, reflected Resident #39 had BIMS score of 0 which indicated she was severely cognitively impaired. Record review of Resident #39's care plan with a revision date of 07/16/24 did not address resident's bilateral contractures or interventions required to maintain good skin integrity to her hands. Observation on 08/06/24 at 10:00 a.m. revealed Resident #39 lying in bed. Both hands were contracted with no hand rolls in place. Resident was non-verbal. Observation and interview on 08/07/24 at 11:20 a.m revealed CNA F entered Resident # 39 room to check for incontinence. Carrots (soft device used for contracted hands) were noted on the bedside table. CNA F attempted to open her hands slightly and resident resisted. CNA F stated they used to put carrots in her hands, but stated it caused her so much pain they were not doing that anymore. Residents' nails were long, and her right thumb nail was about a 3/4 of inch in length. In an interview with LVN A on 08/07/24 at 11:30 a.m. she stated she stated they had tried carrots for her hands but stated it hurt her too much to try and open her hands enough to get them in her hands. In an interview with the MDS coordinator on 08/08/24 at 11:00 a.m. she stated all Contractures were to be care planned. She stated they had tried splints and carrots in the past with Resident #39, but stated it hurt her too much. She stated they should have care planned about her nails and skin monitoring on her contracted hands and coordinated with hospice on who was going to carry out those interventions. In an interview with the DON on 08/08/24 at 02:45 p.m. she stated contractures were to be care planned. She stated she knew the care plans were not comprehensive. She stated she had gotten with therapy 2 weeks ago and had gotten a list of the residents with contractures and who had splints or other interventions. She stated they had just not gotten the care plans updated yet. She stated she was still learning a lot the residents. She stated the MDS nurse was responsible for updating the care plan. She stated going forward care plans will be updated as changes occur. She stated herself, the ADON and MDS nurse would all update the care plans when new problems or updated interventions occurred. She stated the care plan should be patient centered and reflect the current care needs of the resident to ensure accurate care and resident wishes. (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 the facility policy, Care Plan Process, Person-centered Care, dated May 2023, reflected, . The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care .The services provided or arranged by the facility, as outlined by the comprehensive person-centered care plan, will meet professional standards of quality .Thru ongoing assessment, the facility will initiate person-centered care plans when the resident's clinical status or change of condition dictates the need .The person-centered care plan includes .Problem .Interventions, discipline specific services, and frequency .Refusal of services and/or treatments .evaluation of resident's decision-making capacity .Educational attempts .Attempts to find alternative means to address the identified risk/need .Resolution/Goal Analysis . 47690

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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** 34918 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for three of sixteen residents (Residents #41, Resident #44, and Resident #47) reviewed for ADL care. The facility failed to ensure staff provided consistent showers/baths and grooming for Resident #41, Resident #44, and Resident #47. This failure could place residents at risk of not receiving needed hygiene care which could cause skin breakdown, a loss of dignity and self-worth. Findings include: 1. Record review of Resident #41's quarterly MDS assessment, dated 06/12/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. She had a BIMSscore of 11, which indicated her cognition was moderately impaired. Resident #41 required substantial/maximum assist with toileting and shower/bathe dependent. Resident #41 had diagnoses which included neurogenic bladder (loss of bladder control due to brain, spinal cord, or nerve problems), diabetic mellites, dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), and depression. Record review of Resident #41's care plan, with an onset date of 05/29/24, reflected no ADLs were care planned for the Resident#41. Record review of Resident #41's ADLs flow sheet record history report for July 2024 through 08/08/2024 reflected Resident#41 received partial bed bath on 7/06/2024, partial bed bath on 07/13/2024; bed bath on 07/16/2024; and other bed bath on 07/29/2024, none recorded for the first week of August. Record review of Resident #41's ADLS and shower sheets in the electronic medial record and paper medical records revealed no documentation of Resident#41 refusals of bed bath. Record review of Hall 3 Monthly shower schedule for July 2024, and August 2024, reflected Resident #41 was scheduled for a shower on Tuesday's, Thursday's, and Saturdays on the 2 p.m. to 10 p.m. shift. Record review of staff schedule from July 29, 2024, to August 8, 2024, revealed CNA K last worked in Hall 3 was July 29, 2024. Record review of Resident#41 shower sheets for the Months of June 2024, July 2024, and first week of August 2024, revealed only two sheets had been completed for Resident#41's on 06/25/24, and 07/16/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an Observation and Interview with Resident #41 on 08/08/24 at 02:50 p.m. revealed the resident was lying in bed covered with a blanket. Residents face and hands were clean. Resident#41 stated she only gets a bed bath due to her inability to sit on the shower chair. Resident#41 stated she was okay with getting a bed bath and liked to have it three times a week. Resident#41 stated CNA K was the last one to give her a bed Bath before she stopped working with her more than a week ago. Resident#41 pointed to her face, neck and hands and stated that was all the staff cleaned. In an interview with CNA H on 08/09/2024 at 11:02 a.m. over the phone he stated the last time he gave Resident#41 a bed bath was Tuesday 07/30/2024, and on Thursday 08/01/2024 resident refused, he stated he notified the charge nurse. He stated when a resident refused a bath the Charge Nurse had to go and speak to the resident, and if the resident still refused, the refusal was documented in resident's record. In an interview with LVN M on 08/09/24 at 11:32 a.m., she stated the Nurse in charge were responsible for ensuring the resident's showers and ADLs care were performed. She stated the CNAs were supposed to let them know if a resident refused ADLs care or if they were unable to give the scheduled shower or bath. She stated she had not been notified by any of the CNAs that Resident #41 had refused a bed bath. In an interview with the ADON on 08/09/24 at 1:25 p.m., the ADON stated Resident #41 was supposed to get showers according to her scheduled shower days and documented in the record. She stated it was the responsibility of the CNAs and the Charge Nurse to make sure residents got their showers, and if the resident refused to take a shower it should be documented in the system or the ADL's binder, which included the attempt by the staff member to find out why the resident refused a shower, and what was done about it. The ADON stated the risk to Resident #41 not getting her shower for many days was that she may become stinky, sweaty, and just not feeling good. The ADON confirmed CNA K's last day worked was 08/02/24 on 2p. m. to 10 p.m. shift. A call was call on 08/08/2024 at 4:17 p.m. to CNA K with no answer. Voice message left with call back number. No call back received. 2. Record review of Resident #44's undated face sheet reflected he was a [AGE] year-old male with the latest return to the facility on [DATE]. Diagnoses included disruption of traumatic injury wound repair, initial encounter, pressure ulcer of sacral region, sepsis, methicillin resistant staphylococcus aureus infection as the cause of diseases (severe bacterial infection) and diabetes. Record review of Resident #44's quarterly MDS assessment dated [DATE], indicated an initial admitted [DATE]. Resident #44 was able to make himself understood and understood others. He had a BIMS score of 14, which indicated he was cognitively intact. Resident #44 required substantial to total assistance with toileting, personal hygiene, transfers, and bed mobility and had a foley catheter and colostomy bag. Resident #44 was receiving treatment for 3 stage 4 pressure ulcers (full thickness tissue loss with exposed bone, tendon, or muscle) to the sacral region. Record review of Resident #44's care plan with an initiated date of 07/12/24 reflected, [Resident #44] has a stage 4 pressure ulcer on his sacrum related to impaired mobility, diabetes, and acute kidney injury . Interventions .CNAs to inspect skin, especially over bony prominences, during bathing and personal care report findings to licensed nurse .ADL interventions included .give shower, shave, oral, hair, nail care per schedule and prn . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Hall 100's shower schedule reflected Resident #44 was to receive a shower on Tuesday, Thursday, Saturday shower on the 2-10 p.m. shift. Record review of Resident #44's ADL report from 07/25/24 (most recent readmission) through 08/08/24 revealed no bathing provided from 07/25/24 through 07/31/24. Partial bath was noted on 08/01/24, 08/02/24 and 08/03/24. No notations of any form of bath was noted from 08/04/24 through 08/08/24. Personal hygiene was noted as provided from 07/25/24 through 08/08/24. During an observation on 08/06/24 at 09:03 a.m. Resident #44 was observed in bed. Foley catheter in use. Resident stated he was not doing well due to to the wound on his butt. Resident was un-shaven and had approximately 1/2 inch facial hair over his face. He stated he had not been able to shave, and no one had offered to shave him. He stated he had not gotten in the shower. Residents' nails were noted to be dirty, and the resident had a slight body odor. In a second observation on 08/06/24 at 01:50 p.m. CNA F and CNA Scheduler entered Resident #44's room. Resident stated he felt wet. CNA Scheduler told him he should not be wet since he had a catheter and colostomy. Resident #44 stated he can't' help that, he was wet. CNA F removed the brief and took a peri-wipe and wiped down his groin under his scrotum revealing a brown substance with dark flakes on the wipe. CNA F stated that was dirt and dried skin. She stated Resident #44 was a 2-10 p.m. shower. In an interview with the ADON on 08/08/24 at 11:15 a.m. she stated the CNA staff were supposed to log in their ADL care on the Kiosk. She stated MDS assessments and the ADL documentation that populated to the MDS was the only thing computerized and stated everything else was paper records. She stated the CNAs were also supposed to turn in a shower sheet on every scheduled shower day for the resident. She stated she had checked and could not locate any shower sheets for Resident #44 from July to August. She stated CNAs were expected to shave and provide nail care on the shower days. She stated diabetic residents' nails had to be trimmed by the nurse, but the CNAs could clean and file the nails. In an interview with Agency LVN C on 08/08/24 at 03:15 p.m. he stated they had a shower schedule which let them know who was scheduled for showers. Agency LVN C looked in the 24-hour book but could not locate the shower sheet. He stated there used to be one in the book. He stated he assumed the CNAs turned in a shower sheet but could not be certain. He stated nail care was done by activity director and the CNAs. He stated he did not know why Resident #44 had not had a shower and stated he was not aware he was on the 2-10 p.m. shift for showers. He stated he only had 3 skin assessment he was responsible for on his shift. 3. Record review of Resident # 47's undated face sheet reflected a [AGE] year-old female with and admitted [DATE]Diagnosis include rash and other nonspecific skin eruptions, diabetes, bipolar disorder (mental health illness that causes wild mood swings) and mild intellectual disabilities. Record review of Resident #47's quarterly MDS assessment dated [DATE] reflected a BIMS score of 12 which indicated she was moderately cognitively impaired, and she had not refused care. Resident #47 required substantial assistance with bathing and partial to moderate assistance with personal hygiene and dressing. The resident was frequently incontinent of urine and bowel. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #47's care plan with a start date of 05/03/24, reflected, ADLs .Goal .[Resident #47] will maintain sense of dignity by being clean, dry, odor free and well-groomed Interventions .Assist with ADLs as needed . Record review of Hall 100's shower schedule reflected Resident #47 was a Monday, Wednesday, Friday shower on the 6 a.m.-2 p.m. shift. Record review of Resident #47's ADL report for July 2024 through August 8th, 2024, reflected no shower on scheduled days for 07/10/24, 07/12/24, 07/19/24, and 08/17/24. A shower was document for 08/05/24. There were documentation for any the days indicated for personal hygiene. An observation on 08/06/24 at 09:00 a.m. revealed Resident #47 up in her wheelchair in her room. Resident had chin hair that was over 1/2 inch long. She stated she gets herself up in the wheelchair but needed assistance with bathing. A second observation of Resident #47 on 08/06/24 at 10:00 a.m. revealed all facial hair had been removed. Resident #47 stated someone came in right behind the surveyor and shaved her. She stated she was supposed to get a shower Monday-Wednesday and Friday and stated she did not get one yesterday (Monday 08/05/24), so she would need one today. Residents' nails were observed to have old, chipped nail polish and dirt under her nails. Resident #47 stated that was why she needed her shower today because her nails were dirty, and she wanted to stay clean. In an interview and observation on 08/07/24 at 11:00 a.m. with Resident # 47 stated she did not get a shower a shower on Monday and did not get one yesterday. She stated she wants her showers 3 times a week. She stated she wanted to stay clean and did not want to smell. Resident's nails were still dirty but were not long. She stated she cut her own nails, but then stated she bites them off. She stated no one had offered to cut her nails. In an interview with CNA F on 08/08/24 at 10:20 a.m. she stated she did not give Resident #47 her shower yesterday (08/06/24) because when she had time to do it, the resident was up in the dining room or out smoking. She stated she did bath her Monday (08/05/24). She stated she did not let anyone know about the missed shower. She stated the resident was diabetic, so she did not touch her nails. She stated the nurses were supposed to take care of the diabetic's nails. She stated since she documented in the Kiosk, she did not know she had turn in a shower sheet. In an interview with LVN A on 08/08/24 at 10:25 a.m. she stated they had a shower book on the hall, but honestly could not tell me who was scheduled for showers. She stated it used to be A beds on one cycle and B on the other, but since they had shuffled residents' rooms so much in the past, she could not tell me who was scheduled for showers. She stated the Aides were supposed to turn in a paper shower sheet to them. She stated she does not recall getting any shower sheets lately. She stated once the nurse's got the shower sheets and reviewed them they were supposed to turn them in to management. She stated CNA F had not told her anyone had refused a shower. She stated she does not know if the residents got their showers or not. She stated the aides have access to orange sticks and nail files to clean the residents' nails. She stated they can clean diabetic resident nails; they just can't cut them. In an interview with the ADON on 08/08/24 at 11:15 a.m. she stated she could not locate any shower sheets for Resident #47 from July to August. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation 08/08/24 at 11:30 a.m. with the ADON she stated Resident #47's nails were dirty and needed cleaning. She stated Resident #44's nails were dirty and needed cleaning. She stated the charge nurse was responsible for ensuring everyone was assigned a shower day. She stated the CNAs were to clean the nails on shower days or any time they were dirty. She stated failing to clean their nails or keep them trimmed could lead to infections and skin issues. In an interview with the DON on 08/08/24 at 02:38 p.m. she stated the lack of showers and personal hygiene posed a risk of infection, skin issues and dignity. She stated she had told the ADON a few weeks ago to check the shower schedule and ensure staff were turning in their shower sheets because she knew showers were always looked at on survey. She stated she had assumed the ADON had done that. She stated she had not seen any of the shower sheets. She stated going forward she was implementing a new system where the CNAs will have to turn in the assigned shower sheet each day. she stated if a resident refused then the nurse and the CNA had to go to the resident and confirm with the resident, they did not want a shower and have the resident initial the shower sheet. She stated the CNAs would be handed their assigned shower sheet each day and she expected it to be turned in at the end of the shift. She stated since they were paper records this was the way she could effectively monitor to ensure care was provided. Record Review of the facility's policy, Actives of Daily living, Optimal Function, dated May 2023, reflected, . The Facility provides necessary care to all residents that are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming and hygiene .Facility staff revises the approaches and interventions as appropriate . 47690

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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** 49427 Based on observation, interview, and record review the facility failed to ensure all residents were provided, based on the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility sponsored activities and individual activities, designed to meet the interests and support the physical, mental, and psychosocial well-being of each resident for 3 of 4 residents (Residents #10, #12, and #43) reviewed for activities. The facility failed to provide regular, individualized activities for Resident #10, Resident #12, and Resident #43. This failure placed residents at risk of decreased physical, mental, and psychosocial well-being. Findings included: Record review of Resident #10's face sheet, undated, revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had the diagnoses of dementia (loss of cognition), heart failure, major depressive disorder (persistent feels of sadness and loss of interest) and hypertension (high blood pressure). Review of Resident #10's Comprehensive MDS dated [DATE] revealed she had a BIMS score of 5 (severely impaired cognition). Review of Section F Preferences for Customary Routine and Activities revealed it was very important to Resident #10 to have books to read, listen to music she liked, be around animals, keep up with the news, do things with groups of people, do her favorite activities, and go outside to get fresh air when the weather was good and to participate in religious services. Review of Resident #10's care plan, dated of 08/06/2024, revealed she resided in the secure unit because she wandered, was overstimulated, and had safety awareness concerns. Further review revealed the problem area of activities, start dated 05/03/2023 and edited 06/13/2024- she enjoyed bingo, parties, food type activities, reading political based books, veterans programming, current events, facility pets, pretty nails, tv, movies, being outdoors, trivia, baking club and outings; with a long-term goal to participate in both group and activities of choice and facility outings 3 or more times a week over the next 90 days. Care plan intervention dated 05/03/2023 included the Activity Director continued to assess for personal activity preferences. Review of Resident #10's activities assessment titled Activities Evaluation dated 12/30/2021 revealed she enjoyed independent activities as well as animals or pets, arts and crafts, bingo, board games, cultural events, current events/news, exercise, group discussion, movies, music, radio, and reading. Review of Resident #10's activity progress notes revealed most recent note was dated 01/24/2024 by the Activity Director and stated the resident enjoyed bingo, food type activities, crafts, social parties, reading in her room and met current activity goals. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 08/07/2024 at 3:09 PM revealed Resident #10 was lying in bed in her room with the lights on low. She stated her past interests were active physical activities like swimming and hiking and did not think those kinds of activities were available to her. Resident #10 stated she did feel bored at times and sometimes depressed. She stated that sometimes she colored, sometimes watched television or played bingo, and read, or slept in her room. Resident #10 stated she had a lot of books and had read them all. Resident #10 stated she did not know who the Activity Director was or if she had spoken with her about activity interests. Review of Resident #12's face sheet, undated, revealed she was a [AGE] year-old female who was admitted to the facility on [DATE] and was initially admitted on [DATE]. Further review revealed she had diagnoses of major depressive disorder (persistent feeling of sadness or loss of interest), intermittent explosive disorder (behavioral disorder characterized by explosive outbursts of anger), anxiety disorder (persistent feeling of fear or worry), Alzheimer's disease (loss of cognition). Review of Resident #12's Comprehensive MDS dated [DATE] revealed she had a BIMS score of 9 (moderate cognitive impairment). Review of Section F Preferences for Customary Routine and Activities revealed the activities that were very important to Resident #12 were to be around animals such as pets, group activities, and go outside to get fresh air when the weather was good. Review of Resident #12's care plan revealed resident had a focus area of activities, start dated 11/04/2024, with the long-term goal of .enjoy activities of interest such as group exercise, social parties, and lifelong skill stations three times weekly as evidenced by decreased behaviors and positive demeanor, edited 06/28/2024. Review of Resident #12's activity progress notes revealed the most recent note was dated 01/19/2024 by the Activity Director and stated the resident enjoyed .socializing, smoke breaks, and listening to country music and she was meeting her current activity goals. Observation on 08/06/2024 at 9:09 AM of secure unit revealed Resident #12 was seated in her wheelchair inside the office with LVN AA a while she whimpered and stated she was upset, LVN AA reassured the resident. Observation on 08/07/2024 at 3:19 PM of Resident #12 revealed she was seated in the hallway in her wheelchair and she cried and stated that all the other residents were in the damn way and said please, I want to go outside and have a cigarette. Resident #43 and two other residents attempted to calm Resident #12 and CNA LL told Resident #12 that it was too hot to go outside. (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 08/07/2024 at 3:20 PM with CNA LL revealed that she started working at the facility in December of 2023 and typically worked on the secure unit on the 2 PM to 10 PM shift and was familiar with the residents. CNA LL stated that it was too hot to take the residents outside and if it was 99 degrees Fahrenheit allowed them to smoke one cigarette but if it was 100 degrees they were not allowed to take the residents outside. CNA LL stated when residents asked to go outside during the hot weather, they redirected the resident. CNA LL stated that she had not seen the Activity Director this afternoon and did not know if she was coming to the secure unit or not. CNA LL stated the Activity Director visited the secure unit 2-3 times a week to set up an activity like volleyball with a beach ball and the CNA's were supposed to do complete the activities with the residents. CNA LL stated for activities they watched television in the common room, had puzzles, word searches, snacks, listened to the radio and colored. CNA LL stated Resident #10 sometimes watched television and sometimes came out of her room. CNA LL stated that smoking was the most important activity for Resident #12 and #43. Record review of Resident #43's face sheet, undated, revealed resident was an [AGE] year-old female admitted to the facility initially on 09/27/2023 and readmitted on [DATE] with diagnoses of depression (persistent feelings of sadness or loss of interest), cognitive communication deficit, bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs), hypothyroidism (underactive thyroid activity), anxiety disorder (persistent feelings of fear or worry), hypertension (high blood pressure), Review of Resident #43's Comprehensive MDS dated [DATE] revealed she had a BIMS score of 7 (severe cognitive impairment). Review of Section F Preferences for Customary Routine and Activities revealed it was very important to Resident #43 to do things with groups of people, get outside and get fresh air when the weather was good, and listened to music she likes. Review of Resident #43's care plan revealed a focus area of activities with interventions of offer programs using retained long term memory rather than short term memory .offer activities that recreate past experiences, place in small group activities rather than large gatherings, dated 01/03/2024. Review of Resident #43's initial activities evaluation dated 01/18/2024 and signed by the Activity Director revealed resident enjoyed animals/pets, cooking/baking, music, and religious services in the secure unit at frequency of 2 times a week. Review of Resident #43's activity progress notes revealed the last note was dated 01/18/2024 and signed by the Activity Director, and stated the resident enjoyed therapy pets, cooking/baking activities, music, bible study and currently met her activity goals. Observation and interview on 08/06/2024 at 9:34 AM revealed Resident #43 was seated in her wheelchair in the hallway wearing nasal cannula oxygen, she was confused and wanted to go outside. CNA BB checked Resident #43's oxygen, reassured resident, and stated she would take Resident #43 and Resident #12 outside for a smoke break and some fresh air and told Resident #43 she would be right back. Resident #43 stated okay, and she was going to wait right there for her. Record review of the August 2024 Activity Schedule indicated: -08/06/2024: 9 AM Daily Chronicle; 9:30 AM Hydration Pass; 10 AM [NAME] Ball Day (I Love [NAME]); 2 PM Bingo; One to One Visits (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-08/07/2024: 9 AM Daily Chronicle; 9:30 AM Hydration Pass; 10 AM Group Exercise; 10:30 AM Bible Study; 2 PM Pretty Nails -08/08/2024: 9 AM Daily Chronicle; 9:30 AM Hydration Pass; 10 AM Bowling Day; 2 PM Bingo; One to One Visits -08/09/2024: 9 AM Daily Chronicle; 9:30 AM Hydration Pass; 10 AM Group Exercise; 2 PM Smore's Day Observation on 08/06/2024 at 10:00 AM of the secure unit revealed there were no meaningful activities, there were about 5-6 residents in the living room area and the television was on, CNA CC was seated in the living room with the residents. Observation on 08/06/2024 at 12:20 PM revealed about 6 residents in the dining room eating lunch. Observation on 08/06/2024 at 4:35 PM of the secure unit revealed there were no meaningful activities, the radio was on in the dining room and the television was on in the living room with about 3 residents in the room. Observation on 08/07/2024 at 9:15 AM of the secure unit revealed Residents #12 and #43 were in a group activity in the dining room. Observation on 08/07/2024 at 11:15 AM of the secure unit revealed there were about 5-6 residents in the living room with the television on, no meaningful activities were provided. Observation on 08/07/2024 at 3:00 PM of secure unit revealed Resident #12 was seated in her wheelchair in the hallway and appeared upset, there were about 3 residents in the living room with the television on and word searches on the table and music played from the dining room radio. Observation on 08/08/2024 at 8:50 AM revealed 3 residents were in the living room with the television on, no meaningful activities were provided. Observation on 08/08/2024 at 3:10 PM revealed 3-4 residents were in the living room with the television on, no meaningful activities were provided, and Resident #43 was in her room in bed. Observation on 08/09/2024 at 10:50 AM of the secure unit revealed four residents were seated in their wheelchairs in the living room with the television on. Resident #12 and Resident #43 were in the nurse's office with LVN AA. Observation on 08/09/2024 at 11:08 AM revealed CNA CC standing outside the secured unit's dining room doorway and CNA BB standing in the doorway of the living room. Several residents were seated in their wheelchairs in the living room with the television on. Resident #12 was seated in her wheelchair in the hallway and appeared upset, she whimpered and said everyone was mean. Resident #43 was seated in her wheelchair in the hallway and appeared upset, placed her blanket over her head, and stated she needed to go outside. CNA BB stated she was taking the resident outside and she was able to have a cigarette if she wanted and was going to go get the supplies for her. (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 08/09/2024 at 11:52 AM with LVN AA revealed typically the CNA's and aides did activities with the residents on the secure unit and the activity director sometimes set up activities and it was the responsibility for the staff to continue the activity. She stated there was a closet with activity supplies such as matching games, paintless water coloring, magnet fishing game. She stated there was not enough staff to provide activities due to the high level of supervision the residents required during activities. She stated for safety reasons they had to provide close supervision for residents because many of the residents attempted to eat things like playdough or tried to drink the water they water painted with. LVN AA stated that activities were very important for residents on the secure unit because it distracted residents, reduced difficult behaviors and provided mental stimulation. LVN AA revealed Resident #12 had challenging behaviors, she whimpered and cried frequently over any perceived slights and was demanding of staff's time. LVN AA stated that earlier, Resident #12 cried because staff were assisting a different resident and Resident #12 had entered the resident room during patient care and demanded they assisted her. LVN AA stated that they attempted to redirect her and to keep her close to staff. LVN AA stated the only activity Resident #12 participated in was smoking and they took her to smoke when she asked. LVN AA stated Resident #43 would have panic episodes where she said she needed to go outside and required supervision when outside. LVN AA stated that the most important activity for Resident #43 was smoking. She stated Resident #10 had resided at the facility for a while and she typically stayed in her room. LVN AA stated Resident #10 sometimes ate with other residents in the dining room and sometimes lingered in the common space then went back to her room. LVN AA stated she did not know any activities that Resident #10 participated in other than the morning current events. Interview on 08/09/2024 at 12:30 PM with CNA BB revealed she had worked at the facility for over [AGE] years. She stated that normally they had an activity after breakfast for the residents on the secure unit. She stated that sometimes the Activity Director set up the activity and handed it off to the CNA's and sometimes the CNA's selected an activity from the supply closet in the secured unit dining room, there was not a set schedule. CNA BB stated that Resident #10 was a veteran, commonly stayed to herself, and read books. CNA BB stated that Resident #12 required a lot of attention and redirection. She stated that Resident #12 used to color, listened to music, and read. CNA BB stated that Resident #43 was hospitalized for COVID recently and when she returned to the facility she was more emotionally fragile. CNA BB stated that Resident #43 will frequently say she was not able to breathe and asked to go outside and was unable to be redirected. CNA BB stated that she thought a hand massage helped to calm Resident #43 and she did not have the time or access to those supplies that were used during their pretty nails activity. CNA BB stated that activities were very helpful and soothing to residents on the secure unit. Interview on 08/09/2024 at 12:45 PM with CNA CC revealed she and CNA BB did activities with the residents throughout the day such as coloring, passing a ball around, and a magnetic fish game for the male residents. CNA CC stated that activities helped reduce difficult behaviors and distracted residents. CNA CC stated that she had not seen the Activity Director in the secure unit today and did not know if she was going to visit the unit today, she did not always come according to the schedule. CNA CC stated that Resident #10 stayed in her room a lot and came out for dinner or lunch and sometimes was taken off the unit for activities. CNA CC stated that Resident #12 required a lot of one-on-one time and followed staff. She stated Resident #43 fairly frequently panicked, cried, or was frustrated with other residents and it helped her to go outside. CNA CC stated that they had the Olympics on the television, movies as entertainment, coloring, and word searches the last few days. (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 08/09/2024 at 4:00 PM with the Activities Director revealed she worked at the facility in 2020 in the housekeeping department and started as the Activity Director in February of 2023. She stated she usually went to the secure unit to set up an activity 3 days a week and the CNA's finished the activity with the residents. She stated she was unable to go to the secure unit daily because she had other activities off the secure unit. She stated she ensured the activity closet stayed stocked with supplies for the CNA's to use with residents on the secure unit and it was up to the CNA's to choose activities for the residents on the secure unit. She stated that the Daily Chronicle was a newsletter distributed to each resident, Hydration Pass was when she brought juice or tea or something special for the residents to drink. She stated that she sometimes took up to 3 residents off of the secure unit for activities with the main unit for activities like group exercise and did not take out residents from the secure unit for every group exercise on the main unit because she needed to be present during the entire activity. She stated that she typically was not able to take Resident #10 off of the unit because she was exit seeking and required extensive supervision. She stated Resident #12's and Resident #43's most important activity was smoking and they enjoyed having their nails done. She stated Resident #12 also required one on one time and frequent redirection during activities. She stated Resident #43 was a resident she brought to the main unit occasionally for movement activities and was very social. She stated that Activity Assessments and the case notes and progress notes were updated quarterly during a resident's MDS review, and they were kept in the resident's chart under the activity tab. She stated that she had missed some resident assessments and was still catching up and was not aware of which residents she had not gotten to yet. The Activity Director stated that she did not have previous experience as an Activity Director was not able to describe activities for residents with dementia. She stated the Administrator assisted her with generating ideas but not with implementing the ideas. She stated that no one had gone over how to do the assessments, but she knew that they determined a resident's interests and what level of assistance they needed. Interview on 08/09/2024 at 5:11 PM with the ADON revealed she was not sure how often the Activity Director was in the secure unit for activities and knew that she set up the activities and the CNA's would supervise and finish the activity with the residents. The ADON stated the Activity Director ensured the activity closet had activities that the CNA's used for activities with the residents when they had the time. The ADON stated that she did not think that the activities provided on the secure unit were sufficient to engage the dementia residents. She stated that activities were important for the secure unit because they helped to stimulate the resident's mind and sometimes got the resident out of their dementia, and were imperative for the resident's quality of life and reduced difficult behaviors. Interview on 08/12/2024 at 3:30 PM with the Activity Director revealed she was still in school for her Activities Certificate and when there was entertainment on the main unit, such as when she dressed up as the Easter bunny, she also dressed up and took the costume to the secure unit. She stated there was not any live entertainment on the secure unit other than when she dressed up and performed on the secure unit. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/12/2024 at 3:47 PM with the Interim Administrator revealed she expected activities were provided that were of interest to a resident and that the Activities Director surveyed the residents on their likes and dislikes and brought in activities appropriately. She stated that the Activity Director was responsible for assessing the resident's activity interests for their MDS quarterly and annual review. She stated a calendar was distributed monthly to the Activity Director with the names of residents who were up for their review and the Activity Director would be required to provide the results of her assessments to the Interdisciplinary Team during the MDS assessments and would expect to see a progress note and activity assessment in the resident's chart. She stated that it was important activities were personalized and residents were assessed on a schedule because it was important to keep residents engaged, especially those with dementia, were kept alert and orientated so that cognitive declines was slowed as much as possible. Record review of the facility's activities policy titled Activity Policies and Procedures, dated revised 09/01/2022, reflected: Based on a comprehensive assessment, individualized care plan and the preferences of each resident, the Activity/Recreation Director and staff will provide an ongoing Activity/Recreation program to support resident personal choice of activities, facility-sponsored group and individual activities, and independent activities designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident, encouraging both independence and community interaction . 4. Activity/Recreation programs are designed based on patient and resident leisure interests, hobbies, cultural preferences and implemented to address the needs (physical, cognitive, creative, social, spiritual, independent, empowerment, and sensory stimulation). The programs will be geared to maintain functional ADLs, provide social interaction while protecting from over stimulation. Individuals with dementia will have programs designed that are personal and customized based on previous lifestyle (occupation, family, and hobbies), preferences and comforts . 6. Programming includes large groups, small groups, one to one visit and independent opportunities. 7. Programs take place mornings and afternoons, 7 days/week, and include holidays and evenings. 8. Programs take place in various areas, including but not limited to activity rooms, lounge areas, dining rooms, in house TV channels, virtually through live video feeds/conferencing on facility owned devices, phone conferencing, hallways, resident rooms, outdoor courtyards, patios, etc. 9. The patient and resident population is cognitively assessed on a regular basis to determine the number of functional level programs needed. Developing cognitive levels of function will help individuals participate at an appropriate level and have a more fulfilling experience. The Activity/Recreation Director will use a functional assessment tool to assess this need that has been completed by the Nursing or Social Services staff. 10. Documentation at least quarterly is conducted to note patient/resident progress, response and outcome.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview and record review, the facility failed to ensure proper treatment and assistive devices to maintain hearing abilities for one of one resident (Resident #13) reviewed for hearing devices. The facility failed to have Resident #13 assessed for his hearing loss and failed to provide any amplification device to assist with his hearing impairment. This failure could place residents at risk for limited social interactions. The findings included: Record review of Resident # 13's undated Face sheet reflected an [AGE] year-old male admitted to the facility on [DATE] with a readmitted [DATE]. Diagnoses included visual loss, chronic obstructive pulmonary disease (disease that blocks air flow and makes it difficult to breath), adult failure to thrive, and conductive hearing loss (when sounds cannot get through the outer and middle ear). Record Review of Resident #13's quarterly MDS assessment, dated 06/28/24, reflected he was moderately cognitively impaired with a BIM score of 9. He required substantial assistance with transfers, toileting, and personal hygiene. Hearing was coded as minimal difficulty in some environments. Review of Resident #13's care plan revised on 07/02/24 did not address his hearing loss. An observation on 08/12/24 at 08:30 a.m. revealed NA J pushing Resident #13 to his room to transfer him from his wheelchair to the bed. Observation revealed NA J explaining to Resident # 13 what she was going to do for the transfer and what the resident needed to do during the transfer. She asked the resident to grab around her neck, but due to his hearing loss he never understood her. NA J then placed her feet outside of the resident legs and lifted him by his arm pits and his pants and the resident hollered ouch while she transferred him to the bed. CNA F entered the room and they both lifted the resident up in the bed and repositioned him. Resident #13 smiled at them both and said, thank you. In an attempted interview and observation with Resident #13 on 08/12/24 at 08:35 a.m. resident could not understand the question when asked if he had experienced pain during the transfer. The resident cupped his hand behind his left ear to hear the question but was unable to hear the question. He just smiled and stated, Thank you. In an interview with the SW on 08/12/24 at 08:55 a.m. she stated she had been trying to get someone to see Resident # 13 for hearing aids, but stated she had not been able to find anyone who took Medicaid. She stated it was over 6 months ago that she had tried to find someone. She stated she had not kept a list of who she had contacted, she made phone calls to the local hearing aid business. She stated she had not spoken to anyone about requesting an amplifier for the resident or checking on a referral to an ear nose and throat physician. She stated she would reach out again today. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the ADON on 08/12/24 at 12:15 p.m. she stated Resident # 13 had always been hard of hearing. She stated he had never been evaluated for hearing aids as far as she knew. In an interview with the Interim Administrator on 08/12/24 at 01:00 p.m. she stated anyone with hearing loss needed to be evaluated within a reasonable amount of time. She stated she would expect a reasonable amount of time is 30 to 45 days to at least get someone a referral into the ENT to ensure what the residents needs were. She stated if a vendor could not be found that accepted Medicaid then they needed to reach out for other resources. She stated at the very least an amplifier should had been requested. She stated they would also reach out to the physician and get an order for Debrox (ear wax removal) drops to see if Resident #13 he some wax had built up and get a referral for a ENT visit as well as request an amplifier for the resident. She stated loss of hearing increased confusion and isolation in residents. Record review of the facility's policy titled, Medical, Vision, Hearing, and dental care Providers -Resident Right For, dated June 2023, reflected, The facility respects and upholds the patient and resident's right to choose providers for medical, vision, hearing and dental care, treatment and services .Facility staff assist with or schedule appointments and transportation arrangements for medical, vision, hearing, or dental care . Facility staff assists with interaction and communication with providers , being mindful of potential speech, language, hearing, vision or comprehension impairments .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review the facility failed to ensure residents receive adequate supervision and assistance devices to prevent accidents for one of two residents (Resident #13) reviewed for assisted transfers The Facility failed to ensure NA J used a gait belt when transferring Resident #30 from his wheelchair to the bed. These failures could affect the residents by placing the residents at risk for discomfort, pain, falls, injuries, and skin tears. Findings included: Record review of Resident # 13's undated Face sheet reflected an [AGE] year-old male admitted to the facility on [DATE] with a readmitted [DATE]. Diagnoses included visual loss, chronic obstructive pulmonary disease (disease that blocks air flow and makes it difficult to breath), adult failure to thrive, and conductive hearing loss (when sounds cannot get through the outer and middle ear). Record Review of Resident #13's quarterly MDS assessment, dated 06/28/24, reflected he was moderately cognitively impaired with a BIM score of 9. He required substantial assistance with transfers, toileting, and personal hygiene. He was always incontinent of bowel and urine. Review of Resident #13's care plan revised on 07/02/24 reflected, ADLs functional status/rehabilitation potential .transfers extensive one person assistance .Interventions .Assist with transfer as needed . An observation on 08/12/24 at 08:30 a.m. revealed NA J pushing Resident #13 to his room to transfer him from his wheelchair to the bed. NA J turned his wheelchair facing the foot of the bed at an angle. She attempted to get the resident to grab around her neck, but due to his hearing loss he never understood her. NA J then placed her feet outside of the resident legs and lifted him by his arm pits and his pants and the resident hollered ouch. Resident #13 was not able to bear weight or assist in the transfer. The Resident was not positioned high enough in the bed, and stated she would have to go get help to lift him up in the bed. NA J lifted his legs and feet and placed them on the bed and left the room. NA J returned in a few moments with CNA F and they both lifted the resident up in the bed and repositioned him. Resident #13 smiled at them both and said, thank you. In an attempted interview with Resident #13 on 08/12/24 08:35 a.m. the resident could not understand the question when asked if he had experienced pain during the transfer, he just smiled and stated, Thank you. In an interview with NA J on 08/12/24 at 08:36 a.m. she stated she was only PRN. She stated she had not worked in the facility for over 2 weeks. She stated she was supposed to use a gait belt when transferring residents. She stated not using a gait belt could lead to a fall, or she could injure herself. She stated she had been in serviced on gait belt transfers when she was hired in 2023. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the ADON on 08/12/24 at 08:50 a.m. she stated staff were to use gait belt for transfers. She stated she was not sure when the last gait belt training had been done, but stated she would get NA J in serviced today. In an interview with the DOR on 08/12/24 at 11:15 a.m. she stated she did the gait belt training in the facility. She stated she does one annually. She stated the last one she had done was last year around May or June of 2023, right before their annual survey. She stated the facility used to bring any new hires to her for training but stated since they had been using so much agency that system had fallen to the wayside. She stated she was going to put the system back in place and tell them that as part of their orientation process they need to bring the staff to her skills check them on gait belts transfers and transfers in general. She stated it was not acceptable lifting someone under their arm pits due to the potential for injury. She stated it increased the risk of falls, fractures and nerve damage. In an interview with the DON on 08/12/24 at 03:26 p.m. she stated NA J came and told on herself. She stated they had an in-service today (08/12/24) on proper transfers. She said it was the expectation for staff to use a gait belt when providing transfers to residents to prevent the risk of injury to the resident and the staff. She stated at no time were they to lift a resident under the arms. She stated they had issued gait belts to all the CNAs today and she expected them to always have the belts with them. She stated going forward any new hire will be taken to the therapy department to receive training before they are placed on the floor. Record review of NA J's general orientation checklist reflected she had been skills checked for body mechanics on 03/12/2023. It did not specify gait belt training. Record review of the facility's policy, Gait Belts revised March 2019, reflected, Gait belts must be used when ambulating or transferring patients/resident who require physical assistance.Always use the gait belt when the patient/resident requires hands on assistance to ambulate or transfer .

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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** 47690 Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for one of three residents (Resident #41) reviewed for catheter and incontinence care. The facility failed to ensure CNA I did not place the urine catheter drainage bag on the bed during Resident #41's incontinent care, and wound dressing change. The facility failed to ensure CNA I did not perform hand hygiene during Resident #41's incontinent care. These failures could place residents at risk for not receiving care appropriate to address their incontinence and could increase the risk of urinary tract infections. Findings included: Record review of Resident #41's quarterly MDS assessment, dated 06/12/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. She had a BIMS score of 11, which indicted her cognition was moderately impaired. Resident #41 required substantial/maximum assist with toileting and had an indwelling catheter and was always incontinent of bowel. Resident #41 had diagnoses which included neurogenic bladder (loss of bladder control due to brain, spinal cord, or nerve problems), diabetes mellitus, dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), and depression. Record review of Resident #41's care plan, with an onset date of 05/29/24, reflected she did not have a care plan for activities of daily living, bowel incontinence, or urinary indwelling foley catheter care. Record review of Resident #41's Doctor order, dated 07/11/24, reflected Change Foley catheter, Special Instruction: 16F , 10 cc once A Day on 1st Monday of the Month; 10:00 PM-06:00 AM. Observation on 08/06/24 at 9:48 AM revealed LVN B, and CNA I entered Resident #41's room. Both staff performed hands hygiene, and donned gloves. CNA I put Resident #41's indwelling foley catheter drainage bag, which had approximately 1300 cc of urine, on the bed by the resident's feet. CNA I uncovered Resident #41, unfastened the brief, and cleaned Resident #41's front private area with wipes, using one wipe per stroke. CNA I with LVN B turned Resident #41 to her right side., CNA I cleaned Resident #41's buttocks area using one wipe per stroke, and disposed of the dirty brief in the trash bag. CNA I changed gloves without any form of hand hygiene and put a clean brief on Resident #41., CNA I hanged the indwelling foley catheter drainage bag in its place at the left side of the bed. CNA I covered Resident #41, removed her gloves, and washed her hands. LVN B removed her gloves, and washed her hands. (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 08/06/24 at 10:05 AM LVN B stated she was trained to always keep the catheter drainage bag below the resident's bladder. She stated she did not notice CNA I had put the urine drainage bag on the bed. She stated having it above the bladder could possibly cause the urine to run backwards, which could cause an infection. She stated placing the bag on the bed could cause a risk of cross contamination. Interview on 08/06/24 at 10:21 AM CNA I stated she should not have placed the urine catheter drain bag on Resident #41's bed. She stated she knew the catheter bag and tubing were to be kept below the resident's bladder to prevent urine from backing up and might cause an infection. Interview on 08/06/24 at 10:21 p.m. with CNA I she stated she was supposed to perform hand hygiene every time she removed her gloves, and before she put on clean gloves. She stated she had hand sanitizer in her pocket and forget to use it. She stated putting gloves under her arm pit would not affect the status of the gloves. She stated the risk to the resident was spreading bacteria on the resident's skin, and if there were a cut on the skin, there could be an infection. She stated it was also to prevent the resident from getting a UTI (urinary tract infection). She stated the facility did training on hand hygiene all the time and she thought the last one was in July 2024. In an interview with ADON on 08/08/24 at 11:52 a.m., she stated any resident with a foley catheter should always have the bag and tubing below the bladder and should never be placed on the bed. She stated not keeping the foley catheter bag below the resident's bladder, placed them at risk of a urinary tract infection and cross contamination. She stated all the staff had been trained numerous times on the expectation of performing hand hygiene after completion of care, after removing gloves and before they leave the resident's room. Record review of the copy from [NAME] nursing book page 433 furnished by the facility, titled Indwelling Urinary Catheter Care and Removal, reflected, Keep the drainage bag below the level of the patient's bladder to prevent backflow of urine into the bladder, which increases the risk of CAUTI (Catheter urinary tract infection). Don't place the drainage bag on the floor, to reduce the risk of contamination and subsequent CAUTI.

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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** 34918 Based on observation, interview and record review, the facility failed to provide treatment and services to prevent complications of enteral feeding for one of three residents (Residents #39) reviewed for feeding tubes. The facility failed to ensure staff followed physician ordered water flushes before and after medication administration given via the G-Tube for Resident #39. These failures could place residents at risk of tube obstruction and a decrease in hydration. Findings include: Record review of Resident #39's undated face sheet reflected a [AGE] year-old female with and admitted [DATE] and a re-admitted [DATE]. Diagnoses included dehydration, dysphagia(difficulty swallowing), cerebral vascular accident (stroke), contractures (a permanent tightening or shortening of the muscles, tendons and skin that causes a physical deformity) and unspecified severe protein-calorie malnutrition. Record review of Resident #39's quarterly MDS assessment, dated 04/26/24, reflected Resident #39 had BIMS score of 0 which indicated she was severely cognitively impaired. She was totally depended on all ADL and always incontinent of bowel and bladder and she received 51% or more of total calories through a feeding tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach). Resident was on hospice services. Record review of Resident #39's Physician orders report dated 07/31/24 reflected, .Flush G-tube with 60 ml of H2O before and after meds tid . with a start date of 03/01/23. Record review of Resident #39's care plan with a revision date of 07/01/24 reflected, .[Resident #39] require PEG feeding .Interventions .Provide tube feeding and water flush as ordered . Record review of Resident #39's Medication administration record for August 2024 reflected, .Flush G-tube with 60 ml of H2O before and after meds tid . with a start date of 03/01/23. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 08/06/24 at 03:30 p.m. of G-Tube medication administration for Resident #39 revealed Agency LVN C prepared medication for Resident #39. Agency LVN C placed 1 tablet Xanax 0.25 mg (anti-anxiety), 1 tablet of Hydrocodone-acetaminophen 10-325 mg (opioid for pain), 1 tablet of Baclofen 5 mg (muscle relaxant), and 1 tablet of hydroxyzine HCL 25 mg and placed them in an individual cup and crushed each tablet in each cup. Agency LVN C opened one Gabapentin 100 mg capsule and placed it in a plastic cup. and then crushed each tablet and entered the resident's room. Agency LVN C then filled a plastic cup with water from the bathroom sink and poured approximately 5-10 ccs of water into each medication cup. He then retrieved a 60-cc piston syringe and placed the piston syringe into the G-tube connector and checked for residual (the volume of fluid remaining in the stomach at a point in time during enteral nutrition feeding) and flushed the G-tube with 30 ccs of water. Agency LVN C then administered each medication by gravity and flushed with 5 cc of water between each medication. At the completion of the medication administration Agency LVN C then flushed with 30 ccs of water. Agency LVN C then reconnected the feeding tube and turned the pump back on. In an interview with Agency LVN C on 08/06/24 at 03:40 p.m. he stated he was required to flush the G-tube with 30 cc of water before and after each med pass. When Agency LVN C looked at the medication administration record, he stated oh it was supposed to be 60 cc of water before and after. Agency LVN C stated he was required to review physicians' orders prior to giving any medication and had not reviewed it, stating 30 cc was the standard water flushes before and after. He stated not flushing with the prescribed amount of water could result in tube occlusion (clogged) or a resident not getting their calculated water intake. In an interview with the DON on 03/12/24 at 3:25 p.m., the DON stated staff were to always follow the doctors' orders on the amount of fluid to flush before and after medications. She stated failing to follow the orders could result in a clogged G-tube which would require the resident to be sent out to the hospital for replacement and it could result in a decrease in hydration. She stated all nurses are skills checked prior to G-tube medications. She stated they would also be doing follow up monitoring to ensure staff are following proper procedures. Record review of Agency LVN C's Staff Education/Orientation Policies and Procedures dated 06/17/24 reflected staff followed the facility policy and procedures for G-tube medication administration. Record review of the facility's Policy and Procedure from the Lippincott Nursing Procedure ninth edition, pages 303-305 titled, Enteral Tube Drug Instillation, reflected, .Verify the practitioners order, including the drug, dose, dosage form, route and access device .Potential complication of enteral drug administration include .a clogged feeding tube .The risk of complications increase with inappropriate preparation or administration technique .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on interviews and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for one of 2 residents (Resident #30) reviewed for dialysis. The facility failed to ensure post dialysis communication sheets were reviewed and completed for Residents #30. This failure could place residents at risk of inadequate post dialysis care. Findings included: Record review of Resident #30's undated face sheet reflected a [AGE] year-old male with the latest return to the facility on [DATE]. Diagnoses included type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar) with diabetic chronic kidney disease and dependence on renal dialysis. Record review of Resident #30s Annual MDS assessment dated [DATE], reflected an initial admission of 12/26/23. Resident #30 was able to make himself understood and understood others and had a BIMs score of 15, which indicated he was cognitively intact. The MDS reflected the resident was receiving dialysis care. Record review of Resident #30's care plan with a revised date of 08/06/24, reflected, [Resident #30 received dialysis three times a week and is at risk for increased SOB, chest pains .infected or malfunctions access site .Dialysis schedule is as follows: Monday Wednesday Friday .Interventions .Give Meds as ordered, and monitor labs as needed . Record review of Resident #30's Physicians order Report dated 07/09/24 to 08/09/24 reflected, Monitor shunt to left arm for thrill/bruit (vibration and sound) q shift .Dialysis M-W-F [Dialysis company] . Record review of Resident #30's dialysis binder for July and August 2024 reflected no post dialysis assessment completion on the communication sheets for July 1st, 3rd, 5th, 6th, 13th, 17th, 19th, 26th, 29th and August 5th, 2024. In an interview with Resident #30 on 08/06/24 at 09:08 a.m. he stated he was doing fine. He stated he goes to dialysis on Monday Wednesday and Fridays. He stated the facility arranged transportation for him. He stated he felt rough yesterday (08/05/24) during his treatment but felt better today. He stated he was provided a communication sheet that he takes to the dialysis center, and he brings it back to the facility. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Agency LVN C on 08/07/24 at 03:35 p.m. he stated he had worked at the facility on a regular basis for the past 2 years. He stated he normally worked the 100 hall but if the memory care LVN called in they pulled him there since he knew the residents a little better. He stated Resident #30 returned to the facility on the 2-10 p.m. shift from dialysis. He stated he always completed the post dialysis assessment on the communication form and placed it in the binder. He stated he got pulled to different shifts and floors a lot in July. In an interview with the ADON on 08/07/24 at 01:55 p.m. she stated when the residents go to dialysis, they provide the resident with a communication form to take to the dialysis. She stated nursing staff complete the pre and post dialysis communication forms. The ADON reviewed Resident #30's dialysis communication forms and stated they had several missing post dialysis assessments. She stated it was probably agency staff who worked on those days. She stated she would get with the scheduler to see if it was all agency staff who had missed completion of the communication form. In a follow up interview on 08/08/24 at 11:40 a.m. with the ADON she stated she had checked the schedule against the missing documentation on the dialysis communications sheets and found it was all agency staff who worked those days. She stated they had not put the procedure in their orientation packet for the agency staff and had since added it to the packet. She stated nurses were expected to check vitals, monitor, and document. She stated the risk of not monitoring or documenting could lead to infections and not being aware of a change in the resident's vital signs. In an interview with Agency LVN D on 08/09/24 at 3:21 p.m. she stated she had worked on 08/05/24. She stated that was only the second time she had worked at the facility and was not aware of any dialysis communication form she was required to fill out. She stated she assessed Resident # 30 when he returned from dialysis but did not know about a paper communication sheet from dialysis. She stated she checked his blood pressure when he returned that day and put it on the paper Medication Administration record. In an interview with the DON on 08/12/24 at 03:30 PM she stated they realized the agency staff were not educated on the dialysis communication sheets they used. She stated they had added this to orientation since she was made aware of this failure on 08/08/24. She stated the risk to residents could be death, hospitalization , ineffective medications or there could be something they needed to follow up with the physician. She stated going forward the dialysis binder would be reviewed weekly to ensure staff were completing the required pre and post assessments. Record review of the facility's policy Shunt Care-Arteriovenous, dated May 2023, reflected, .Post dialysis care .measure vital signs upon return from dialysis and as needed or as ordered by the physician .Check for bruit upon return from dialysis and then once per shift .Inspect the shunt site for color, warmth, redness, and edema (build up on fluid in the tissue, a type of swelling) .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 34918 Based on observations, interviews, and record review the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 3 of 9 residents (Resident #44, Resident #47, and Resident #30) and one of one medication room reviewed for drugs and biologicals. 1. The facility failed to ensure Resident #44's Dakins Solution (a bleach based wound cleanser) was stored properly. 2. The facility failed to ensure Resident # 47's anti-fungal powder was stored properly. 3. The facility failed to ensure Resident #30's Sevelamer carbonate blister pack (used to lower phosphate in the blood for chronic kidney disease) was labeled with the correct dosage. 4. The facility failed to remove expired medication from the medication room refrigerator. These failures could place residents at risk of medication misuse, administration of incorrect dosage of medications which could result in non-therapeutic treatments or injuries and ineffective treatment with the use of expired medications. Findings included: 1. Record review of Resident #44's undated face sheet reflected he was a [AGE] year-old male with the latest return to the facility on [DATE]. Diagnoses included disruption of traumatic injury wound repair, initial encounter, pressure ulcer of sacral region (bottom of the spine) sepsis (a serious condition in which the body responds improperly to an infection), methicillin resistant staphylococcus aureus infection as the cause of diseases (severe bacterial infection) and diabetes. Record review of Resident #44's quarterly MDS assessment dated [DATE], indicated an initial admitted [DATE]. Resident #44 was able to make himself understood and understood others. He had a BIMS score of 14, which indicated he was cognitively intact. Resident #44 required substantial to total assistance with toileting, personal hygiene, transfers, and bed mobility and had a foley catheter and colostomy bag. Resident #44 was receiving treatment for 3 stage 4 pressure ulcers (full thickness tissue loss with exposed bone, tendon, or muscle) to the sacral region. Record review of Resident #44's care plan with an initiated date of 05/29/24 reflected, [Resident #44] has a stage 4 pressure ulcer on his sacrum related to impaired mobility, diabetes, and acute kidney injury . Interventions .Wound care as ordered. See treatment record. Record review of Resident #44's Physician order report dated 07/11/24 through 08/11/24 did not reflect an order for the use of Dakins solution in the wound care orders. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation 08/06/24 at 09:03 a.m. Resident # 44 stated he was not doing very well. He stated his butt hurt from the wound he had. He stated the facility was providing wound care daily. Observed a bottle of Dakin's Solution on his chest of drawers by his bed. During a wound care observation on 08/06/24 at 02:08 p.m. revealed the DON prepared supplies for Resident #44's wound care. Treatment included anasept gel (antimicrobial gel) normal saline and collagen powder (protein wound filler) . The bottle of Dakin's solution remained on the resident's chest of drawers. 2. Record review of Resident # 47's undated face sheet reflected a [AGE] year-old female with and admitted [DATE]. Diagnoses included rash and other nonspecific skin eruptions, diabetes, bipolar disorder (mental health illness that causes wild mood swings) and mild intellectual disabilities. Record review of Resident #47's quarterly MDS assessment dated [DATE] reflected a BIMS score of 12 which indicated she was moderately cognitively impaired, and she had not refused care. Resident #47 required substantial assistance with bathing and partial to moderate assistance with personal hygiene and dressing. Record review of Resident #47's care plan with a start date of 05/26/24, reflected, [Resident #47 takes 9 plus meds and has a potential for drug interactions and side effects. Record review of Resident #47's Physicians order Report dated 07/13/24 to 08/09/24 reflected no orders for anti-fungal powder. An observation and interview with Resident #47 on 08/06/24 at 10:00 a.m. revealed a bottle of Antifungal powder on resident's chest of drawers. Resident #47 stated she had a rash and was using it on her rash. She stated she got the powder from the facility but did not know who brought it to her. In an interview and observation on 08/06/24 at 10:11 a.m. with LVN A she stated residents had to have an order for antifungal powder and it should not be kept at the resident's bedside. LVN A entered Resident #47's room and asked the resident about her rash and told her she would contact the doctor. LVN A removed the bottle of antifungal powder. LVN A stated any medication had to have an order and had to be secured for safety. She stated the resident had not complained to her about a rash. 3. Record review of Resident #30's undated face sheet reflected a [AGE] year-old male with the latest return to the facility on [DATE]. Diagnoses included type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar) with diabetic chronic kidney disease and dependence on renal dialysis. Record review of Resident #30's Annual MDS assessment dated [DATE], reflected an initial admission of 12/26/23. Resident #30 was able to make himself understood and understood others and had a BIMs score of 15, which indicated he was cognitively intact. The MDS reflected the resident was receiving dialysis care. Record review of Resident #30's care plan with a revised date of 08/06/24, reflected, [Resident #30 received dialysis three times a week and is at risk for increased SOB, chest pains .infected or malfunctions access site .Dialysis schedule is as follows: Monday Wednesday Friday .Interventions .Give Meds as ordered, and monitor labs as needed . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #30's Physicians order Report dated 07/09/24 to 08/09/24 reflected, Renvela (sevelamer carbonate) tablet 800 mg 2 tablets three times a day with a start date of 07/30/24. Record review of Resident #30's Medication Administration record for August 2024 reflected, Renvela (sevelamer carbonate) tablet 800 mg 2 tablets three times a day with a start date of 07/30/24. During a medication pass observation on 08/07/24 at 8:16 a.m. revealed LVN A pulled Resident #30's medications. LVN A pulled the blister pack for sevelamer carbonate and punched out 2 tablets. LVN A stated the blister pack indicated 3 tablets three times a day but stated the order had changed to 2 tablets three times a day. She stated it had changed a few weeks ago. An observation of Resident #30's blister pack for sevelamer carbonate on 08/07/24 at 8:18 a.m. reflected it was 4 of 9 blister packs filled on 04/14/24. Order reflected 3 tablets (2400 mg) by mouth three times a day with breakfast, lunch, and dinner. In an interview and observation of the medication cart for hall 100 on 08/07/24 at 02:45 p.m. with Agency LVN C he stated Resident # 30's orders for sevelamer carbonate had changed from 3 tablets three times a day to 2 tablets three times a day several weeks ago. When asked if they had change in order labels, he looked in the top drawer of the medication cart and pulled out a roll of change in order stickers. He stated he was not sure why no one had placed one on the pack. Agency LVN C then placed a sticker on the blister pack of the sevelamer carbonate which indicated the order had changed. He stated not labeling the blister pack could cause a medication error if someone did not check the order and just went by the blister pack. 4. In an observation with LVN B of the one and only medication room on 08/06/24 at 08:46 a.m. there were 2 vials of unopened Flu vaccine that had expired on 05/28/24 and 1 box of Bisacodyl suppositories (laxative) opened on 06/06/23 that had expired July 2024. Both medications were stored in the medication rooms refrigerator and were available for use. Observation with LVN B revealed there was no other flu vaccine available in the facility. In an interview with LVN B on 08/06/24 at 08:50 a.m. she stated it was everybody's responsibility to check for expired medications. She stated since the medication was in the refrigerator someone could have used it and they would have given an expired medication. She stated expired medications would not be effective and not provide the intended effectiveness of the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 08/07/24 at 02:00 p.m. she stated any expired medication were to be removed from the medication room or medication carts immediately. She stated having expired medications available for use could result in a resident receiving an expired medication which would provide ineffective benefits to the residents. She stated antifungal powder and Dakin's Solution should not be in the resident's room. She stated both required a physician's order for use and having them at bedside could result in a resident using something incorrectly or ingesting something harmful. She stated any change in the dosage of medication should have a change label on the blister pack. She stated if someone just looked at the blister pack and failed to check the physician orders, they could give the incorrect dosage of medication. She stated she had only been here 2 months and was not sure if the facility had change order stickers. She stated with the number of agency staff they were using they really needed to make sure they had clear directions on the medication blister packs. She stated she expected all staff to check for expiration dates prior to administration of any medication and to check both the physician orders against the prescribed medication. She stated the charge nurse were expected to make rounds daily and should be checking to ensure there were no medications at the bedside. The DON said it was important for medications to be stored properly for the safety of the residents. Record review of the facility policy Medication Storage, dated 04/2022, reflected, . Medications and biologicals are stored safely, securely, and properly following manufactures' recommendations or those of the supplier. In accordance with State and Federal laws, the facility will store all drugs and biological in n locked compartments under proper temperatures and other appropriate environmental controls to preserve their integrity. The medication and biological supply is only accessible to licensed nursing personnel, pharmacy personnel or authorized staff members .Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the Pharmacy, if replacements are needed .

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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. 34399 Based on observations, interviews and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for the facility's only kitchen, in that, 1. The facility failed to ensure chest freezer was free of ice accumulation. 2. The facility failed to ensure freezer items were labeled, dated and sealed. 3. The facility failed to ensure the kitchen was free of gnats and flies. 4. The facility failed to ensure steam table was not dripping. These failures could place residents at risk for food contamination. Findings include: 1. Observation on 08/06/24 at 9:26 AM revealed inside the chest freezer, which had turkeys and frozen popsicles in it, in the kitchen had ice accumulation of at least inch on the sides and back. Interview on 08/06/24 at 9:27 AM with Dietary Manager revealed he did not open the chest freezer very often and was unaware of ice accumulation in the chest freezer. 2. Observation on 08/06/24 at 9:28 AM of 1 of 3 freezers revealed three pizza crusts in a plastic bag not labeled, dated or sealed with a scoop of ice in the bottom of the opened plastic bag. Interview on 08/06/24 at 9:29 AM with Dietary Manger revealed the pizza crusts should be labeled, dated and sealed. He stated there was ice in the bottom of the plastic bag and he was unsure when the pizza crust was put in the freezer. 3. Observation on 08/06/24 at 9:20 AM revealed 2 flies in the kitchen lying on the counter and in dry storage. There were gnats flying and landing near the garbage disposal. There were flies in the dry storage and kitchen prep area, and two flies in the kitchen prep area landed on counters. Observation on 08/07/24 at 11:55 AM during lunch meal time revealed 3 gnats near the garbage disposal where food debris was inside of the garbage disposal. There were two flies in the kitchen landing on the counter. 4. Observation on 08/07/24 at 12:10 PM during lunch revealed the steam table was in use and was dripping under the faucet with two containers under with water in both. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 08/09/24 at 10:35 AM with Dietary Manager revealed he had gnats/flies in the kitchen since it had gotten warmer. He stated he would tell Maintenance Director about it but was short staffed and did not know where to document about pests. He stated he had been short a dietary staff so he was having to help out daily. He stated Pest Control Company N treated the kitchen drain yesterday (08/08/24) for gnats. He had been aware of gnats and flies in the kitchen but it was difficult to keep them out of the kitchen especially during meal time when the doors are open to assist with meals. He stated Maintenance Director was aware of pests in the kitchen. He stated the steam table had been dripping for a couple of weeks and he put the containers under for the dripping. He stated Maintenance Director had fixed some of the dripping already but was awaiting parts to fix the rest of the dripping under the steam table faucets. Interview on 08/11/24 at 11:50 AM with Dietary Manager revealed Maintenance Director has addressed the freezer issue. He stated the freezer was not sealing properly allowing in air so the ice would build up on the sides and top of the freezer. He stated he had not had an opportunity to put the dripping under the steam table in the Maintenance Log since he had been working in the kitchen. He stated the steam table dripping had not been fixed yet. Interview on 08/11/24 at 12:10 PM with Executive Director revealed he and Dietary Manager would let Interim Maintenance Director know about the steam table to look at it. He was not aware of the steam table dripping until now. Review of facility's policy Cleaning the Freezer last revised 06/20/23 reflected Freezers will be clean and free of odors .3. Discard out-of-date products or products that have become freezer burned. 4. Verify that all products are labeled and correctly sealed. Review of facility's policy Safe Food Handling last revised 06/20/23 reflected .3. All food removed from the original packaging are stored in a closed container or tightly wrapped package and labeled with the common name of the item and the date it was opened.

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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** 34918 Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two of 16 residents (Resident #41 and Resident # 6) reviewed for infection control. 1 The facility failed to ensure LVN B completed hand hygiene during wound care for Resident #41. 2. The facility failed to ensure LVN B used proper infection control prevention by taking the multi-use absorbent dressing (Alginate calcium with silver 4x4 dressing) packet inside Resident #41's room, cut a piece of it to use on the resident and returned the packet to the wound care cart for further use. 3. The facility failed to ensure LVN B used proper infection control prevention by returning the pair of scissors used to cut the Alginate calcium with silver dressing back in her cart without any form of sanitization. 4. The facility failed to ensure Agency CNA E completed hand hygiene during incontinence care and wore appropriate PPE for Resident #6. These failures could place residents at-risk of cross contamination which could result in infections or illness. Findings included: 1. Record review of Resident #41's quarterly MDS assessment, dated 06/12/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. She had a BIMS score of 11, which indicted her cognition was moderately impaired. Resident #41 required substantial/maximum assist with toileting and had an indwelling catheter and was always incontinent of bowel. Resident #41 had diagnoses which included neurogenic bladder (loss of bladder control due to brain, spinal cord, or nerve problems), diabetes mellitus, dementia (loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), stage 4 pressure ulcer (Full thickness tissue loss with exposed bone, tendon, or muscle). Record review of Resident #41's care plan, with an onset date of 05/29/24, reflected she did not have a care plan for activities of daily living, bowel incontinence, or urinary indwelling foley catheter care. Problem . Resident#41 is on Enhanced Barrier Precautions related to an pressure ulcer and at increased risk for infection .Goal: the resident will remain in Enhanced Barrier Precautions r/t pressure ulcer Record review of Resident#41's physician order dated 06/27/2024 revealed Coccyx: clean with normal saline, pat dry, apply calcium alginate with silver, cover with border island dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 08/06/24 at 9:48 a.m. revealed LVN B and CNA I entered Resident #41's room. LVN B placed wax paper onto the bedside table and placed the following supplies onto the table: border dressing, alginate calcium with silver dressing packet (type of dressing that absorbs excess wound drainage), a pair of scissors, two 4x4 gauze and two normal saline disposable vials. CNA I placed a pair of gloves under her armpit while she performed handwashing in the resident's bathroom sink. LVN B washed her hands and both staff put on gloves. CNA I unhooked Resident #41's urinary catheter drainage bag from the bed rail and placed it onto the bed by the resident's feet. CNA I uncovered resident; unfastened Resident #41's brief and cleaned resident from front to back with peri wipes, using one wipe per stroke. CNA I with LVN B turned Resident #41 to her right side, and CNA I cleaned Resident #41's buttocks area from front to back, using one wipe per stroke. CNA I disposed of the dirty brief in the trash bag. LVN B removed the old dressing and disposed of it in the trash bag. LVN B removed her gloves and without performing hand hygiene and then put on clean gloves and cleaned Resident #41's wound with a 4x4 gauze soaked with normal saline. LVN B then patted the wound dry with a 4x4 gauze. At bedside LVN B cut a piece of Alginate calcium with silver and put it over Resident #41's wound and then covered it with a border dressing. CNA I removed her gloves and put on clean gloves without performing hand hygiene and placed a clean brief on Resident #41. CNA I covered Resident #41 with a sheet, removed her gloves, and washed her hands. LVN B removed her gloves, washed her hands, and retrieved the remaining alginate calcium with silver packet, and the pair of scissors and put them back in her treatment cart without any form of sanitization for the pair of scissors. In an interview on 08/06/24 at 10:05 a.m. with LVN B, she stated reusable equipment, like the scissors, should be sanitized with wipes between each resident use to prevent transmitting an infection from one resident to another. She stated she forgot to wipe the scissors before putting them back in the cart. She stated she should have only taken the amount of Alginate calcium with silver dressing needed for the wound care, instead of taking the whole packet to prevent cross contamination. LVN B stated not washing her hands or using hand sanitizer between glove changes could cause an infection control problem for the residents. 2. Record review of Resident # 6's 5-day MDS assessment dated [DATE] reflected a [AGE] year-old female with an admitted [DATE]. Resident had a BIMS score of 14 which indicated she was cognitively intact. The resident required substantial to extensive assistance with all ADLs. Diagnoses included septicemia (bacteria, virus or fungal infection that has entered the blood stream) cerebral vascular accident (stroke) and scoliosis (curvature of the spine). The resident admitted to the facility with 2 stage 3 decubitus (full-thickness loss of skin that extends to the subcutaneous tissue). Record review of Resident #6's care plan with an initiation date of 07/08/24, reflected, [Resident #6] has an actual pressure ulcer on right side of neck, left buttock and left heel .and is Incontinent of bowel and bladder related impaired mobility .Interventions .Enhance Barrier precautions during wound care or close contact with wound. PPE required: gloves, gowns, face protection if procedure has risk of splashes or sprays .minimize skin exposure to moisture from incontinence, perspiration, or wound drainage by cleaning with mild cleansing agents . (continued on next page)

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The Terrace at Denison	1300 Memorial Dr Denison, TX 75020

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 08/06/24 at 04:20 p.m. Agency CNA E entered Resident # 6's room, to transfer her from her wheelchair to bed. Agency CNA E put on gloves and placed a gait belt around the resident and transferred the resident to bed. Agency CNA E gathered supplies to perform incontinence care. She did not put on a gown prior to care. Agency CNA E removed the residents' pants and unfastened her brief. She provided peri care from front to back and rolled the resident over on her side to reveal a moderate bowel movement. The resident had a dressing on her coccyx area dated 08/06/24 which was soiled with bowel movement. Agency CNA E started wiping from front to back and ran out of wipes. While wearing dirty gloves, she opened the dresser drawer and searched for more wipes, then stated she was going to have to go and retrieve more wipes. Agency CNA E removed her gloves and left the room without performing hand hygiene. Approximately 2 minutes later, she returned to the Resident's room and washed her hands and re-gloved. Agency CNA E continued to clean the bowel movement from the resident and then removed the soiled dressing from her coccyx, revealing a stage 3 decubitus. Agency CNA E cleaned the bowel movement from around the wound and placed the clean brief under the resident while still wearing soiled gloves and rolled her back onto the brief. She fastened the brief and stated she was going to change the resident's shirt, since it was soiled. Agency CNA E then removed her gloves and without performing hand hygiene went to the resident's closet and retrieved a clean shirt. She gently removed the resident's shirt. (Resident had a severe neck contracture and was unable to straighten her head). Resident had a white pad between her jaw and shoulder which was wet. Agency CNA E removed it revealing a pressure ulcer on her shoulder. The Resident stated she had had this for years because of her contractures. Agency CNA E gently placed the shirt on the resident. Agency CNA E removed her gloves, washed her hands, and left the room with the soiled linen and trash. In an interview with Agency CNA E on 08/06/24 at 4:55 p.m. she stated she was not aware of the enhanced barrier precautions and did know she was supposed to wear a gown with any resident with a wound. She stated she had not been instructed not to remove wound dressing and stated she knew it needed to be removed because it was soiled and she did not want the bowel movement to get into the wound. She stated she was going to let the nurse know the wounds needed to be re-dressed. Agency CNA E stated she was to perform hand hygiene during incontinence care before and after she finished, then stated she should have changed her gloves and performed hand hygiene when going from dirty to clean and stated not doing so could cause infections. Observed Agency CNA E 08/06/24 at 05:00 p.m. informed Agency LVN C that Resident #6's wounds needed to be re-dressed. In an interview with Agency LVN C on 08/07/24 at 03:35 PM he stated most of the wound care is done on the day shift but if the dressing comes off or becomes soiled, he had PRN wound care orders. He stated he did re-dress Resident #6's wounds yesterday after Agency CNA E told him the dressing were off. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with ADON on 08/08/24 at 11:52 a.m., she stated infection control was important during residents' care. The ADON stated during care the staff were to use the hand sanitizer or wash hands if they were physically soiled. The ADON stated the staff were expected to complete hand hygiene before care and after care. She also stated during incontinent care the staff were supposed to change their gloves and use hand sanitizer when going from dirty to clean. The ADON stated hand hygiene was to be completed for infection control. The ADON stated staff were not supposed to put gloves under their arm pit before entering residents' rooms for care. ADON said she was the infection preventionist and was in the process of re-educating the staff on infection control this week. She stated the agency staff were expected to read and sign off on the policies of the facility as part of their orientation process. She stated there is a book at the desk that had all the policy and procedures which included hand hygiene and donning and doffing gloves. She stated at no time should a CNA intentionally remove a dressing. She stated she should have called for the nurse to come. She stated each resident who was on enhanced barrier precautions had signs posted on the door and in the room and had a cart in the room with the necessary supplies. She stated the charge nurses should also monitor the CNAs to ensure they are using the proper PPE. ADON stated LVN B should not take a multi-use dressing supplies inside the residents' rooms and put them back in the clean cart. Record review of CNA I's skills checks dated 06/11/24 reflected she was competent in hand hygiene and incontinence care. Record review of the Agency Orientation Facility guide located at the nurses' station, reflected policies on Hand Hygiene, Donning and Doffing and shared equipment. Record review of the facility's policy, Hand Hygiene/Handwashing, dated May 2023, reflected, Hand Hygiene/Hand washing is the most important component for preventing the spread of infection .Hand hygiene/hand washing is done before .patient/resident contact .before performing an aseptic task .After . contact with soiled or contaminated articles, such as articles that are contaminated with body fluids .after patient/resident contact .after contact with a contaminated object or source where there is a concentration of microorganism, such as, mucus membranes, non-intact skin, body fluids, blood or wounds .After removal of medical/surgical or utility gloves .Wash hands at end of procedures where glove changes are not required . Contact with a patient's/resident's intact skin(.lifting the patient/resident in bed). Contact with environmental surfaces in the immediate vicinity of patients/residents 47690

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 47690 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to keep the facility free from pests for 16 of 26 residents (Resident #2, Resident #13, Resident #17, Resident #25, Resident #28, Resident #39, Resident#44 and 9 Confidential Group Residents) reviewed for pest control, in that: 1. The facility failed to ensure an effective pest control program was in place to keep ants out of resident rooms, resulting in 102 ant bites on Resident #2's upper middle chest, over the right breast, right side of the neck, right shoulder, right arm, and right elbow. 2. The facility failed to maintain an effective pest control to address the outside of hall 100 and hall 200 for ant activity. The facility failed to ensure resident secure unit common area windows were free of ants on 08/06/24 and 08/07/24. 3. The facility failed to ensure Resident #13 and #17's room was free of pests and failed to ensure their window was closed. 4. The facility failed to ensure Resident #28 room was free of gnats, flies, and ants. 5. The facility failed to ensure Resident #39's room was free of ants. 6. The facility failed to ensure Resident #25's room was free from flies and gnats. 7. The facility failed to ensure kitchen and dining room was free of flies and gnats. 8. The facility failed to ensure Resident #44's room was free of gnats and ants. On 08/08/2024 at 4:11 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 08/12/2024 at 4:20 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of its Plan of Removal (POR). These failures placed residents at risk for injury related to ant bites, and infection from pests. The findings included: (continued on next page)

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Review of Resident #2's face sheet, dated 08/07/24, revealed she was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included Hypertension (high blood pressure), diabetes mellitus, Acute and chronic respiratory failure with hypoxia (a condition in which the body or a region of the body is deprived of adequate oxygen supply at the tissue level), Quadriplegia (paralysis of all four limbs), Cognitive communication deficit, aphasia (a language disorder that affects a person's ability to communicate.) following cerebral infarction (type of ischemic stroke resulting from a blockage in the blood vessels supplying blood to the brain), chronic pain, and adult failure to thrive (a syndrome that describes a decline in older adults that can be caused by many factors.) Review of Resident #2's MDS quarterly assessment, dated 04/28/24 revealed Resident#2's BIMS score of 00 indicating severe cognitive impairment. Review of Resident #2's care plan, dated 03/29/23, and updated 08/08/24, reflected the following Problems: Resident #2 has scattered insect bites (ant bites) on her right neck, right shoulder, right arm, and right breast. Goal: Resident #2 insect bites will heal without complications over the next 90 days. Approach: Monitor for s/s of infection and report findings to MD. Treatment as ordered. Record review of Resident #2's weekly skin assessment, dated 07/29/2024, revealed Resident #2's skin was intact. Record review of Resident #2's skin assessment, dated 07/30/2024, revealed Resident #2 had redness, bites/welts on the right shoulder, and right arm. Record review of Resident #2's physician order dated 07/30/2024 revealed Resident #2 had an order for, Kenalog cream apply to right of neck and right forearm three time a day till healed. Record review of Resident #2's nursing progress note, dated 07/30/2024 at 06:00 p.m., revealed a note reflecting Resident #2 . Approximately 06:00 pm walked into resident's room to administer medication via G tube (gastrostomy tube is a tube that is surgically inserted through the abdominal wall and into the stomach to provide an alternative way to deliver nutrition, fluids, and medications directly to the stomach) and noted ants on resident R arm/elbow, and right side of her face. Removed ants as quickly as possible, assessing resident and noted resident to have reddened welts to R elbow, and bend of AC (Antecubital - the area on the front side of the upper part between the arm and forearm) and to the right side of her neck. Notified Doctor (Resident primary doctor) new order received to apply Kenalog three time a day. Resident moved to another bed in another room. Notified DON. Notified resident representative . Vital signs: Blood pressure: 118/75, Heart rate, Temperature: 98.2 F, Respiratory rate: 20. Record review of Resident #2's nursing progress note dated 07/31/2024 at 01:00 am., revealed a note stating Resident #2 currently in bed resting no signs and symptoms of pain or discomfort noticed, small bites to right inner elbow, no edema (swelling caused by too much fluid trapped in the body's tissues) noted to the areas. Record review of Resident #2's nursing progress note, dated 08/01/2024 at 09:00 a.m., revealed a note reflecting Resident #2 . new order Benadryl 25 mg via peg tube bid for 7 days . (continued on next page)

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's nursing progress note, dated 08/7/2024 at 10:00 a.m., revealed a note reflecting Resident #2 . day 7/7 Benadryl r/t insect bites Record review of Resident #2's Doctor orders revealed Resident #2 had an order dated 06/01/2024 for Tylenol-Codeine #3 (Acetaminophen with codeine, pain medication) one tablet every four hours as needed for pain via G-tube feeding. Record review of Resident #2's MAR revealed Resident #2 received Tylenol-Codeine #3 (prescription drug used to relieve mild to moderately severe pain that is not well-controlled with over-the-counter medication) one tablet on 07/31/24 at 08:00 a.m., 08/01/24 at 08:00 a.m., and 08/02/2024 at 08:00 a.m. via G-tube feeding, with the note of pain level 6/10, and pain reassessment after medication revealed effectiveness. Observation of Resident #2's assigned room at the facility, on 08/06/2024 at 09:13 AM, revealed Resident #2's bed was located next to the window. Resident #2 was up in the wheelchair, cleaned, groomed, wearing appropriate attire, and connected to G-tube feeding. Ant bites were visible on Resident #2's right side of her neck, and right arm around the anti-cubital fossa (front of the elbow). There were G tube feeding formula spots on the floor, and on the G tube pump pole, and electric wire. No ants were observed in the room. Resident#2 was unable to participate in interview related to severe cognitive impairment. Observation and Interview with the ADON on 08/06/24 at 4:13 PM revealed skin assessment with ADON on Resident #2. Resident had multiple healing ant bites on her right arm, upper chest, neck and face. ADON stated when she came in that night (07/30/24) after the incident it broke her heart to think of Resident #2 lying there, not being able to speak, not being able to call out for help. She stated the ants were crawling on the resident and crawling in the bed linens. She stated the ants were everywhere. Interview on 08/07/24 at 09:51 AM with CNA I revealed she was assigned to care for Resident # 2 on the day of the incident (07/30/2024). CNA I stated during her last rounds on 07/30/24 around 1:00pm, Resident #2 was incontinent of bowel and bladder. CNA I stated she cleaned Resident #2. CNA I stated she did not see ants in Resident # 2's room and/or the Hall 300 hallway on 07/30/24. She stated she could not see if there were ants in the window because the resident's family member covered the window with a blanket. Interview on 08/07/2024 at 10:03 am of LVN B revealed at around 12:45 PM on 07/30/24, she administered routine medication via the G Tube to Resident #2. Interview revealed she pulled the linens away from the resident to administer the G-Tube medication. LVN B stated she did not notice anything on the resident. Observation on 08/07/2024 at 10:07 am of Resident #2's Skin assessment by LVN B with the help of CNA I revealed : 8 ant bites at the middle chest by the neck; 9 ant bites over the right breast; 15 ant bites on the right side of resident neck; 25 ant bites on the right shoulder; 30 ant bites in top of the right arm in front of the elbow; 15 ant bites on the resident's right elbow. Observation and interview revealed Resident # 2 sustained a total of 102 ant bites. Observation on 08/07/2024 at 10:07 am revealed Resident #2's G tube feeding formula drip spots on the floor, and on the G tube pump support, pole, and power cord. (continued on next page)

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 08/07/2024 at 10:16 am of LVN B revealed Resident #2's equipment looked like it needed cleaning from the G Tube formula drip stains. LVN B said it was the responsibility of everyone to clean the formula drip stains, including CNAs, Nurses, and Housekeepers. She stated was going to clean it right way. Interview on 08/07/2024 at 10:18 am of CNA I stated Resident #2's equipment needed a good cleaning from the G tube formula drip stains. Interview revealed she did not know whose responsibility it was to clean the G tube formula drip stains on residents' equipment. She stated she mentioned it to the housekeeper a few days ago, but the housekeeper replied that it was the nurses' responsibility to clean residents' equipment. Interview on 08/07/2024 at 11:13 am over the phone with Resident #2's family member revealed she saw ants in the resident room on 07/21/24. Interview revealed she asked a facility staff member to clean the dirty floor and clean up the G-Tube formula drip stains on the floor. The family member stated the facility did not do anything on 07/21/24. The family member stated on 07/26/24, she saw ants in the resident room. Interview revealed she asked a housekeeping staff member to clean up the floor and the floor mat to remove the G Tube formula drip stains. The family member stated housekeeping did not clean the floor. The family member stated she moved the resident bed , kneeled to clean up the floor and floor mat on 07/26/24. Interview with the family member revealed she visited the resident on the day of the incident, 07/30/24 for about 30 minutes. She stated she did not uncover the resident to look at the resident. The family member stated she saw G Tube feeding formula drip stains on the floor and feeding tube equipment each time she visited the resident. Interview revealed she did not inform the Administrator about the ants, the dirty floor and dirty resident equipment. Interview on 08/07/2024 at 1:14 with CNA H revealed he did not see ants on Resident #2 during his initial rounds on 07/30/24 between 2:30 PM- 3:00PM. CNA H stated at around 4:00pm, he changed Resident #2's brief and that he did not see ants on the resident at that time. CNA H stated at around 6:00PM, the nurse called him to clean the resident and to move Resident # 2 to a different room. CNA H went to the room of Resident # 2 and saw black, tiny ants crawling on Resident # 2. He cleaned the ants off the resident and then moved the resident to a different room. Interview over the phone on 08/07/2024 at 1:22 pm with agency LVN M revealed she saw G Tube formula drip stains on the floor and G Tube equipment. She stated it was not her responsibility to clean the floor and equipment. Interview revealed she did not know whose responsibility it was to clean the floor and resident equipment. Agency LVN M stated at around 6:00PM on 07/30/24, she went to Resident #2's room to administer scheduled medications to Resident #2. Interview revealed she noted ants crawling on the right side of Resident #2's face. She uncovered the resident and there were ants crawling on Resident #2's right arm and right leg. Agency LVN M stated she saw ant bites around Resident #2's neck and arm. Agency LVN M stated she saw black big ants and black small ants crawling on the resident and ants crawling in the linens. She stated she removed the top linens off the resident. Agency LVN M stated she used her hands to remove the ants that were crawling on the resident. Agency LVN M stated she called CNA H to help her. Interview on 08/08/2024 at 08:16 am with contracted Housekeeper II via phone interpreter line with Spanish speaking interpreter revealed she did not see ants in the facility or resident rooms. She denied Resident #2's family member showing her the ants and the request to clean the resident room. Housekeeper II stated another housekeeper told her that in the past, she saw ants in the 200 and 300 Halls. (continued on next page)

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Attempted interview on 08/08/2024 at 08:28 am with contracted Housekeeper HH via phone interpreter line with a Spanish speaking interpreter. There was no answer and a voicemail with instruction to call back was left. No call back received from Housekeeper HH by the date and time of exit. Interview on 08/08/2024 at 10:40 am with contracted Housekeeper Supervisor S stated she had never been notified by housekeeping staff or the other facility staff about ants in the building. She denied been notified of residents' rooms needing to be cleaned. She stated she was made aware of ants in the building on the day of the reported incident (07/30/2024). Interview on 08/08/2024 at 10:44 am with contracted Housekeeper JJ revealed she saw some ants in the last room by the emergency exit door in the Hall #100. She stated maybe there were ants because the resident in that room urinated on the floor sometimes. She stated she did not report it to Contract Housekeeping Supervisor S. Interview on 08/08/2024 at 2:45 pm with the Administrator revealed she did not personally see ants in the facility. The Administrator stated in April 2024, she and the Maintenance Director were notified about ants in the building. Interview revealed the facility called pest control and that pest control came in and treated the building. She stated after that the Maintenance Director would do spot treatments in the facility for pests if anybody reported ants to her. The Administrator stated no resident's family member asked for room cleaning or notified her of ants in the facility. Interview with the Administrator revealed Resident #2's bed was next to the window per the resident's family request. She stated that when she was notified of Resident #2's ant bites incident on 07/30/24, the facility conducted an incident internal investigation. The Administrator stated the investigation process included moving Resident #2 and her roommate to a clean room; notifying Resident #2's family, and primary doctor; and conducting a full skin sweep for all residents in Hall 300. She stated facility staff were in serviced on pest control. She stated the facility staff were instructed to make sure if they noticed ants or insects in the building to inform the management team; and make sure if there was food in the residents' rooms to seal it in a closed container. She stated the G-tube feeding formula spill spots on the resident's linen, floor, and the pump pole was a food source for ants and gnats, and the facility reeducated the staff to clean the area and keep the rooms of residents who had G tube feedings free of any G tube feeding formula dripping spots. Interview on 08/08/2024 at 03:09 pm with the DON revealed she denied seeing ants in the building or being notified by the staff, or residents' family member of the existence of ants. She stated the day of the incident (07/30/2024) Resident #2 was cleaned and removed with her roommate to a clean room. She stated skin, and pain assessments were done for the resident. She stated Resident #2's primary doctor was notified and ordered Kenalog cream to apply to the affected area to ease the skin irritation from ant bites, and continuous with the chronic pain medication order if any signs and symptom of pain and discomfort were noticed on Resident #2. She stated G Tube feeding formula drip spots on the resident's room floor could attract ants, and gnats. She stated she expected nurses, CNAs, and housekeepers to keep residents' rooms clean, and free of any kind of food that could attract ants and gnats. (continued on next page)

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 08/06/24 at 5:08 PM revealed a trail of small ants crawled along the length of the foundation of Hall 100 with two windows cracked open and window screen bent near bottom of the windows. Observation of a crepe [NAME] tree approximately 6 feet from the secure unit and Hall 100 revealed numerous ants of different types crawled around the perimeter of the tree and crawled up the trunk of the tree. Observation on 08/07/2024 at 9:19 AM of the foundation line of Hall 100 revealed a line of small black ants that started from the middle of the building crawled up from cracks in the ground, along the concrete foundation of and below the first line of bricks. The ants entered into cracks in the concrete foundation and cracks between bricks and crawled along the foundation line along Hall 1 and the secure unit hall foundation. Observation on 08/07/24 at 9:29 AM of the outside of the secure unit living room second window revealed one of the secure unit's living room windows was opened and there was a trail of ants that crawled up and into both sides of the window frame. Observation on 08/07/24 at 9:30 AM revealed one resident window on the secure unit had the window opened about 1/8 of an inch, and 3 windows on Hall 100 had windows that were cracked open. Observation of one of the three windows on Hall 1 included window of Resident #13 and Resident #17's from outside revealed their window was cracked open with dead bugs between the window screen and window frame. 3. Review of Resident #28's face sheet undated reflected Resident #28 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Bipolar disorder, Dysphagia (Swallowing disorder), Cognitive Communication deficit, Chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), Respiratory Failure, Schizoaffective disorder (mental health condition combining symptoms of schizophrenia and mood disorders), diabetes and heart failure. Review of Resident #28's Quarterly MDS assessment dated [DATE] reflected Resident #28 had a BIMS score of 12 indicating he was moderately cognitively impaired. Observation on 08/06/24 at 9:26 AM revealed Resident # 28 was in his room lying across his bed dressed. Resident #28 was surrounded by clutter. There were numerous gnats noted swarming around his chest of drawers and bedside table. There was a dirty sheet wadded up on the floor with brown substance. Resident #28 stated he wasted some of his coffee. Resident #28's room smelled of urine. There was a milk crate with dirty clothes. Interview on 08/06/24 at 9:32AM with Contract Housekeeping Supervisor S revealed housekeeping had Resident # 28's room on their high priority cleaning schedule and it should be cleaned twice daily. She stated he hoarded a lot of paper and other stuff. She stated they clean the room twice a day and deep clean it once a week. She stated she knew there were gnats in his room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455806	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terrace at Denison	1300 Memorial Dr Denison, TX 75020

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 08/06/2024 at 10:52 AM of Resident #28's room revealed there was a strong smell of urine and a swarm of small flying insects on the resident's privacy curtain, on his bedside table, his dresser top, on his bed, and on soiled linens tangled and laid on the floor. There were over 25 small flying insects on Resident #28's bedside table with sticky residue and crumbs of food and debris. Observation of Resident #28's bathroom revealed his toilet had a yellow liquid that smelled strongly of urine. Interview on 08/06/2024 at 10:54 AM with LVN A revealed she was aware of the state of Resident #28's room and that he commonly clogged the toilet and hoarded food and trash. Observation on 08/08/2024 at 9:17 AM of Resident #28's room revealed there was soiled linen wrapped and laid on the floor with 5 small flying insects on top. There were large crumbs of food on his bed spread with two flies on top. Observation on 08/09/2024 at 2:22 PM of Resident #28's room revealed he was still in the same room and there was a sticky residue on the bedside table with 18 small flying insects on the bedside table. Observation on 08/11/2024 at 2:25 PM of Resident #28's room revealed he had been moved to a different room. Resident #28 was not in his room and it had a bed that was placed away from the wall and window with a privacy curtain, night stand, and bedside table with mini sodas, instant coffee and a loveseat on the wall next to the entry door. Observation of the floor under Resident #28's loveseat revealed food crumbs and paper trash. Interview on 08/11/2024 at 2:30 PM with CNA X, revealed she had been in-serviced on pests and cleaning of resident rooms and knew there was a binder they put any pest sightings or housekeeping concerns in. She stated that she observed what looked to be food residue on Resident #28's bed spread, a live fly on the bed spread, and that it did not look like the floor under the loveseat had been swept as there were food crumbs and small paper trash. She stated she had not looked at the windowsills of the resident's room yet and planned to at the end of her shift. 4. Review of Resident #39's undated face sheet reflected a [AGE] year-old female with an admitted [DATE] and a re-admitted [DATE]. Diagnoses included dehydration, dysphagia (difficulty swallowing), cerebral vascular accident (stroke), contractures (abnormal and permanant shortening of muscle tissue resulting in reduces movement and flexibility of a part of the body), and unspecified severe protein-calorie malnutrition. Review of Resident #39's quarterly MDS assessment, dated 04/26/24, reflected Resident #39 had BIMS score of 0 which indicated she was severely cognitively impaired. She was totally dependent on all ADLs and always incontinent of bowel and bladder and she received 51% or more of total calories through a feeding tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach). Record review of Resident #39's care plan with a revision date of 07/01/24 reflected, .[Resident #39] require PEG feeding . Observation on 08/07/24 at 11:20 AM revealed while observing incontinent care of Resident #39 there was an ant crawling on the windowsill. Resident #39 was lying in her bed next to the windowsill. (continued on next page)

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 08/07/24 at 11:25 AM revealed three ants were in Resident #39's open window blinds and 1 ant crawling on the windowsill. Resident #39 was connected to g-tube feeding while lying in her bed next to the window where ants were located. The surveyor notified LVN A about ants in Resident #39's room. LVN A moved Resident #39's bed away from window. Observation reveled Resident #39's g-tube pole had drops of feeding on the middle of the pole and on the bottom of the pole and stand along with 4 to 5 drops of feeding to the right of the g-tube pole on the floor. Interview on 08/07/24 at 11:32 AM with LVN A revealed the g-tube feeding pole did have drops of feeding on the g-tube pole and it needed to be cleaned along with the floor. LVN A stated she would move Resident #39 to another room due to ants in the resident's window. She stated she did not see any ants on the resident's bedding. 5. Review of Resident #25's face sheet dated 08/08/24 reflected Resident #25 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Diabetes, Chronic Obstructive Pulmonary Disease, Dysphagia, Hemiplegia (Paralysis) on left side, End Stage Renal Disease, Seizure Disorder, Heart Failure and Legal Blindness. Review of Resident #25's quarterly MDS assessment dated [DATE] reflected Resident #25 had a BIMS score of 15 indicating he was cognitively intact. It reflected Resident #25 required substantial/maximal assistance with toileting. Review of Resident #25's Comprehensive Care Plan last updated 06/24/24 reflected Resident #25 was at risk for falling R/T (related to) impaired mobility and impaired vision. Has left bka (below knee amputation) with prosthetic. Intervention included Assure the floor is free of glare, liquids, foreign objects. Observation on 08/06/24 at 12:01 PM revealed Resident #25's room had a yellowish stain on the floor from the closet and inside the closet there was wetness on the closet floor with Resident #25's clothing on the floor. There was a strong odor in resident room and 2 flies on the bedside table and landing on his bed while Resident #25 was sitting in the middle of the bed. There was bubbling on the wall between the window and the closet. There was bubbling on the walls between the closet and bathroom door for Resident #25. Resident #25's bed was next to the window and the window sill had particles and dead bugs on it. Interview with Resident #25 revealed he was blind and could not see if there were any ants in his room. He stated he had flies and gnats in his room and knew they were there because the flies landed on him. Observation on 08/06/24 at 12:04 PM of Resident #28's bathroom revealed the sink was dripping into a plastic cup with a spoon in it and his toilet had yellowish/brownish stains in the toilet with the floor having yellowish/brownish stains around the toilet on the floor. Resident #28's bathroom floor was sticky with stains and wetness covering the floor. Interview on 08/07/24 at 2:31 PM with Contract Housekeeping Supervisor S revealed Resident #28 stored a lot of stuff, spilled drinks and spits on the floor. She stated Resident #28 had flies and gnats in his room. She stated Resident #17's bathroom had spills on it and Resident #17 urinated on the floor. She was aware of flies in Resident #17's room before. She stated Resident #28 had flies and gnats in his room. (continued on next page)

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F 0925 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 08/07/24 at 3:20 PM with the Administrator revealed she was aware of the gnats in Resident #28's room but the resident hoarded and kept food in his room. She stated she was not aware of any ants coming in residents' rooms since Resident #2 had gotten bit by ants and ants were found on her and her bedding. She stated Maintenance sprayed the ants that evening on 07/30/24 and pest control came out on 07/31/24 to spray ants. She stated DON in-serviced the staff after the incident with Resident #2 having ant bites and ants found in her room on 07/30/24. She stated she had not in-serviced housekeeping about pests and cleanliness. She stated Maintenance Director was addressing the pest control. 6. Observation and Interview on 08/06/24 at 10:02 AM revealed Resident #4 had noticed the flies and the gnats in her room since it had gotten warmer especially with her food left in her room. Gnat flying around landing on her styrofoam cup. Her breakfast tray was still in her room. 2 Flies noted in resident room landing on bedside table and bedding. Observation of the main dining room on 08/06/2024 at 1:55 PM revealed all the dining room tables had various amounts of food crumbs, smears, and drink residue on their surfaces and there were 2 flies in the dining room. In confidential group interview on 08/06/2024 at 2:00 PM with 9 residents revealed their biggest concern regarded housekeeping and they had brought up the concern in previous meetings with the Activity Director. Residents stated that the gnats and flies were another concern and that the gnats really bothered them when they flew around their face or landed on them. Residents stated that the flies bothered them a lot and that housekeeping had not wiped down the dining room tables after lunch, which was about 2 hours ago, and there was still food residue and crumbs and sticky drink residue on the tables. The residents stated there were numerous flies and gnats throughout the facility, in the common areas, and sometimes in their rooms. They stated they had not observed ants. All residents in the confidential group meeting stated they felt that the lack of housekeeping quality and frequency bothered them greatly because it felt gross when things were dirty. Interview on 08/07/24 at 8:25 AM with Maintenance Director revealed he would attempt to contact the main number to get hold of Pest Control Service Tech P for surveyor. He stated Pest Contr [TRUNCATED]