STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455893	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Care Center of Henrietta	807 W Bois D Arc Henrietta, TX 76365

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41871 Based on observation, interview, and record review, the facility failed to promote and facilitate resident self-determination through support of resident choice, for 1 of 7 (Resident #1) residents reviewed for resident rights. The facility failed to provide Resident #1 hospice care per resident's request. This failure placed residents at risk of their rights to make choices about their life being disregarded. Findings include: Record Review of Resident #1 Admission Record dated 02/22/25 revealed Resident #1 was an [AGE] year-old female with an original admitted [DATE] with the latest return date of 02/06/25. Resident had a diagnosis of multiple myeloma in remission (bone cancer) and Poly osteoarthritis (a form of arthritis that affects multiple joints simultaneously. This condition is characterized by the degeneration of cartilage and the underlying bone within a joint, leading to pain, stiffness, and impaired movement). The resident was her own responsible party. Record review of Resident #1's Admission MDS, dated [DATE] revealed Resident #1 had a BIMS score of 13 (cognitively intact). Her pain assessment was negative for the 5-day look back period. Record review of Resident #1's Care Plan on 02/16/25 revealed a care plan for pain related to multiple myeloma, osteoarthritis, and skin blisters. Record review of Resident #1 electronic record revealed the Resident #1 requested hospice services on 02/16/25 due to uncontrolled pain. The facility physician wrote an order for hospice services on 02/16/25 and an order for Tylenol 3 every 4 hours as needed for pain. A progress note dated 02/16/25, by LVN A revealed Corporate is to be notified before any ancillary services are permitted into the facility. DON to send email to proper corporate person. Record review of Resident #1's pain levels revealed on 02/16/25, Resident #1 started experiencing pain at a pain level of 8 and constantly stayed at a high level since that time with intermittent reduction related to pain medication administration. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Medication Administration Record for February 2025, revealed she was prescribed: Acetaminophen-Codeine Oral Tablet 300-30mg at bedtime for Poly osteoarthritis and Multiple Myeloma in relapse with an order date of 02/16/25 and Acetaminophen-Codeine Oral Tablet 300-30mg every 4 hours as needed for pain with an order date of 02/16/25. In an interview during the entrance conference on 03/07/25 at 9:30 am, LVN A stated Resident #1 has requested hospice services on 02/16/25 but the CEO had not approved the services. She said Resident #1 was in pain, the Facility Physician has ordered pain medication, but it only helped some. In an interview and observation with Resident #1 on 02/23/25 at 12:30 pm, the resident was sitting up in her recliner very still and stiff and did not move any part of her body throughout the conversation. She expressed that she was in a lot of pain , especially in her right shoulder. She rated her pain at an 8 on a scale of 1-10 and said her pain never gets below a 6. She said she received pain medications, but they only help a little and just takes the edge off. She said she would like hospice services to help with pain. She said she requested hospice services but did not know the status of hospice care. In an interview with the DON on 02/24/25 at 10:50 am, she said the CEO had to approve hospice services before they could proceed with getting the resident hospice care. She said she emailed the owner of the facility on 02/17/25 requesting hospice services for Resident #1. The DON provided documentation of the email. Stated the Owner never responded to the e-mail. In a record review of an e-mail dated 02/17/25 at 11:05 am from the Director of Nursing to the CEO, the DON requested Patient Care Coordination as Resident #1 has expressed interest in initiating care with hospice. Can we please being the process to set this up? In an interview on 02/25/25 at 9:30 am with Resident #1 's POA, she said Resident #1 expressed to her on 02/16/25 that she wanted hospice services due to pain. She said she talked to Resident #1 daily on the phone and Resident #1 had expressed to her that she had been a lot of pain daily. She said she was told by the facility that corporate had to approve hospice care before hospice services could be obtained and are waiting on that to happen. She said she was upset due to the long time it was taking to get Resident #1 on hospice services to help with her pain. In an interview with the DON on 02/25/25 at 10:00 am, she said she went ahead and contacted hospice services for Resident #1 without the permission of the CEO due to the resident being in pain. In an interview with the facility physician on 02/25/25 at 12:00 pm, she said the facility contacted her on 02/16/24 that Resident #1 was requesting hospice services per patient request and that she was in pain. She said she wrote an order for hospice services on 02/16/24 and an order to increase her pain medication. She said it was her expectation the order would be carried out the same or next day as it was a critical situation and you do not know what the resident is going through. She said she was informed by the facility the CEO had to approve hospice services before they could be started. She said this was the first time this had happened, and the facility did not give an explanation as to why. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/25/25 at 3:15 pm, The DON stated the CEO just contacted her and would not approve hospice services for Resident #1 until the hospice company contacted him personally . She said she gave the information to the hospice company. In an interview with the CEO on 02/25/25 at 4:20 pm, he stated hospice contracts had to be reviewed on a case-by-case basis. He said Resident #1 could have hospice care, but a contract had to be signed first, he said he contacted the Human Resource Director this morning to sign a contract for hospice services. When the CEO was informed it had been 8-days since Resident #1 requested hospice services at this time due to the resident being in pain, he said he felt like it was an adequate response time by the facility for the resident to be placed on hospice services . In an interview with the CEO on 02/25/25 at 4:55 pm, he said Resident #1 had been placed on hospice services. In an interview on 02/26/25 at 1:00 pm, the Social Worker she said an acceptable time for a resident to be placed on hospice services would be 24 to 48 hours. Record review of the facility policy Resident Rights, dated a revised December 2016, revealed the following [in part]: Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: e. self-determination f. communication with and access to people and services, both inside and outside the facility h. be supportive by the facility in exercising his or her rights s. choose an attending physician and participate in the decision-making regarding his or her care. In a record review of the facility policy Hospice Program, dated Quarter 2, 2020, revealed the following [in part]: Policy statement: Hospice services are available to residents at the end of life. Policy Interpretation and Implementation: 8. When a resident has been diagnosed as terminally ill, the Director of Nursing/designee will contact the hospice agency and request that a visit /interview with the resident/family be conducted to determine the resident's wishes relative to participation in the hospice program.

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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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. 41871 Based on observation, interview, and record review, the facility failed to provide a working telephone for the residents to use. The facility failed to pay their phone vendor and phone services were terminated on 02/07/25. This failure could leave residents without the contact from their family/representative which could make them feel isolated. Findings included: Interview on 02/22/25 at 01:45 PM with the Human Resource Director, she stated the facility phone was cut off on 02/07/25 and has never been turned back on. She said an anonymous staff member purchased a prepaid cell phone out of their own pocket on 02/10/25 so that the residents and their families could communicate with each other. She said the residents did not have access to a facility phone from 02/07/25 to 02/10/25. Interview on 2/22/25 at 02:50 PM with family member of Resident #5 stated she has difficulty getting through to the facility as the phone will ring and no one will answer. She was not aware the phone service had been disconnected. Interview on 2/23/25 at 10:15am with LVN E stated resident's families have expressed frustration about not being able to contact the facility or their loved ones. Interview on 2/24/25 at 2:00pm with Ombudsman stated it is hard to contact the facility. She said family members have contacted her regarding their concern about the inability to call the facility. Interview on 2/27/25 at 10:25am with Social Worker stated she had resident families call her personal cell phone 2- 3 times per week for the past 3-4 weeks complaining about not being able to contact family members in the facility and stated many of them very worried about loved ones. Observation on 2/28/25 at 12:40pm this investigator tried to contact facility phone number and it gave a busy signal. Interview on 3/10/25 at 2:23pm with family member of resident #7 stated the facility phones are not working and it has made it difficult to contact her family member. Interview on 3/13/25 at 3pm with resident #14 stated the phones don't work and she cannot call her mom. Observation on 3/16/25 at 9:43am this investigator tried to contact facility phone number and it gave a busy signal. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 3/17/25 at 9:05am with DON stated she calls the facility phone number from her personal cell every day to see if the phone is working because the CEO says he paid the bill, but it is not on. Observation on 3/17/25 at 9:50am investigator tried to contact facility phone number and it gave a busy signal. Record review of Resident Rights policy dated December 2016 revealed f. communication with and access to people and services, both inside and outside the facility .cc. access to a telephone, mail and email.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47044 Based on interview and record review the facility failed to ensure the resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 4 (Resident # 1, Resident #2, Resident #9, Resident #11) of 14 residents reviewed for Quality of Care. The facility failed to ensure Residents #2, #9, and #11 made it to their scheduled doctor appointments for follow up and other scheduled appointments. The facility failed to provide needed care and services in accordance with Resident #1's preferences to attain hospice services. This failure could affect the ability for residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Findings included: Observation on [DATE] at 1:15 pm revealed the facility Van appeared dusty inside. The registration tags expired ,d+[DATE]. In an interview on [DATE] at 10:00 am the Human Resource Director stated the van registration was not completed and had expired in December. The Human Resource Director stated it had not been renewed due to the petty cash account was not accessible. She stated no residents went out to the hospital. In an interview on [DATE] at 10:16 am the vehicle insurance company stated the policy was cancelled and would not provide the date it was cancelled. Record review of electronic file for Resident #9 revealed he was a [AGE] year-old male with admitted [DATE]. Resident #9 had diagnoses of acute on chronic diastolic (congestive) heart failure (weakening of heart when heart can't pump blood to give normal supply), type 2 diabetes mellitus with diabetic chronic kidney disease (adult onset diabetes and kidneys damaged due to high blood sugar levels), atherosclerotic heart disease of native coronary artery without angina pectoris (buildup of plaque inside arteries causing heart disease), benign prostatic hyperplasia with lower urinary tract symptoms (non-cancerous enlargement of prostate gland), chronic kidney disease, stage 3 unspecified (mild to moderate kidney damage and may struggle to filter waste), pressure ulcer of right ankle, unstageable (wound where base is covered by slough making it impossible to determine true depth). The Resident was his own responsible party. In an interview on [DATE] at 10:50 am the DON stated she saw the documentation a few weeks ago that the insurance policy for the van was canceled. She stated Resident #9 had missed some doctors' appointments due to the van situation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 11:00 am LVN E stated Resident #9 had an appointment on [DATE] with the nephrologist that had not been rescheduled as of this date, and an appointment with the cardiologist on [DATE] that had been rescheduled for [DATE] that were missed due to not having the facility van insurance. In an interview on [DATE] at 12:25pm CNA H stated she stopped driving residents in the van in January due to the van not having insurance. In an interview on [DATE] at 12:50 pm the DON stated there was no log of van usage because it has not been used due to no van insurance. In an interview on [DATE] at 9:00 am the vehicle insurance company stated the insurance policy was not reinstated. Record review of electronic file for Resident #2 revealed she was a [AGE] year-old female with an original admitted [DATE] with the latest return date of [DATE]. Resident #2 had diagnoses of Alzheimer's disease (disease that destroys memory and other important mental functions), type 2 diabetes mellitus with diabetic chronic kidney disease (kidneys damaged due to high blood sugar levels), anemia (low iron), diverticulosis of both small and large intestine without perforation or abscess without bleeding (small bulging pouches that can form in lining of digestive tract), urinary tract infection (bladder infection). The resident was her own responsible party. In an interview on [DATE] at 9:00 am LVN A stated Resident #2 was having light vaginal bleeding and physician A wanted to see her and we could not send her due to the van not having insurance. LVN A said physician A said she would come to the facility. In an interview on [DATE] at 11:03 am the DON stated Resident #2 was having light vaginal bleeding on [DATE]; They contacted physician A and wanted her to be brought to her office but told Physician A they were not able to transport the resident due to no insurance on the van. Physician A said she would come up to the facility to see the resident but never did. The resident was transferred to theER on [DATE] via hospital ambulance. Record review of hospital record for Resident #2 reflected No new orders. Still Has UTI. All bleeding was negative. Transvaginal ultrasound was negative. All labs good. X-rays completed with no findings. Record review of electronic file for Resident #11 revealed she was a [AGE] year-old female with an admitted [DATE]. Resident #11 had diagnoses of type 1 diabetes mellitus with diabetic chronic kidney disease (juvenile diabetes and kidneys damaged due to high blood sugar levels), chronic kidney disease (kidney failure), type 1 diabetes mellitus with diabetic neuropathy (nerve damage caused by persistent high blood sugars), essential (primary) hypertension (high blood pressure), neuromuscular scoliosis, lumbar region (sideways curvature of spine), hyperlipidemia (high fat in blood), legal blindness, deficiency of other specified b group vitamins (B vitamin levels lower than normal), magnesium deficiency (levels lower than normal), vitamin d deficiency (levels lower than normal), hypokalemia (high potassium), elevation of levels of liver transaminase levels (liver damage), other seizures (uncontrolled jerking, loss of consciousness, other symptoms caused by abnormal electrical brain activity). The Resident was her own responsible party. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 11:00 am LVN E stated Resident #11 had an appointment scheduled for [DATE] with physician B that was missed due to not having the facility van insurance. In an interview on [DATE] at 8:24 am Physician B stated Resident #11 had an appointment with him yesterday, but the facility called and cancelled, stated they didn't have enough staff. In an interview on [DATE] at 12:00 pm Physician A stated she was not aware residents missed doctor appointments due to no insurance on the van. Physician A stated she was not informed by the facility about Resident #9's missed cardiology and kidney appointments and said those appointments were considered critical to attend. Physician A stated the facility called and Resident #2 reported bleeding from her vaginal area; Physician A said she asked them to bring her to her office, but they stated they could not due to no insurance on the van. Record review of an appointment book revealed Resident #11 missed an appointment on [DATE] with the Primary care doctor; Resident #9 missed an appointment on [DATE] with the cardiologist and it was rescheduled for [DATE]. Resident #9 missed an appointment on [DATE] with the kidney doctor. Record review of progress notes dated [DATE] by LVN E revealed Resident #11 Rescheduled residents appt today due to unable to transfer in company van. Rescheduled for [DATE] at 9:30am. Record review of Transportation, Social Services policy dated [DATE] revealed Our facility shall help arrange transportation for residents as needed. Record review of Resident #1's Admission Record dated [DATE] revealed Resident #1 was an [AGE] year-old female with an original admitted [DATE] with the latest return date of [DATE]. Resident #1 had diagnoses of multiple myeloma in remission (bone cancer) and Poly osteoarthritis (a form of arthritis that affects multiple joints simultaneously. This condition is characterized by the degeneration of cartilage and the underlying bone within a joint, leading to pain, stiffness, and impaired movement). The resident was her own responsible party. Record review of Resident #1's Admission MDS, dated [DATE] revealed Resident #1 had a BIMS score of 12 (moderate cognitive impairment). Record review of Resident #1's care plan, dated as revised on [DATE] revealed the following [in part]:Focus: [Resident #1] has pain related to multiple myeloma, osteoarthritis, and skin blisters. Goal: The resident will not have an interruption in normal activities due to pain through the review period. Interventions: *Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. * Resident will not have an interruption in normal activities due to pain. *Comfort will be maintained. *Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Record review of Resident #1's Physician Orders revealed the following: A. May have hospice of resident choosing, evaluate for service, start date of [DATE]. B. Tylenol with Codeine #3 tablet ,d+[DATE]mg at bedtime for Poly osteoarthritis and Multiple Myeloma in Relapse with a start date of [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Tylenol with Codeine #3 tablet ,d+[DATE]mg every 4 hours as needed for Poly osteoarthritis and Multiple Myeloma in Relapse with a start date of [DATE]. Record review of Resident #1's electronic record revealed Resident #1 requested hospice services on [DATE] due to uncontrolled pain. The facility physician wrote an order for hospice services on [DATE] and an order for Tylenol #3 at bedtime and Tylenol #3 PRN every 4 hours as needed for pain. A progress note dated [DATE], by LVN A revealed Corporate is to be notified before any ancillary services are permitted into the facility. DON to send email to proper corporate person. In an interview on [DATE] at 10:50 a.m., the DON said she was aware Resident #1 was expressing pain that was not resolved with current treatment. The facility Physician increased her pain medication and referred resident to Hospice on [DATE]; however, Hospice could not be obtained because it required the CEO's approval. The DON provided e-mail communication with the CEO requesting hospice services. In a record review of an e-mail dated [DATE] at 11:05 a.m., from the Director of Nursing to the CEO, the DON requested Patient Care Coordination as Resident #1 has expressed interest in initiating care with hospice. Can we please begin the process to set this up? In a record review of a progress note dated [DATE] at 9:06 a.m. revealed, Resident #1 asked the LVN When is the hospice person coming to see me. In an interview on [DATE] at 9:30 a.m., Resident #1's POA said Resident #1 expressed to her on [DATE] that she wanted hospice services due to pain. She said she was told by the facility that corporate had to approve hospice care and they were waiting on that. She said she was upset and did not know why it was taking so long for Resident #1 to be placed on hospice services. In an interview on [DATE] at 10:00 a.m., the DON reported she went ahead and contacted hospice services on this date for Resident #1 without the permission of the CEO. In an interview on [DATE] at 12:00 p.m., facility Physician A said the facility contacted her on [DATE] as Resident #1 was requesting hospice services because her pain was not resolving with current regiment. She said on [DATE] she ordered for Tylenol #3 at bedtime and Tylenol #3 PRN every 4 hours and referred her to hospice for more effective pain management. She said it was her expectation the order would be carried out the same day ordered if possible as it was a critical situation and you do not know what the resident is going through. She said she was informed by the facility the CEO had to approve hospice services for a resident before they would be evaluated for services. She said this was the first time that [a resident was not provided hospice directly after Physician put in order]had happened. In an interview on [DATE] at 4:20 p.m., the CEO stated hospice contracts have to be on a case-by-case basis and a contract had to be signed first. He said he contacted the Human Resource Director this morning to get a contract signed. When informed it had been 8-days since Resident #1 requested hospice services and the resident had been experiencing uncontrolled pain, he said he felt like it was an adequate response time by the facility for the resident to be placed on hospice services. In a follow-up interview on [DATE] at 4:55 pm, the CEO reported Resident #1 was now on hospice services. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident Rights policy dated [DATE] revealed f. communication with and access to people and services, both inside and outside the facility.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41871 Based on observation, interview, and record review, the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 7 (Resident #1) residents reviewed for pain. The facility failed to manage Resident #1's pain at an acceptable level per her preference until hospice services could be obtained. It took the facility 8-days to arrange hospice services. This deficient practice could place residents at risk of increased pain, discomfort, being unable to perform daily activities, psychological effects, and a diminished quality of life. Findings included: Record review of Resident #1's Admission Record dated 02/22/25 revealed Resident #1 was an [AGE] year-old female with an original admitted [DATE] with the latest return date of 02/06/25. Resident #1 had diagnoses of multiple myeloma in remission (bone cancer) and Poly osteoarthritis (a form of arthritis that affects multiple joints simultaneously. This condition is characterized by the degeneration of cartilage and the underlying bone within a joint, leading to pain, stiffness, and impaired movement). The resident was her own responsible party. Record review of Resident #1's Admission MDS, dated [DATE] revealed Resident #1 had a BIMS score of 12 (moderate cognitive impairment). MDS was negative for pain. Record review of Resident #1's Pain assessment dated [DATE] revealed the resident expressed pain in the last 5 days, pain was frequent, hard to sleep at night. It stated Resident #1 was ordered Tylenol #3 for 7 days on previous admission but was admitted to the hospital before regimen was completed. Medication was not reordered when Resident #1 was readmitted . Revealed resident is repositioned and is somewhat effective. Record review of Resident #1's care plan, dated as revised on 02/16/25 revealed the following [in part]: Focus: [Resident #1] has pain related to multiple myeloma, osteoarthritis, and skin blisters. Goal: The resident will not have an interruption in normal activities due to pain through the review period. Interventions: *Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. * Resident will not have an interruption in normal activities due to pain. *Comfort will be maintained. *Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Record review of Resident #1's Physician Orders revealed the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Care Center of Henrietta	807 W Bois D Arc Henrietta, TX 76365

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Monitor for pain every shift, use 1-10 scale for alert residents and use pain aide for confused residents, document which pain scale used to assess residents pain rating, start date of 01/30/25. B. May have hospice of resident choosing, evaluate for service, start date of 02/16/25. C. Tylenol with Codeine #3 tablet 300-30mg at bedtime for Poly osteoarthritis and Multiple Myeloma in Relapse with a start date of 02/16/25. D. Tylenol with Codeine #3 tablet 300-30mg every 4 hours as needed for Poly osteoarthritis and Multiple Myeloma in Relapse with a start date of 02/16/25. Record review of Resident #1's electronic record revealed Resident #1 requested hospice services on 02/16/25 due to uncontrolled pain. The facility physician wrote an order for hospice services on 02/16/25 and an order for Tylenol #3 at bedtime and Tylenol #3 PRN every 4 hours as needed for pain. A progress note dated 02/16/25, by LVN A revealed Corporate is to be notified before any ancillary services are permitted into the facility. DON to send email to proper corporate person. In a record review of an e-mail dated 02/17/25 at 11:05 a.m., from the Director of Nursing to the CEO, the DON requested Patient Care Coordination as Resident #1 has expressed interest in initiating care with hospice. Can we please begin the process to set this up? In an observation and interview with Resident #1 on 02/23/25 at 12:30 p.m., the resident was sitting up in her recliner very still and stiff and didn't move her body throughout the conversation. She expressed that she was in pain. She said that she received pain medications, but they only help a little. She said her pain was currently at a level 6. She said her pain never got below a 6 with medication, just took the edge off. She said that she would like hospice services to help with pain. She said she requested hospice services but did not know the status of hospice care. Record review of the MAR revealed the resident had received pain medication on 2/23/25 at 12:00 pm. With a follow up pain score of 2- effective at 2:20pm. Record review of Resident #1's progress notes and MAR reflected they failed to have documentation of the physician order to monitor pain every shift as ordered on 01/30/25. Record review of Resident #1's MAR for February 2025 revealed the resident did not receive her schedule Tylenol #3 at bedtime on 02/15/25 and 02/21/25. No adverse effect noted. In an interview on 02/24/25 at 10:50 a.m., the DON said she was aware Resident #1 was expressing pain that was not resolved with current treatment. The facility Physician increased her pain medication and referred resident to Hospice on 02/16/25; however, Hospice could not be obtained because it required the CEO's approval. The DON provided e-mail communication with the CEO requesting hospice services. In a record review of a progress note dated 02/24/25 at 9:06 a.m., Resident #1 asked the LVN When is the hospice person coming to see me. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/25/25 at 9:30 a.m., Resident #1's POA said Resident #1 expressed to her on 02/16/25 that she wanted hospice services due to pain. She said that she talks to Resident #1 daily on the phone and Resident #1 has expressed to her that she was in a lot of pain. She said she was told by the facility that corporate had to approve hospice care and they were waiting on that. She said she was upset and did not know why it was taking so long for Resident #1 to be placed on hospice services. In an interview on 02/25/25 at 10:00 a.m., the DON reported she went ahead and contacted hospice services on this date for Resident #1 without the permission of the CEO. In an interview on 02/25/25 at 12:00 p.m., the facility Physician A said the facility contacted her on 02/16/25 as Resident #1 was requesting hospice services because her pain was not resolving with current regiment. She said on 02/16/2 she ordered for Tylenol #3 at bedtime and Tylenol #3 PRN every 4 hours and referred her to hospice for more effective pain management. She said it was her expectation the order would be carried out the same day ordered if possible as it was a critical situation and you do not know what the resident is going through. She said she was informed by the facility the CEO had to approve hospice services for a resident before they would be evaluated for services. She said this was the first time that had happened. Record review of Resident #1's electronic record revealed: 2/16/25 at 2:45pm, pain score of 7. PRN pain medication given, and it was effective. 2/17/25 at 4:03am, pain score of 5. PRN pain medication given, and it was effective. 2/19/25 at 8:14am, pain score of 7. PRN pain medication provided, and it was effective. 2/20/25 at 12:35am, pain score of 4. PRN pain medication provided and was effective. 2/20/25 at 3:19pm, pain score of 7. PRN pain medication provided, and it was effective. 2/21/25 at 8:47am, pain score of 7. PRN pain medication given, and it was effective. 2/23/25 at 11:49pm, pain score of 7. PRN pain medication provided, and it was effective. 2/24/25 at 9:02am, pain score of 8. PRN pain medication provided, and it was effective. 2/24/25 at 1:03pm, pain score of 7. PRN pain medication provided, and it was effective. 2/25/25 at 5:01am, pain score of 8. PRN pain medication provided, and it was effective. In an interview on 02/25/25 at 4:20 p.m., the CEO stated hospice contracts have to be on a case-by-case basis and a contract had to be signed first. He said he contacted the Human Resource Director this morning to get a contract signed. When informed it had been 8-days since Resident #1 requested hospice services and the resident had been experiencing uncontrolled pain, he said he felt like it was an adequate response time by the facility for the resident to be placed on hospice services. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow-up interview on 02/25/25 at 4:55 pm, the CEO reported Resident #1 was now on hospice services. In an interview on 02/27/25 at 9:50 am, Physician A said the facility did not contact her regarding Resident #1's breakthrough pain she was experiencing. She said it was her expectation the facility should have contacted her. She said she would have prescribed something different until she was placed under hospice care. In an interview on 2/28/25 at 12:30 pm, the DON said she was not aware that Resident #1 did not receive her scheduled Tylenol #3 at bedtime on 02/15/25 and 2/21/25. In a follow up interview on 4/7/25 at 12:38pm, Physician A stated that if pain improved, she considers that effective but if not then it is not effective. Physician A said it depends on the patient. Physician A ordered hospice services for Resident #1 due to patient preference and terminal prognosis. Physician A stated Resident #1's pain is being managed now and she believes it took a minute [last break through pain noted on 2/28/25] when Hospice took over to prevent breakthrough pain. Physician A stated Hospice can provide care and comfort and that is their purpose. In an interview on 4/7/25 at 4:30pm with LVN D, she stated that Resident #1 had never told her the medications were not effective and Resident #1 could tell her if it was effective or not effective and she went by what Resident #1 told her. In an interview on 4/7/25 at 4:49pm with LVN D, she stated that she considers pain medication effective if residents tell her it is effective or if she goes back and they are asleep. She stated Resident #1 never told her it wasn't effective. A record review of the facility policy Pain assessment and Management, not dated, revealed the following [in part]: Purpose: The purpose of this procedure is to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. Monitoring and Modifying Approaches: 1. Reevaluate the resident's pain and consequences of pain at least each shift or significant changes in levels of chronic pain and at least weekly in stable chronic pain. 2. Monitor the following factors to determine if the resident's pain is being adequately controlled: a. The resident's response to interventions and level of comfort over time. 4. If pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated. Documentation: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Document the resident's reported level of pain with adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program. Reporting: Report the following information to the physician or practitioner: 1. Significant changes in the level of the resident's pain. 3. Prolonged, unrelieved pain despite care plan interventions.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41871 Based on record review and interviews, the facility failed to use the services of a registered nurse (RN), for at least 8 consecutive hours a day, 7 days a week for 3 of 12 months (January 2025, February 2025, and March 2025) reviewed for RN coverage. The facility failed to ensure that an RN worked 8 consecutive hours a day, seven days a week for 28 of 47 days. This failure placed the residents at risk for not having decisions made that would have required an RN to make in the management of the residents' healthcare needs and in managing and monitoring of the direct care staff. Findings include: In a record review and interview on 02/23/25 at 10:00 am, the Human Resource Director provided the Nurse Staffing Information from January 1, 2025, to February 21, 2025. It revealed there was no RN coverage for dates of 01/01/25, 01/02/25, 01/03/25, 01/04/25, 01/05/25, 01/06/25, 01/07/25, 01/08/25, 01/09/25, 01/10/25, 01/11/25, 01/12/25, 01/13/25, 01/14/25, 01/15/25, 01/16/25, 01/17/25, 01/18/25, 01/19/25, 01/20/25, 01/26/25, 01/27/25, 02/01/25, 02/02/25, 02/08/25, 02/09/25, 02/15/25, and 02/16/25, 03/01/25 and 03/04/25. The Human Resource Director confirmed there was no RN coverage for the dates. She said the DON was out on medical leave and returned on 01/21/25. The DON works Monday-Friday. There is no RN coverage for the weekends, but staff can call the DON if needed. In an interview on 02/23/25 at 10:50 am, the DON said she was on medical leave and returned to the facility on [DATE]. She said during the time she was off, there was no RN coverage for the building. She said she only works Monday-Friday so there is no RN in the facility on the weekends, but staff can call her if needed. In an interview on 02/25/25 at 4:20 pm, the CEO said the DON works Monday - Friday and no one has applied for the RN position to cover the weekend. He said the DON is available by phone if needed. In an interview on 02/28/24 at 12:30 pm, the DON said possible negative outcomes of not having a RN coverage is a resident might not be accessed correctly and it would be hard to run a code. A facility policy was requested but not provided by the time of exit. A policy was requested but not provided by the time of exit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41871 Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of each resident for 12 of 12 residents (Resident's #1, #2, #3, #4, #5, #6, #7, #8, #9, #11, #15, #16) during medication pass. A: Resident #7 and Resident #5 did not receive medications at 8:00 am medication pass. B: CMA F administered Resident's #2, #3, #4, #6, #8, #9, #11, #15, #16 medications greater than one hour after the scheduled administration time on [DATE]. C: CMA F operated outside of her scope of practice by administering an initial dose of a narcotic to Resident #1 and assessed Resident #1's pain. These failures could place residents at risk for adverse outcomes to resident care and/or services and may also include the potential for physical and psychosocial harm. Findings Include: A. Resident #7 Record review of Resident #7's Admission Records, dated [DATE], revealed an [AGE] year-old female, with the latest admitted [DATE]. Diagnosis included congestive heart failure (the heart cannot pump blood effectively), dementia (progress decline in cognitive functioning), hypertension (high blood pressure), and presence of cardiac pacemaker (implanted medical device to regulate the heartbeat). Record review of Resident #7s Quarterly MDS, dated [DATE] revealed a BIMS score of 15 (cognitively intact). Record review of Resident #7's Physician's Order Summary Report dated [DATE] revealed the following orders: Amiodarone HCl for atrial fibrillation 100mg at 0800. Order date of [DATE]; Amlodipine Besylate 5mg for atrial fibrillation at 0800. Order date of [DATE]; B12 Fast Dissolve 5000mg for B12 deficiency at 0800. Order date of [DATE]; Folic acid 1mg for anemia at 0800. Order date of [DATE]; Furosemide 20mg for diastolic heart failure at 0800. Order date of [DATE]; Med plus 2.0. at 0800. Order date of [DATE]; Pantoprazole sodium 40mg for GERD at 0800. Order date of [DATE]; Potassium chloride ER 20meq for hyperkalemia at 0800. Order date of [DATE]; Probiotic acidophilus oral capsule for UTI at 0800. Order date of [DATE]; Vitamin C 1000mg for allergic rhinitis at 0800. Order date of [DATE]; Gabapentin 300mg for polyneuropathy at 0800. Order date of [DATE]; Muro 128 ophthalmic ointment 5% for eyes at 0800. Order date of [DATE]; Tropism chloride oral tab 20mg for overactive bladder at 0800. Order date of [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's MAR for [DATE] revealed the resident did not receive the following medications on [DATE]: Amiodarone HCl for atrial fibrillation 100mg at 0800. Order date of [DATE]; Amlodipine Besylate 5mg for atrial fibrillation at 0800. Order date of [DATE]; B12 Fast Dissolve 5000mg for B12 deficiency at 0800. Order date of [DATE]; Folic acid 1mg for anemia at 0800. Order date of [DATE]; Furosemide 20mg for diastolic heart failure at 0800. Order date of [DATE]; Med plus 2.0. at 0800. Order date of [DATE]; Pantoprazole sodium 40mg for GERD at 0800. Order date of [DATE]; Potassium chloride ER 20meq for hyperkalemia at 0800. Order date of [DATE]; Probiotic acidophilus oral capsule for UTI at 0800. Order date of [DATE]; Vitamin C 1000mg for allergic rhinitis at 0800. Order date of [DATE]; Gabapentin 300mg for polyneuropathy at 0800. Order date of [DATE]; Muro 128 ophthalmic ointment 5% for eyes at 0800. Order date of [DATE]; Tropism chloride oral tab 20mg for overactive bladder at 0800. Order date of [DATE]. In an interview with Resident #7 on [DATE] at 2:45 pm, she said there was one day when she didn't get any meds but couldn't remember the day. She denied having any negative consequences due to the missed medications. Resident #4 Record review of Resident #5's Admission Record, dated [DATE], revealed an [AGE] year-old female, was a last admitted [DATE]. Diagnosis included cerebral infarction (stroke) and hypertension (high blood pressure). Record review of Resident #5's Quarterly MDS, date [DATE] revealed the resident had a BIMS score of 04 (severe impairment). Record review of Resident #5's Physician's Order Summary Report dated [DATE] revealed the following orders: Aspirin delayed release 81mg for cerebral infarction at 0800. Order date of [DATE]; Donepezil HCl 5mg for cognitive function and awareness at 0800. Order date of [DATE]; Escitalopram oxalate 20mg for major depressive disorder at 0800. Order date of [DATE]; Furosemide 40mg at 0800. Order date of [DATE]; Lisinopril oral tablet 5mg for hypertension at 0800. Order date of [DATE]; Multiple vitamins-minerals oral tablet at 0800. Order date of [DATE]; Omeprazole 20mg capsule delayed release for GERD at 0800. Order date of [DATE]; Vitamin C oral tab 1000mg for type 2 diabetes with diabetic chronic kidney disease at 0800. Order date [DATE]. 0800; Atorvastatin Calcium oral tab 80mg for hyperlipidemia. Order date of [DATE]; Carvedilol 6.25mg for hypertension at 0800. Order date of [DATE]; Docusate Sodium 100mg for constipation at 0800. Order date of [DATE]; Memantine HCl 10mg for cognitive functions and awareness at 0800. Order date of [DATE]; Senna oral tab 8.6mg for constipation at 0800. Order date of [DATE]; Verapamil HCl ER 180mg for hypertension at 0800. Order date of [DATE]; Hydralazine HCl 25mg for hypertension at 0800. Order date of [DATE]; THCG Protein powder for diabetes at 0800. Order date of [DATE]; Clonidine HCl oral tab 0.1 mg for hypertension at 0800. Order date of [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's MAR for [DATE] revealed the resident did not receive the following medications on [DATE]: Aspirin delayed release 81mg for cerebral infarction at 0800. Order date of [DATE]; Donepezil HCl 5mg for cognitive function and awareness at 0800. Order date of [DATE]; Escitalopram oxalate 20mg for major depressive disorder at 0800. Order date of [DATE]; Furosemide 40mg at 0800. Order date of [DATE]; Lisinopril oral tablet 5mg for hypertension at 0800. Order date of [DATE]; Multiple vitamins-minerals oral tablet at 0800. Order date of [DATE]; Omeprazole 20mg capsule delayed release for GERD at 0800. Order date of [DATE]; Vitamin C oral tab 1000mg for type 2 diabetes with diabetic chronic kidney disease at 0800. Order date [DATE]. 0800; Atorvastatin Calcium oral tab 80mg for hyperlipidemia. Order date of [DATE]; Carvedilol 6.25mg for hypertension at 0800. Order date of [DATE]; Docusate Sodium 100mg for constipation at 0800. Order date of [DATE]; Memantine HCl 10mg for cognitive functions and awareness at 0800. Order date of [DATE]; Senna oral tab 8.6mg for constipation at 0800. Order date of [DATE]; Verapamil HCl ER 180mg for hypertension at 0800. Order date of [DATE]; Hydralazine HCl 25mg for hypertension at 0800. Order date of [DATE]; THCG Protein powder for diabetes at 0800. Order date of [DATE]; Clonidine HCl oral tab 0.1 mg for hypertension at 0800. Order date of [DATE] . B: Resident #2 Record review of Resident #2's Admission Record, dated [DATE], revealed a [AGE] year-old female, with a latest admitted [DATE]. Diagnosis included Alzheimer's Disease (a decline in memory, thinking, and behavior) and Hypertension (high blood pressure). Record review of Resident #2's Quarterly MDS, dated [DATE] revealed a BIMS score of 08 (moderately impaired). Record review of Resident #2's Physician's Order Summary Report, dated [DATE] revealed the following orders: Amlodipine besylate 10mg for Hypertension at 0730. Order date of [DATE]; Cephalexin 250mg for UTI at 0730. Order date of [DATE]; Famotidine Oral tablet 40mg for indigestion at 0730. Order date of [DATE]; Hydrochlorothiazide 25mg for blood pressure and edema at 0730. Order date of [DATE]; Lexapro 5mg for depressive disorders at 0730. Order date of [DATE]; Metoprolol Succinate ER 25mg for Hypertension at 0730. Order date of [DATE]; Potassium Chloride ER 20meq for Hyperkalemia at 0730. Order date of [DATE]; Vitamin D3 tablet 2000IU for age-related osteoporosis at 0730. Order date of [DATE]; hydralazine HCl 10mg for Hypertension at 0730. Order date of [DATE]. Record review of Resident #2's MAR for [DATE] revealed the resident did not receive her 0700 medications until after 1100 on [DATE]: Amlodipine besylate 10mg for Hypertension at 0730.; Cephalexin 250mg for UTI at 0730. Order date of [DATE]; Famotidine Oral tablet 40mg for indigestion at 0730. Hydrochlorothiazide 25mg for blood pressure and edema at 0730.; Lexapro 5mg for depressive disorders at 0730. ; Metoprolol Succinate ER 25mg for Hypertension at 0730. ; Potassium Chloride ER 20meq for Hyperkalemia at 0730. ; Vitamin D3 tablet 2000IU for age-related osteoporosis at 0730. ; hydralazine HCl 10mg for Hypertension at 0730. In an interview on [DATE] at 12:00 pm, Resident #2 was ambulating in the hallway in wheelchair. She failed to answer any questions regarding medications/high blood pressure. Resident #3 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's Admission Records, dated [DATE], revealed a [AGE] year-old male, with the latest admitted [DATE]. Diagnosis included cerebral infarction (stroke), hypertension (high blood pressure), and tachycardia (heart rate exceeding 100 beats per minute while at rest). Record review of Resident #3's Quarterly MDS, dated [DATE] revealed a BIMS score of 05 (severe impairment). Record review of Resident #3's Physician's Order Summary Report dated [DATE] revealed the following orders: amlodipine Besylate 5mg for hypertension at 0700. Order date of [DATE]; Lisinopril 40mg for Hypertension at 0700. Order date of [DATE]; Buspirone HCl 10mg for anxiety at 0700. Order date of [DATE]; Glipizide 20mg for Diabetes with Chronic Kidney disease at 0700. Order date of [DATE]; MED PASS 2.0 120cc for moderate protein-calorie malnutrition at 0800. Order date of [DATE]; Metoprolol Tartrate oral tablet 25mg for hypertension at 0700. Order date of [DATE]. Record review of Resident #3's MAR for [DATE] revealed the resident did not receive his 0700 medications until after 1100 on [DATE]: amlodipine Besylate 5mg for hypertension at 0700. Order date of [DATE]; Lisinopril 40mg for Hypertension at 0700. Order date of [DATE]; Buspirone HCl 10mg for anxiety at 0700. Order date of [DATE]; Glipizide 20mg for Diabetes with Chronic Kidney disease at 0700. Order date of [DATE]; MED PASS 2.0 120cc for moderate protein-calorie malnutrition at 0800. Order date of [DATE]; Metoprolol Tartrate oral tablet 25mg for hypertension at 0700. Order date of [DATE]. Resident #4 Record review of Resident #4's Admission Records, dated [DATE], revealed an [AGE] year-old female, with the latest admitted [DATE]. Diagnoses included chronic combined systolic and diastolic heart failure (the heart to too weak and stiff to pump blood effectively) and hypertension (high blood pressure). Record review of Resident #4's Quarterly MDS, dated [DATE] revealed a BIMS score of 10 (moderately impaired). Record review of Resident #4's Physician's Order Summary Report, dated [DATE] revealed the following orders: Aspirin oral tab chewable 81mg for Chronic combined systolic and diastolic heart failure at 0800. Order date of [DATE]; Fluoxetine HCl 20mg for recurrent depressive disorders at 0800. Order date of [DATE]; Lasix tablet 40mg for diastolic heart failure at 0800. Order date of [DATE]; Potassium Chloride ER capsule 10meq for diastolic heart failure at 0800. Order date of [DATE]; Ativan 0.5mg for anxiety disorder at 0800. Order date of [DATE]; Senna Plus tab 8XXX,d+[DATE]mg for constipation at 0800. Order date of [DATE]; Artificial tears solution 1% for hypertension at 0800. Order date of [DATE]. Record review of Resident #4's MAR for [DATE] revealed the resident did not receive her 0800 medications until after 1100 on [DATE]: Aspirin oral tab chewable 81mg for Chronic combined systolic and diastolic heart failure at 0800. Order date of [DATE]; Fluoxetine HCl 20mg for recurrent depressive disorders at 0800. Order date of [DATE]; Lasix tablet 40mg for diastolic heart failure at 0800. Order date of [DATE]; Potassium Chloride ER capsule 10meq for diastolic heart failure at 0800. Order date of [DATE]; Ativan 0.5mg for anxiety disorder at 0800. Order date of [DATE]; Senna Plus tab 8XXX,d+[DATE]mg for constipation at 0800. Order date of [DATE]; Artificial tears solution 1% for hypertension at 0800. Order date of [DATE]. (continued on next page)

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	455893	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Care Center of Henrietta	807 W Bois D Arc Henrietta, TX 76365

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #6 Record review of Resident #6's Admission Records, dated [DATE], revealed an [AGE] year-old male, with an admitted [DATE]. Diagnosis included dementia (loss of cognitive functioning that interferes with daily life), anxiety disorder (a group of mental health conditions characterized by excessive fear, dread, and symptoms out of proportion to the situation) and bipolar disorder (a mental disorder characterized by periods of depression and periods of abnormally elevated mood). Record review of Resident #6's Quarterly MDS, dated [DATE] revealed a BIMS score of 03 (severe impairment). Record review of Resident #6's Physician's Order Summary Report dated [DATE] revealed the following orders: Aspirin 81MG for hypertension at 0800. Order date of [DATE]; Magnesium oxide 400mg for indigestion at 0800. Order date of [DATE]; Omeprazole oral capsule delayed release 20mg for GERD at 0800. Order date of [DATE]; Vitamin D 50mg for vitamin D deficiency at 0800. Order date of [DATE]; Ativan 0.5mg for anxiety/agitation at 0800. Order date of [DATE]' Buspirone HCl 5mg for generalized anxiety disorder at 0800. Order date of [DATE]; Depakote ER 250mg for behaviors at 0800. Order date of [DATE]; Quetiapine Fumarate 50MG for bipolar/behavior at 0800. Order date of [DATE]. Record review of Resident #6's MAR for [DATE] revealed the resident did not receive his 0800 medications until after 1100 on [DATE] : Aspirin 81MG for hypertension at 0800. Order date of [DATE]; Magnesium oxide 400mg for indigestion at 0800. Order date of [DATE]; Omeprazole oral capsule delayed release 20mg for GERD at 0800. Order date of [DATE]; Vitamin D 50mg for vitamin D deficiency at 0800. Order date of [DATE]; Ativan 0.5mg for anxiety/agitation at 0800. Order date of [DATE]' Buspirone HCl 5mg for generalized anxiety disorder at 0800. Order date of [DATE]; Depakote ER 250mg for behaviors at 0800. Order date of [DATE]; Quetiapine Fumarate 50MG for bipolar/behavior at 0800. Order date of [DATE]. Resident #8 Record review of Resident #8's Admission Records, dated [DATE], revealed a [AGE] year-old female, with an admitted [DATE]. Diagnosis included Schizophrenia (a mental health condition that affects how people think, feel, and behave) and hypertension (high blood pressure). Record review of Resident #8's Quarterly MDS, dated [DATE] revealed a BIMS score of 14 (cognitively intact). Record review of Resident #8's Physician's Order Summary Report dated [DATE] revealed the following orders: Colchicine-Probenecid 0XXX,d+[DATE]mg for gout at 0800. Order date of [DATE]; Fenofibrate Micronized 200mg for hyperlipidemia at 0800. Order date of [DATE]; hydrochlorothiazide 12.5mg for hypertension at 0800. Order date of [DATE]; Jardiance 25mg for type II diabetes at 0800. Order date of [DATE]; Lisinopril 10mg for hypertension at 0800. Order date of [DATE]; Multivitamin-Minerals tablet for vitamin deficiency at 0800. Order date of [DATE]; Pioglitazone 30mg for chronic kidney disease at 0800. Order date of [DATE]; Vitamin D3 125mcg for vitamin deficiency at 0800. Order date of [DATE]; Combigan Ophthalmic Solution 0XXX,d+[DATE].5% for glaucoma 0800. Order date of [DATE]; Cosopt Ophthalmic Solution ,d+[DATE].5% for glaucoma at 0800. Order date of [DATE]; refresh tears ophthalmic solution 0.5% for dry eyes at 0800. Order date of [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's MAR for [DATE] revealed the resident did not receive her 0800 medications until after 1100 am on [DATE]: Colchicine-Probenecid 0XXX,d+[DATE]mg for gout at 0800. Order date of [DATE]; Fenofibrate Micronized 200mg for hyperlipidemia at 0800. Order date of [DATE]; hydrochlorothiazide 12.5mg for hypertension at 0800. Order date of [DATE]; Jardiance 25mg for type II diabetes at 0800. Order date of [DATE]; Lisinopril 10mg for hypertension at 0800. Order date of [DATE]; Multivitamin-Minerals tablet for vitamin deficiency at 0800. Order date of [DATE]; Pioglitazone 30mg for chronic kidney disease at 0800. Order date of [DATE]; Vitamin D3 125mcg for vitamin deficiency at 0800. Order date of [DATE]; Combigan Ophthalmic Solution 0XXX,d+[DATE].5% for glaucoma 0800. Order date of [DATE]; Cosopt Ophthalmic Solution ,d+[DATE].5% for glaucoma at 0800. Order date of [DATE]; refresh tears ophthalmic solution 0.5% for dry eyes at 0800. Order date of [DATE]. Resident #9 Record review of Resident #9's Admission Records, dated [DATE], revealed a [AGE] year-old male, with an admitted [DATE]. Diagnosis included chronic kidney disease (kidneys are damaged and cannot filter blood properly) and hypertension (high blood pressure). Record review of Resident #9's Quarterly MDS, dated [DATE] revealed a BIMS score of 15 (cognitively intact). Record review of Resident #9's Physician's Order Summary Report dated [DATE] revealed the following orders: Aspirin 81mg for CVA at 0700. Order date of [DATE]; Carvedilol 6.25mg for hypertension at 0700. Order date of [DATE]; Iron oral tablet 325mg for chronic kidney disease at 0700. Order date [DATE]; Jardiance 25mg for type 2 diabetes at 0700. Order date [DATE]; Lasix 20mg for weight gain at 0700. Order date [DATE]; Losartan Potassium 50mg for chronic kidney disease at 0800. Order date [DATE]; [NAME]-Vite tablet for muscle weakness at 0700. Order date [DATE]. 0700; Tamsulosin 0.4mg for lower urinary tract symptoms. Order date [DATE]; Vesicare 5mg for lower urinary tract symptoms at 0700. Order date [DATE]; Vitamin A 10000 units for pressure ulcer to right ankle at 0800. Order date [DATE]; Vitamin D 125mcg for vitamin D deficiency at 0700. Order date [DATE]; Zinc 50mg for pressure ulcer of right ankle at 0700. Order date [DATE]; buspirone HCl 15mg for anxiety disorder at 0700. Order date [DATE]; hydralazine HCl 10mg for chronic kidney disease at 0700. Order date [DATE]; Vitamin C tablet 500mg for pressure ulcer of right ankle at 0700. Order date [DATE]. Record review of Resident #9's MAR for [DATE] revealed the resident did not receive his 0700 medications until after 1100 am on [DATE]: Aspirin 81mg for CVA at 0700. Order date of [DATE]; Carvedilol 6.25mg for hypertension at 0700. Order date of [DATE]; Iron oral tablet 325mg for chronic kidney disease at 0700. Order date [DATE]; Jardiance 25mg for type 2 diabetes at 0700. Order date [DATE]; Lasix 20mg for weight gain at 0700. Order date [DATE]; Losartan Potassium 50mg for chronic kidney disease at 0800. Order date [DATE]; [NAME]-Vite tablet for muscle weakness at 0700. Order date [DATE]. 0700; Tamsulosin 0.4mg for lower urinary tract symptoms. Order date [DATE]; Vesicare 5mg for lower urinary tract symptoms at 0700. Order date [DATE]; Vitamin A 10000 units for pressure ulcer to right ankle at 0800. Order date [DATE]; Vitamin D 125mcg for vitamin D deficiency at 0700. Order date [DATE]; Zinc 50mg for pressure ulcer of right ankle at 0700. Order date [DATE]; buspirone HCl 15mg for anxiety disorder at 0700. Order date [DATE]; hydralazine HCl 10mg for chronic kidney disease at 0700. Order date [DATE]; Vitamin C tablet 500mg for pressure ulcer of right ankle at 0700. Order date [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Resident #9 on [DATE] at 11:22 am, he said he has received all of his medications. Resident #11 Record review of Resident #11's Admission Records, dated [DATE], revealed a [AGE] year-old female, with the latest admitted [DATE]. Diagnosis included unspecified intellectual disabilities (impaired development of learning, reasoning, social, and life skills) and hypertension (high blood pressure). Record review of Resident #11's Quarterly MDS, dated [DATE] revealed a BIMS score of 11 (cognitively intact). Record review of Resident #11's Physician's Order Summary Report dated [DATE] revealed the following orders: cyanocobalamin 500mg for vitamin B deficiency at 0730. Order date [DATE]; Kerendia 20mg for chronic kidney disease at 0730. Order date [DATE]; vitamin C 1000mg for chronic urinary tract infection at 0730. Order date of [DATE]; vitamin D3 125mcg for vitamin D deficiency at 0730. Order date [DATE]. 0730. Record review of Resident #11's MAR for [DATE] revealed the resident did not receive her 0730 medications until after 1100 am on [DATE]: cyanocobalamin 500mg for vitamin B deficiency at 0730. Order date [DATE]; Kerendia 20mg for chronic kidney disease at 0730. Order date [DATE]; vitamin C 1000mg for chronic urinary tract infection at 0730. Order date of [DATE]; vitamin D3 125mcg for vitamin D deficiency at 0730. Order date [DATE]. 0730. Resident #15 Record review of Resident #15's Admission Records, dated [DATE], revealed a [AGE] year-old female, with the latest admitted [DATE]. Diagnosis included unspecified dementia (loss of cognitive and reasoning skills) and hypertension (high blood pressure). Record review of Resident #15's Annual MDS, dated [DATE] revealed a BIMS score of 03 (severe impairment). Record review of Resident #15's Physician's Order Summary Report dated [DATE] revealed the following orders: Macrobid 100mg for UTI at 0730. Order date [DATE]; artificial tears 0XXX,d+[DATE].6% for dry eyes at 0730. Order date [DATE]; Lorazepam 0.5mg for anxiety/restlessness at 0730. Order date [DATE]. Record review of Resident #15's MAR for [DATE] revealed the resident did not receive her 0730 medications until after 1100 am on [DATE]: Macrobid 100mg for UTI at 0730. Order date [DATE]; artificial tears 0XXX, d+[DATE].6% for dry eyes at 0730. Order date [DATE]; Lorazepam 0.5mg for anxiety/restlessness at 0730. Order date [DATE] . Resident #16 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #16's Admission Records, dated [DATE], revealed an [AGE] year-old female, with an admitted [DATE]. Resident expired on [DATE]. Diagnosis included Alzheimer's Disease (a neurodegenerative condition that affects memory, thinking, and behavior) and hypertension (high blood pressure). Record review of Resident #16's Quarterly MDS, dated [DATE] revealed a BIMS score of 99 (severe impairment, not able to access). Record review of Resident #16's Physician's Order Summary Report dated [DATE] revealed the following orders: Lorazepam 4mg for agitation at 0600. Order date [DATE]; morphine 0.5mg for pain at 0600. Order date [DATE]; Atropine 3gts for nausea at 0600. Order date [DATE]. Record review of Resident #16's MAR for [DATE] revealed the resident did not receive her 0600 medications until after 1100 am on [DATE]: Lorazepam 4mg for agitation at 0600. Order date [DATE]; morphine 0.5mg for pain at 0600. Order date [DATE]; Atropine 3gts for nausea at 0600. Order date [DATE]. In an interview with CMA F on [DATE] at 11:50 am, she said when she came to work on [DATE], the internet was down and there was no physician orders or MAR available, and she did not feel comfortable giving medications without a MAR. She said she started passing medications as soon as she got the paper MAR at approximately 11:00 am. All morning medications were given after 11:00 am on [DATE]. CMA F said the reason Resident #4 did not receive her 0800 medications was that she was due high blood pressure medications at 1200. CMA F said the reason Resident #7 did not receive her 0800 medications was she got busy and it slipped my mind. In an interview with the DON on [DATE] at 11:03 am, she said she was off on Monday, [DATE] when the internet went down. When she came to work on [DATE], the nurses told her there was no paper copy of the MAR. She contacted the Human Resource Director to get a copy and it was received the next morning on [DATE]. Stated she was aware the resident's received their morning medications late on [DATE]. She said she was not aware Resident #4 and Resident #7 did not receive their 0800 medications on [DATE]. The DON said a potential negative outcome of a resident missing blood pressure medications is the resident could start having symptoms. She said there were no reports of any residents having negative outcomes relating to this failure. In an interview with Facility Physician B on [DATE] at 8:24 am, he was not aware or contacted by the facility on [DATE] that resident's morning medications were given late. He said he was upset and was going to contact the facility to see if he could get any blood pressure readings for those days the residents received their medications late as residents could have symptoms of high and low blood pressures. In an interview with Facility Physician A on [DATE] at 12:00 pm, said she was not contacted by the facility and was unaware on [DATE] the residents did not receive their prescribed medications. She said it was concerning to her as a resident could have had issues with their blood pressures or start experiencing symptoms. C. Resident #1 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1 Admission Record dated [DATE] revealed Resident #1 was an [AGE] year-old female with an original admitted [DATE] with the latest return date of [DATE]. Resident #1 had a diagnosis of multiple myeloma in remission (bone cancer) and Poly osteoarthritis (a form of arthritis that affects multiple joints simultaneously. This condition is characterized by the degeneration of cartilage and the underlying bone within a joint, leading to pain, stiffness, and impaired movement). The resident was her own responsible party. Record review of Resident #1's Admission MDS, dated [DATE] revealed Resident #1 had a BIMS score of 13 (cognitively intact). The presence of pain was negative on the 5-day lookback period. Record review of Resident #1's Physician Orders, dated [DATE], revealed an order for Morphine Sulfate Oral Tablet 15mg, every 6 hours as needed for pain related to Multiple Myeloma in Relapse, start date of [DATE] at 5:46 pm. Record review of Resident #1's MAR dated [DATE] - [DATE] revealed CMA F administered the first dose of Morphine Sulfate 15mg on [DATE] at 6:07 pm. The CMA assessed Resident #1's pain at a level 9. Record review of CMA F's employee file on [DATE] revealed her Certification Medication Aid certificate is current and expires on [DATE]. In an interview on [DATE] at 12:15 am, CMA F confirmed she administered Resident #1's first dose of Morphine on [DATE] at 6:07 pm and accessed her pain. CMA F stated she gives all medications, except for insulin and assesses the resident's pain. In an interview on [DATE] at 12:30 pm, the DON said she thought a CMA could administer all medications except for insulin. When asked if a CMA can assess pain, she stated I don't know. The DON said possible negative outcomes of CMA giving initial doses of medication and assessing resident's pain would be the resident could receive the wrong medication and the resident might not be assessed correctly, 1001 things could go wrong. In a follow-up interview on [DATE] at 3:25 pm, CMA F said she thought she could administer first doses of medication. She did not know assessing resident's pain was outside of her scope of practice. She said she assessed resident's pain and tell the nurses. She said she received her medication certification about a year ago. Record review of the facility policy Adverse Consequences of Medication Errors, not dated, revealed the following [in part]: 5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacture specifications, of accepted professions stands and principles of the profession proving services. 6. Examples of medication errors include: a. Omission - a drug is ordered by not administered g. Wrong time (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	13. The Attending Physician is notified promptly of any significate error or adverse consequences. Record review of Texas Administration Code, Title 22, Part 11, Chapter 224, Rule 224.9 (The Medication Aid Permit Holder), revealed the following [in part]: (b) The following tasks may not be delegated to the Medication Aid Permit Holder unless allowed and in compliance with Chapter 225 of this title (relating to RN Delegation to Unlicensed Personnel and Tasks not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions): (2) administration of the initial dose of a medication that has not been previously administered to the client. Record review of Texas Administration Code, Title 22, Part 11, Chapter 224, RULE S224.8 (Delegation of Tasks), revealed the following [in part]: (c) Nursing Tasks Prohibited from Delegation By way of example, and not in limitation, the following are nursing tasks that are not within the scope of sound professional nursing judgment to delegate: (1) physical, psychological, and social assessment which requires professional nursing judgment, intervention, referral, or follow-up. Record review of the Texas Administration Code, Title 22, Part 11, Chapter 224, Rule 224.9 (Delegation of Tasks), revealed the following [in part]: (b) The following tasks may not be delegated to the Medication Aide Permit Holder unless allowed and in compliance with Chapter 225 of this title (relating to RN Delegation to Unlicensed Personnel and Tasks not Requiring Delegation in Independent Living Environments for Clients with Stable and Predictable Conditions): (2) administration of the initial dose of a medication that has not been previously administered to the client. Record review of the facility job description Medication Aid - Job Description, not dated, revealed the following [in part]: Job Summary: The Medication Aid is responsible for safely administering prescribed medications to residents in accordance with Texas HHSC regulations and facility policies. Their role ensures that medication administration is documented properly, and that residents' health and well-being are monitored. Key Responsibilities: *Administer oral, topical, inhalation, and other prescribed medications as permitted by Texas Medication Aid Certification. Team Collaboration & Communication: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Work under the supervision of a licensed nurse (LVN or RN).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41871 Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for 7 (Resident's #2, #3, #5, #6, #7, #8, #9) of 11 residents reviewed for medication errors. 1. CMA F failed to administer Resident #2's 7:30 am blood pressure medications on 03/05/25 of Amlodipine Besylate 10mg, hydrochlorothiazide 50mg, Metoprolol Succinate 25mg, hydralazine HCl 10mg after 11:00 am. 2. CMA F failed to administer Resident #3's 7:00 am blood pressure medications on 03/05/25 of Amlodipine Besylate 5mg, Lisinopril 40mg, Metoprolol Succinate 25mg until after 11:00 am. 3. CMA F failed to administer Resident #5's 8:00 am blood pressure medications on 03/05/25 of Lisinopril 5mg, Carvedilol 6.25mg, Verapamil HCl 180mg, Hydralazine HCl 25mg, clonidine HCl 0.1mg until after 11:00 am. 4. CMA F failed to administer Resident #6's 8:00 am psychotropic medications on 03/05/25 of Depakote ER 240mg, buspirone HCl 5mg, Quetiapine Fumarate 50mg until after 11:00 am. 5. CMA F failed to administer Resident #7's 8:00 am atrial fibrillation medications on 03/05/25 of Amiodarone HCl 100mg, amlodipine besylate 5mg until after 11:00 am. 6. CMA F failed to administer Resident #8's 8:00 am blood pressure medications on 03/05/25 of hydrochlorothiazide 12.5mg, Lisinopril 40mg until after 11:00 am. 7. CMA F failed to administer Resident #9's 8:00 am blood pressure medications on 03/05/25 of Carvedilol 12.5mg, hydralazine HCl 10mg until after 11:00 am. This failure placed residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician. The findings included: 1. Resident #2 Record review of Resident #2's Admission Record, dated 03/08/25, revealed a [AGE] year-old female, with the latest admitted [DATE]. Diagnosis included Alzheimer's Disease (neurodegenerative condition that affects memory, thinking, and behavior) and Hypertension (high blood pressure). Record review of Resident #2's Quarterly MDS, dated [DATE] revealed a BIMS score of 08 (moderately impaired). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's Physician Order Summary Report, dated 03/16/25 revealed the following orders: Amlodipine Besylate 10mg at 7:30 am for hypertension with a start date of 10/02/21, hydrochlorothiazide 50mg at 7:30 am for hypertension with a start date of 12/19/21, Metoprolol Succinate 25mg at 7:30 am for hypertension with a start date of 03/13/24, and hydralazine HCl 10mg at 7:30 am and 12:00 pm and 8:00 pm for hypertension with a start date of 06/14/23. Record review of Resident #2's MAR for March 2025 revealed the resident did not receive their 7:30 am blood pressure medications until after 11:00 am on 03/05/25: Amlodipine Besylate 10mg at 7:30 am for hypertension with a start date of 10/02/21, hydrochlorothiazide 50mg at 7:30 am for hypertension with a start date of 12/19/21, Metoprolol Succinate 25mg at 7:30 am for hypertension with a start date of 03/13/24, and hydralazine HCl 10mg at 7:30 am and 12:00 pm and 8:00 pm for hypertension with a start date of 06/14/23. In an interview on 03/15/24 at 12:00 pm, Resident #2 was ambulating in the hallway in wheelchair. She failed to answer any questions regarding medications/high blood pressure. 2. Resident #3 Record review of Resident #3's Admission Records, dated 03/16/25, revealed a [AGE] year-old male, with the latest admitted [DATE]. Diagnosis included cerebral infarction (stroke), hypertension (hypertension), and tachycardia (a heart rate exceeding 100 beats per minute at rest). Record review of Resident #3's Quarterly MDS, dated [DATE] revealed a BIMS score of 05 (severe impairment). Record review of Resident #3's Physician Order Summary Report, dated 03/16/25 revealed the following orders: Amlodipine Besylate 5mg at 7:00 am for hypertension with a start date of 02/15/23, Lisinopril 40mg for hypertension with a start date of 11/29/22, and Metoprolol Succinate 25mg at 7:00 am and 8:00 pm with a start date of 06/20/24. Record review of Resident #3's MAR for March 2025 revealed the resident did not receive their 7:00 am blood pressure medications until after 11:00 am on 03/05/25: Amlodipine Besylate 5mg at 7:00 am for hypertension with a start date of 02/15/23, Lisinopril 40mg for hypertension with a start date of 11/29/22, and Metoprolol Succinate 25mg at 7:00 am and 8:00 pm with a start date of 06/20/24. In an interview with Resident #3 on 03/16/25 at 3:10 pm, he was not interviewable. 3. Resident #5 Record review of Resident #5's Admission Record, dated 03/08/25, revealed an [AGE] year-old female, was a last admitted [DATE]. Diagnosis included cerebral infarction (stroke) and hypertension (high blood pressure). Record review of Resident #5's Quarterly MDS, date 01/10/25 revealed the resident had a BIMS score of 04 (severe impairment). (continued on next page)

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Grace Care Center of Henrietta	807 W Bois D Arc Henrietta, TX 76365

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's Physician Order Summary Report, dated 03/17/25 revealed the following orders: Lisinopril 5mg at 8:00 am for hypertension with a start date of 09/30/24, Carvedilol 6.25mg at 8:00 am and 8:00 pm for Hypertension with a start date of 09/30/24, Verapamil HCl 180mg at 8:00 am and 8:00 pm for hypertension with a start date of 01/21/25, Hydralazine HCl 25mg for hypertension at 8:00 and 12:00 pm and 8:00 pm with a start date of 09/30/24, and Clonidine HCl 0.1mg at 8:00 am and 12:00 pm and 5:00 pm and 8:00 pm for hypertension with a start date of 09/30/24. Record review of Resident #5's MAR for March 2025, revealed the resident did not receive their 8:00 am blood pressure medications until after 11:00 am on 03/05/25: Lisinopril 5mg at 8:00 am for hypertension with a start date of 09/30/24, Carvedilol 6.25mg at 8:00 am and 8:00 pm for Hypertension with a start date of 09/30/24, Verapamil HCl 180mg at 8:00 am and 8:00 pm for hypertension with a start date of 01/21/25, Hydralazine HCl 25mg for hypertension at 8:00 and 12:00 pm and 8:00 pm with a start date of 09/30/24, and Clonidine HCl 0.1mg at 8:00 am and 12:00 pm and 5:00 pm and 8:00 pm for hypertension with a start date of 09/30/24. In an interview with Resident #5 on 03/07/25 at 11:49 am, when asked if she received all of her medications, she said I think so but was not positive. She did not remember receiving any medications late. Resident #6 Record review of Resident #6's Admission Records, dated 03/16/25, revealed an [AGE] year-old male, with an admitted [DATE]. Diagnosis included dementia (loss of cognitive functioning that interferes with daily life and activities), anxiety disorder (intense, excessive, and persistent worry and fear) and bipolar disorder (mental disorder characterized by periods of depression and period of abnormally elevated mood). Record review of Resident #6's Quarterly MDS, dated [DATE] revealed a BIMS score of 03 (severe impairment) Record review of Resident #6's Physician Order Summary Report, dated 03/16/25 revealed the following orders: Ativan 0.5mg at 8:00 am and 8:00 pm for anxiety/agitation with a start date of 02/26/25, buspirone HCl 5mg at 8:00 am and 8:00 pm for anxiety disorder with a start date of 02/05/25, Depakote ER 250mg at 8:00 am and 8:00 pm with a start date of 01/24/25 for bipolar disorder, and quetiapine fumarate 50mg at 8:00 am and 8:00 pm with a start date of 01/25/25. Record review of Resident #6's MAR for March 2025 revealed the resident did not receive their 8:00 am psychotropic medications until after 11:00 am on 03/05/25: Ativan 0.5mg at 8:00 am and 8:00 pm for anxiety/agitation with a start date of 02/26/25, buspirone HCl 5mg at 8:00 am and 8:00 pm for anxiety disorder with a start date of 02/05/25, Depakote ER 250mg at 8:00 am and 8:00 pm with a start date of 01/24/25 for bipolar disorder, and quetiapine fumarate 50mg at 8:00 am and 8:00 pm with a start date of 01/25/25. In an interview with Resident #6 on 03/16/25 at 3:15 pm, he was not interviewable. Resident #7 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's Admission Records, dated 03/08/25, revealed an [AGE] year-old female, with the latest admitted [DATE]. Diagnosis included congestive heart failure (the hearts ability to pump blood), dementia (loss of cognitive functioning that interferes with daily life and activities), hypertension (high blood pressure), and presence of cardiac pacemaker (an implanted medical device that prevents the heart from beating too slowly). Record review of Resident #7s Quarterly MDS, dated [DATE] revealed a BIMS score of 15 (cognitively intact). Record review of Resident #7's Physician Order Summary Report, dated 03/17/25 revealed the following orders: Amiodarone HCl 100mg at 8:00 am for atrial fibrillation with a start date of 01/30/25 and amlodipine besylate 5mg at 8:00 am for atrial fibrillation at 8:00 am with a start date of 02/07/25. Record review of Resident #7's MAR for March 2025 revealed the resident did not receive their 8:00 am blood pressure medications until after 11:00 am on 03/05/25: Amiodarone HCl 100mg at 8:00 am for atrial fibrillation with a start date of 01/30/25 and amlodipine besylate 5mg at 8:00 am for atrial fibrillation at 8:00 am with a start date of 02/07/25. In an interview with Resident #7 on 3/10/25 at 2:45 pm, she said there was one day when she didn't get any meds but couldn't remember the day. Resident #8 Record review of Resident #8's Admission Records, dated 03/08/25, revealed a [AGE] year-old female, with an admitted [DATE]. Diagnosis included Schizophrenia (a mental health condition that affects how people think, feel, and behave) and hypertension (high blood pressure). Record review of Resident #8's Quarterly MDS, dated [DATE] revealed a BIMS score of 14 (cognitively intact). Record review of Resident #8's Physician Order Summary Report, dated 03/17/25 revealed the following orders: hydrochlorothiazide 12.5mg at 8:00 am for hypertension with a start date of 01/13/25, Lisinopril 40mg at 8:00 am for hypertension with a start date of 10/04/24. Record review of Resident #8's MAR for March 2025 revealed the resident did not receive their 8:00 am blood pressure medications until after 11:00 am on 03/05/25: hydrochlorothiazide 12.5mg at 8:00 am for hypertension with a start date of 01/13/25, Lisinopril 40mg at 8:00 am for hypertension with a start date of 10/04/24. In an interview with Resident #8 on 03/07/25 at 11:18 am, she said she thinks she has received all of her medications, but not positive. She did not know if she received any medications late. Resident #9 Record review of Resident #9's Admission Records, dated 03/08/25, revealed a [AGE] year-old male, with an admitted [DATE]. Diagnosis included chronic kidney disease (the kidneys are damaged and cannot filter blood properly) and hypertension (high blood pressure). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #9's Quarterly MDS, dated [DATE] revealed a BIMS score of 15 (cognitively intact). Record review of Resident #9's Physician Order Summary Report, dated 03/17/25 revealed the following orders: Carvedilol 12.5mg at 7:00 am for hypertension with a start date of 01/27/23, hydralazine HCl 10mg at 7:00 am and 8:00 pm for hypertension with a start date of 06/10/24. Record review of Resident #9's MAR for March 2025 revealed the resident did not receive their 8:00 am blood pressure medications until after 11:00 am on 03/05/25: Carvedilol 12.5mg at 7:00 am for hypertension with a start date of 01/27/23, hydralazine HCl 10mg at 7:00 am and 8:00 pm for hypertension with a start date of 06/10/24. In an interview with Resident #9 on 03/07/25 at 11:22 am, he said he has received all of his medications and did not know if she received any late medications. In an interview with the CMA F, on 3/11/25 at 11:50 am, she said when she came to work on 03/05/25, the internet was down and there was no physician orders or MAR available, and she did not feel comfortable giving medications without a MAR. She said she started passing medications as soon as she got the paper MAR at approximately 11:00 am. All morning medications were given after 11:00 am on 03/05/25. In an interview with the DON on 03/16/25 at 11:03 am, she said she was off on Monday, 03/03/25 when the internet went down. When she came to work on 03/04/25, the nurses told her there was no paper copy of the MAR. She contacted the Human Resource Director to get a copy and it was received the next morning on 03/05/25. Stated she was aware the resident's received their morning medications late. She said a potential negative outcome of a resident missing blood pressure medications is the resident could have a crisis of low or high blood pressure. She said a potential negative outcome of a resident missing an antipsychotic medication would be the resident would start having symptoms. In an interview with Facility Physician B on 03/12/25 at 8:24 am, he was not aware or contacted by the facility on 03/05/25 that resident's morning medications were given late. He said he was upset and was going to contact the facility to see if he could get any blood pressure readings for those days. He said a potential negative outcome would be the resident would have instances of high or low blood pressures. In an interview with Facility Physician A on 03/12/25 at 12:00 pm, said she was not contacted by the facility and was unaware on 03/05/25 the residents did not receive their prescribed medications. She said it was concerning to her as a resident could have had issues with their blood pressures. Record review of the facility policy Adverse Consequences of Medication Errors, not dated, revealed the following [in part]: 5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacture specifications, of accepted professions stands and principles of the profession proving services. 6. Examples of medication errors include: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Omission - a drug is ordered by not administered g. Wrong time 13. The Attending Physician is notified promptly of any significate error or adverse consequences.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47044 Based on observation, interview and record review, the facility failed to follow menus for one of one facility. The facility failed to follow their menus prepared in advance daily for 11 meals dated 2/10/25 -3/13/25. This failure could affect the residents by the menus failing to meet the residents' choices and dietary needs. Findings included: Interview on 2/22/25 at 11:15am with [NAME] B stated the facility got a truck in yesterday but the food supplies remain low. Stated the facility was out of coffee, milk, bread, sweeter. Stated the facility had to substitute meals due to not having the food on the menu. Stated they try to make it as close as possible to the menus to make sure the residents are receiving the correct nutritional value. At times the facility had no bread or milk. [NAME] B stated she purchased food for the residents out of her own pocket without reimbursement, mostly condiments, ketchup, and mustard. Observation on 2/22/25 at 11:15am of food supply closet showed food supplies low. The facility had can goods most of them dated yesterday. Dishwasher had chemicals. Had 7 days of nonperishables. Interview on 2/22/25 at 9:00am with LVN A stated residents did not have milk, coffee, hot chocolate. LVN and night staff bought it yesterday. There was no sugar free sweetener. LVN A stated the dietary manager was buying food. Interview on 2/23/25 at 10:50am with DON & Human Resource Director stated the vendor does not deliver milk due to non-payment. Observation on 2/23/25 at 12:23pm no menu posted in dining room. Residents stated food is good. Observed pork chops, mixed vegetables, mashed potatoes, roll. Record review of the residents revealed no significant weight loss. Interview on 2/24/25 at 10:45am with Dietary Manager stated the residents had $6 a day for meals. Dietary manager stated she ordered food two times a week for $480. Stated that is not enough food to be able to follow the menus. Stated they had to substitute meals. Dietary manager stated today, the meal required hamburger meat and they didn't have enough money for that, so had chicken instead. Stated the Nutritionist approved the substitutions. Stated the facility used Magic Cups instead of the shakes that were ordered for the residents and the Dietician approved the change. Stated she had purchased food out of her own pocket without reimbursement from the facility. Coffee, milk, sweet & low, tea bags, whatever is needed. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 3/9/25 at 12:55pm with dietary manager stated she had to substitute chicken for roast. Roast is too expensive to buy. Interview on 3/10/25 at 9:15am with LVN E stated they never know what was being served. Stated a resident will ask sometimes, and they had to go and ask dietary. Stated they serve a lot of chicken and fish. Sometimes the activity director will provide snacks. Stated HR went and bought coffee yesterday for the residents. Observation on 3/10/25 at 9:20am showed food pantry appears low. Interview dated 3/10/25 at 10:45am with dietary manager provided substitution list. Stated she had to switch around the menus to what she was able to purchase. Stated she is placed an order today, but did not have enough money to purchase the menu and will have to substitute 2 meals. Stated with what she ordered today she was $12 over. Don't know if they will approve it or not. Dietary manager stated she switched day around to make them work. Stated her budget had not increased, or no one had told her. Stated she provided peanut butter and jelly, or meat sandwiches, or vanilla wafers as snacks. Record review of substitution log, 3/10/25 at 11:38 am. Substituted meals on: 2/10/25 - Meal Chicken breast, rice, California veggies (substituted with chili w/beans, salad, carrots, relish plate). 2/19/25 - Meal Cheeseburger on bun, French fries (substituted with vegetable lasagna, California veggies, rolls). 2/22/25 - Meal BBQ chicken, potato salad, green beans, honeybun cake (substituted with chicken/turkey, carrots, mashed potato, fruit). 2/21/25 - Meal vegetable soup, roast beef sandwich (substituted with tomato soup and turkey sandwich). 2/23/25 - meal spinach, peach cobbler (substituted with 4 way mix veg, sliced peaches). (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/24/25 - Meal fiesta beef bean casserole, Spanish rice, corn relish, pears (substituted with ham with pineapple, baked beans coleslaw, rolls, frosted strawberry cake). 2/25/25 - meal ham, baked beans, [NAME] slaw, pineapples with mandarin oranges (substituted with BBQ chicken, scalloped potatoes, green beans, rolls, Jello). 2/26/25 - green beans, frosted angel food cake (substituted with carrots, frosted yellow cake). 2/27/25 meal sweet & sour meatballs, rice, chocolate eclair (substituted with Italian sausage pizza, cherry Jello). 2/28/25 meal tomato soup, grilled cheese (substituted with chuckwagon steak, mashed potatoes, carrots). 3/9/25 Lunch Meal pot roast over $200, chocolate cream pie (substituted breaded chicken, pineapples) Dinner meal garlic pepper pork, strawberry shortcake (substituted with Salisbury steaks, frosted cinnamon cake). 3/10/25 Lunch meal brussels sprouts, raspberry peaches (substituted with broccoli mixed vegetables, raspberry applesauce) Dinner meal Ham & Cheese sandwiches with lettuce & tomato, crackers, navy bean soup, fruit cup (substituted with BBQ pork sliders, French fries, tomato & zucchini, mandarin oranges). Interview dated 3/10/25 at 11:54am with Dietician stated changed meals due to trucks not coming in. Coming at end of March. Stated change in ownership. She was at facility a few weeks ago and had concern about budget of food. Cannot do anything about upper management and budget. She stated she knew about cuts in food budget from upper management, don't have enough money to order the sufficient amount of food. She stated she was not aware of all substitutions, should be no more than 2 a week and she will reach out to facility about substitutions and to approve them. Going to have to simplify the resident's menus for breakfast due to the high price of eggs. Investigator requested dietary policy and it was not provided.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41871 Based on observation, interview, and record review the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for one of one facility reviewed. The facility failed to have sufficient resources to satisfy (pay) debts timely and when they come due. The phone and internet were disconnected, service repair bills/vendors were not paid, and the facility van did not have insurance or current registration tags. The facility failed to provide enough money to purchase the food necessary to follow the menus and to purchase printer supplies. An Immediate Jeopardy was identified on [DATE] at 3:52 pm. The IJ template was provided to the facility on [DATE] at 3:52pm. While the Immediate Jeopardy was removed on [DATE] at 4:36 pm, the facility remained out of compliance at scope of widespread and a severity level of no actual harm with potential for more than minimal harm because the facility needs to take action to ensure there is a plan for vendors to be paid timely, so services are not rescinded, and the residents have the services required for the highest practicable physical, mental, and psychosocial well-being of each resident. These failures could place residents at risk of not receiving essential care and services that the facility is responsible for providing. Findings included: During an interview on [DATE] at 9:30 am, the DON said the facility had not had an Administrator since [DATE]. She said: the facility had not been paying vendors. The phones/fax were not working. The staff had to utilize their own cell phones to conduct facility business. The facility is not able to send or receive faxes. A staff member bought a pre-paid cell phone, so the residents were able to call their family and vice versa. The staff went and bought milk, coffee, and hot chocolate for the residents, yesterday [DATE], due to the facility not having any for the residents. The ice machine was rented and was scheduled for repossession next Wednesday, [DATE] for non-payment. The nurses had purchased ink cartridges and paper so they could print out packets that needed to be sent with the residents when they go out of the facility. Staff have purchased soap, bodywash, lotion, laundry soap, bleach, bread, gas for the van, and incontinent briefs for the residents. Record review of invoices provided by the Human Resource Director indicated unpaid balances for the following: 1. Telephone and internet vendor invoice dated [DATE]- Past due balance of $16,985.35. The phone was disconnected on [DATE]. Internet was disconnected on [DATE]. 2. Energy vendor invoice dated [DATE] - Past due balance of $41,159.61 with a due date of [DATE]. 3. Water vendor invoice undated - Past due balance of $5292.92 with a due date of [DATE]. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	4. Fire and Security vendor - Past due balance of $11,497.06 as of [DATE] - a total of 11 invoices dated [DATE] - [DATE]. Account was suspended on [DATE] and 10-day termination notice was to be given. 5. Ice machine vendor invoice dated [DATE]- Past due balance of $137.12 with a due date of [DATE] and ice machine to be picked up on [DATE] if not paid. 6. Milk vendor invoice dates from [DATE]-[DATE] (22 invoices)- Past due balance of $1,360.59. Delivery of milk stopped [DATE]. 7. Garbage and waste vendor invoice dated [DATE]- Past due balance of $1,141.08. Subject to service suspension and/or container removal. 9. Pharmacy Consultant invoice dated [DATE]- Past due balance (not disclosed on invoice). Pharmacy services to be terminated on [DATE]. 10. Insurance vendor for van undated- Policy cancelled effective date on [DATE] for non-payment. Amount unknown. In an interview on [DATE] at 11:15 am, [NAME] B said the facility had to substitute meals due to not having the required food for the menu. She said they attempt to make sure the residents were receiving the correct nutritional value. She said at times, the facility does not have milk, bread, coffee, artificial sweetener. [NAME] B said she had purchased ketchup, mustard, and artificial sweetener for the residents. In an interview on [DATE] at 11:30 am, the Maintenance Director stated he could not purchase supplies to fix things at the facility due to the facility having a past due balance at a local hardware store, approximately $7000. The facility had a past due balance with the vendor who serviced the dishwasher, washing machines and dryers and could not get maintenance services. He said the hot water heater for the laundry did not work and could not get it fixed. He stated that he purchased supplies out of his own pocket to fix things at the facility for the residents. He said the facility owed him $125 for supplies he recently purchased, and they have never paid him. In an interview on [DATE] at 01:45 PM with the Human Resource Director, she stated the facility phone was cut off on [DATE] and had never been turned back on. She said an anonymous staff member purchased a prepaid cell phone out of their own pocket on [DATE] so that the residents and their families could communicate with each other. She said the facility could not send or receive faxes. The staff had to use their personal cell phones to conduct facility business. In an interview on [DATE] at 02:10 PM, Housekeeper C stated there was no hot water in the laundry and all laundry was being washed in cold water. She said the washing machine had no chemicals and needed to be serviced. She said staff purchased bleach and laundry soap as the facility had not been purchasing those items due to not paying their bill. In an interview on [DATE] at 10:10 am, LVN D said that she bought out of her pocket soap, bodywash, lotion, ink, and paper for the printer. She said if she did not purchase these things the residents would go without. (continued on next page)

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Grace Care Center of Henrietta	807 W Bois D Arc Henrietta, TX 76365

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on [DATE] at 10:15 am, LVN E said that she purchased ink and paper for the printer. She said when a resident was sent out of the facility, they have to print a paper packet to go with them. She said due to the facility not having phone or fax services, she had to use her own cell phone to conduct facility business. She said the facility was unable to receive faxes from doctors and hospitals. She said the residents' families have expressed to her their frustration about not being able to contact the facility or their loved ones. In an interview on [DATE] at 10:50 am, the DON said she was aware the facility did not have hot water for the laundry. She said when a resident goes out of the facility, they had to print out a packet concerning the resident's information to be sent with them and the nurses had been buying the ink and paper for that. If they did not purchase the items, they would not be able to send out a packet the receiving facility was requesting. In an interview with DON on [DATE] at 10:00am and a record review of an e-mail dated [DATE] at 11:05 am from the Director of Nursing to the CEO, the DON requested Supplies and Payments: We are nearly out of essential supplies, including toilet paper. Could you confirm when the outstanding bills will be settled so that we can restock as needed? Petty Cash: Do we have an estimated timeline for the release of petty cash? Several team members have been using funds to address immediate building needs. Could you advise on the status of these items? The DON said the CEO never responded to the e-mail. In an interview on [DATE] at 10:45 am, the Dietary Manager stated the residents were budgeted $6 a day for breakfast, lunch, and dinner. She said that amount was not enough to purchase all the food items for the menus. As a result, the facility had to substitute items on the menu. An example for today at lunch, it called for hamburger meat but there wasn't enough money to purchase that, so it was substituted with another item on the menu that was chicken. She said she had purchased coffee, milk, artificial sweetener, and tea bags for the residents. In an interview on [DATE] at 11:00 am, the Laundry Supervisor stated there was no hot water for the laundry. The resident's laundry was being washed in cold water. She said the hot water heater had been out for over a month. She said the washing machine did not have the correct chemicals to sanitize the resident's laundry properly. She said the washing machine had an error code and needed to be serviced. She said the facility had not paid the bill to the servicer and they would not come to fix it. She said staff purchased bleach and laundry detergent as the facility did not provide laundry soap or bleach. She said she had purchased laundry supplies for the residents out of her own pocket. She stated it had been reported, and maintenance was aware. In an interview on [DATE] at 2:00 pm, the local Ombudsman reported it was difficult to contact the facility due to having no phone service. Individual facility staff had to be contacted. The ombudsman said she was made aware of the communication with the owner because staff had been forwarding emails from the owner and it is very demeaning, and negative. In an interview on [DATE] at 2:54 pm, the Maintenance Director stated the facility needed a new hot water heater for the laundry. He said the facility could not get anyone to come out and look at the hot water heater due to the facility owing everyone money. He said the washing machine could not be serviced due to an unpaid bill. He said the facility could not order the proper chemicals for the washing machine due to an unpaid bill. He said the CEO was aware. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on [DATE] at 9:30 am, Resident #1's POA expressed her concern about the facility not having an Administrator in the building and questioned as if this was causing a delay of Resident #1 being placed on hospice care requested on [DATE]. In an interview on [DATE] at 11:23 am with the Activity Director, she stated she was purchasing blow-up calendars for the activity bulletin board out of her own pocket and the facility would reimburse her. She said she purchased a calendar for January and the facility did not reimburse her. She said the facility owed her $30. She said she purchased BINGO winnings for the residents such as coke, candy, and popcorn out of her own pocket. If she did not, the residents would not have any BINGO winnings. In an interview on [DATE] at 12:00 pm, Facility Physician A said she was aware the facility was not paying its bills. She said it makes communication very difficult as she could not send or receive faxes with the facility. She had to conduct business on staff's individual cell phones. In an interview on [DATE] at 1:35 pm, CNA F stated she had purchased soap and body wash for the residents so they could have a bath. In an interview with the CEO on [DATE] at 4:20 pm, he said don't worry about the utilities, they will not get shut off. I will not be able to keep up 30-day payments due to all the Medicaid in the facility and them not paying that much. He said he purchased the facility 6 months ago and it takes time to get everything switched over to a new account. He stated he was not going to pay any back service because he was not responsible for anything before he bought the facility. He said the facility staff had not communicated to him about the food or lack of food, and the best he could do was contact his purchase person. He said he was not aware the washing machine did not have hot water and needed to be serviced. CEO stated there was no Interim Administrator, and the position was posted on job website and no one licensed had applied. In an interview with the CEO on [DATE] at 4:55 pm, he stated he signed a new contract for the electric vendor. He said the water bill was only 2 months behind and that it was not late enough to be shut off so that was fine. He said the Fire and Security vendor were still within terms and would complete repairs. He said he would get payment sent out tomorrow for the ice machine vendor. He said they had a new pharmacy consultant to start [DATE]. In an interview with the Social Worker on [DATE] at 1:00 pm, she stated for the last 3 to 4 weeks, she had received calls from family members 2 to 3 times per week on her personal cell phone upset and worried due to the facility phone number not working. In an interview on [DATE] at 10:00 am, the Human Resource Director said the internet was disconnected on [DATE] in the afternoon for non-payment. The facility did not have any internet service from [DATE] to the morning of [DATE]. She stated the facility had insurance on the van and provided an invoice. In an interview on [DATE] at 11:25 am, the Activity Director said she was responsible for taking residents to doctor's appointments but had not taken them in February or March due to the van not having insurance or current tags. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on [DATE] at 12:55 pm, the Dietary Manager said she had to substitute pot roast that was on the menu for chicken due to pot roast being over $200. She said she did not have enough money to purchase the required food items on the menu. In an interview on [DATE] at 1:00 pm, LVN D and LVN E stated due to the internet being down, the nurses were not able to access the computer for medication administration. They stated the residents on the Yellow [NAME] Hallway did not have TV service due to the internet being out and the facility did not purchase a hot spot for that hallway. They reported the residents did not have any coffee today and they were going to go purchase some. In an observation on [DATE] at 1:15 pm, the facility van's tag displayed on the front windshield expired on , d+[DATE]. In an interview on [DATE] at 1:30 pm, the DON said due to the facility having no insurance on the van, 3 residents (Resident #2, Resident #9, and Resident #11) had missed their doctors' appointments. One resident missed a cardiology and nephrology appointment; two residents missed an appointment with their primary doctor and 2 residents have been taken to their appointments by their family. The DON said a potential negative outcome would be the residents would not receive the proper treatment they needed. In an interview on [DATE] at 10:16 am, this writer contacted the van insurance company from the invoice provided by the Human Resource Director and was informed the policy had been cancelled and was not active. In an interview on [DATE] at 10:45 am, the Dietician said she was concerned about the food budget and not enough money to cover the menu. She said she was not aware the facility had been substituting the menu as frequently as they were doing. She said the facility should not be having to substitute more than 2 meals a week. In an interview on [DATE] at 1:15 pm, the laundry supervisor said the facility was not using the recommended bleach or detergent for the laundry, and no alkaline is being used. One washing machine is not equipped anymore to receive chemicals and they wash items in that one that doesn't require bleach. She said it had been over 2 years since the washing machines had been serviced. She said as a result the laundry had the potential to not be sanitized properly. In an interview on [DATE] at 8:24 am, Physician B stated it was very difficult to communicate with the facility due to no phone or fax service. He said a resident had an appointment with him yesterday, but it was cancelled. He was not aware it was cancelled due to the facility not being able to transport residents due to having no insurance on the facility van. In an interview on [DATE] at 12:00 pm, Facility Physician A said she was not aware residents missed doctor's appointments. She said the resident that missed his cardiology and nephrology appointments were considered important appointments. She said the facility called her about Resident #2 that was having slight bleeding from her vaginal area; She said she asked the facility to bring the resident to her office, but was informed they could not due to no insurance on the van. She said as a result, she was going to go to the facility to evaluate her. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview and record review on [DATE] at 10:10 am, the DON provided documentation the van insurance policy was cancelled on [DATE]. She said on [DATE], Resident #3 sustained a fall. The family requested her to be sent to the ER. DON stated the family took her to the ER and left. The facility had to use the facility van to pick her up from the ER, although there was no insurance on the van. In an interview on [DATE] at 11:35 am, the DON said Resident #2 was being sent to the ER, via ambulance for a change in condition. She said Facility Physician A did not get to see her prior to being sent. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 3:52 pm. The DON and Human Resource Director were notified. The DON was provided with the IJ template on [DATE] at 3:52 pm. The following Plan of Removal was submitted by the facility and accepted on [DATE] at 12:47 pm and included: The facility needs to take immediate action to ensure there is a plan for vendors to be paid timely, so services are not rescinded, and residents have the services required for the highest practicable physical, mental, and psychosocial well-being of each resident. Plan of Removal 1). Action: The Chief Executive Officer (CEO) and Managing Partner re-educated the Chief Operating Officer (COO) on the governing board responsibility to ensure management and operation of the facility; emphasis was stressed on the importance of providing oversight of facility care and services in accordance with professional standards of practice and principles, to ensure there is a plan for vendors to be paid timely, so services are not rescinded and residents have the services required for the highest practicable physical, mental, and psychosocial well-being of each resident. The mode of education was in the form of a one-on-one meeting and memo - a copy of the Policy and Procedures entitled Administrative Management (Governing Board). The teach-back method was used to assess comprehension. Start Date: [DATE] Completion Date: [DATE] Responsible: Chief Executive Officer (CEO) and Managing Partner 2). Action: The Chief Executive Officer (CEO) and Chief Operating Officer (COO) will meet to review and make payments or payment arrangements for: 1. Telephone and internet vendor on [DATE], $10,000.00 was paid, the remaining payment was made on [DATE] in the amount of $7987.28, the amount told to us from the company to activate service.; 2. Insurance vendor for the facility van has been paid in the amount of $141.99 on [DATE]. 3. Registration tags for the facility van was paid on 3.17.25 in the amount of $74.00 to County Tax Office. 4. Fire and security vendor - have confirmed that we are not on hold and have sent an email confirming so on 3.14.25. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41871 Based on interview and record review the facility failed to ensure the governing body of the facility had appointed an administrator, who is licensed by the state, to be responsible for the management of the facility and reports to the governing body, in that: The facility had not had an administrator since [DATE]. The governing body failed to provide the facility with enough money to keep up services including telephone service, internet service, food services, van registration/insurance, laundry services, and fire and security services. An Immediate Jeopardy was identified on [DATE] at 3:52 pm. The IJ template was provided to the facility on [DATE] at 3:52pm. While the Immediate Jeopardy was removed on [DATE] at 4:36 pm, the facility remained out of compliance at a scope of widespread and a severity level of no actual harm with potential for more than minimal harm because of the facility's need to evaluate the effectiveness of the corrective systems that were put into place. This deficient practice could place residents at risk of decreased quality of life and quality of care due to a lack of staff oversight and monitoring of care. The findings included: During an interview on [DATE] at 9:30 am, the DON said the facility had not had an Administrator since [DATE]. She said the only administrative staff at the facility were the DON and Human Resource Director. She said the facility had not been paying vendors. The phones/fax were not working. The staff had to utilize their own cell phones to conduct facility business. The facility is not able to send or receive faxes. A staff member bought a pre-paid cell phone, so the residents were able to call their family and vice versa. The staff went and bought milk, coffee, and hot chocolate for the residents, yesterday [DATE], due to the facility not having any for the residents. The ice machine was rented and was scheduled for repossession next Wednesday, [DATE] for non-payment. The nurses had purchased ink cartridges and paper so they can print out packets that need to be sent with the residents when they go out of the facility. Staff had purchased soap, bodywash, lotion, laundry soap, bleach, bread, gas for the van, and incontinent briefs for the residents. Record review of invoices provided by the Human Resource Director indicated unpaid balances for the following: 1. Telephone and internet vendor invoice dated [DATE]- Past due balance of $16,985.35. The phone was disconnected on [DATE]. Internet was disconnected on [DATE]. 2. Energy vendor invoice dated [DATE] - Past due balance of $41,159.61 with a due date of [DATE]. 3. Water vendor invoice undated - Past due balance of $5292.92 with a due date of [DATE]. (continued on next page)

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Grace Care Center of Henrietta	807 W Bois D Arc Henrietta, TX 76365

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	4. Fire and Security vendor - Past due balance of $11,497.06 as of [DATE] - a total of 11 invoices dated [DATE] - [DATE]. Account was suspended on [DATE] and 10-day termination notice was to be given. 5. Ice machine vendor invoice dated [DATE]- Past due balance of $137.12 with a due date of [DATE] and ice machine to be picked up on [DATE] if not paid. 6. Milk vendor invoice dates from [DATE]-[DATE] (22 invoices)- Past due balance of $1,360.59. Delivery of milk stopped [DATE]. 7. Garbage and waste vendor invoice dated [DATE]- Past due balance of $1,141.08. Subject to service suspension and/or container removal. 9. Pharmacy Consultant invoice dated [DATE]- Past due balance (not disclosed on invoice). Pharmacy services to be terminated on [DATE]. 10. Insurance vendor for van undated- Policy cancelled effective date on [DATE] for non-payment. Amount unknown. In an interview on [DATE] at 11:15 am, [NAME] B said the facility had to substitute meals due to not having the required food for the menu. She said they attempt to make sure the residents received the correct nutritional value. She said at times, the facility did not have milk, bread, coffee, artificial sweetener. She said she had purchased ketchup, mustard, and artificial sweetener for the residents. In an interview on [DATE] at 11:30 am, the Maintenance Director stated he could not purchase supplies to fix things at the facility due to the facility having a past due balance at a local hardware store, approximately $7000. The facility had a past due balance with the vendor who services the dishwasher, washing machines and dryers and could not get maintenance services. He said the hot water heater for the laundry did not work and could not get it fixed. He stated that he purchased supplies out of his own pocket to fix things at the facility for the residents. He said the facility currently owed him $125 for supplies he recently purchased, and they have never paid him. In an interview on [DATE] at 01:45 PM with the Human Resource Director, she stated the facility phone was cut off on [DATE] and had never been turned back on. She said an anonymous staff member purchased a prepaid cell phone out of their own pocket on [DATE] so that the residents and their families could communicate with each other. She said the facility could not send or receive faxes. The staff were having to use their personal cell phones to conduct facility business. She said there was no acting interim and that her and the DON were covering. In an interview on [DATE] at 02:10 PM, Housekeeper C stated there was no hot water in the laundry and all laundry was being washed in cold water. She said the washing machine had no chemicals and needed to be serviced. She said staff had purchased bleach and laundry soap as the facility had not been purchasing those items due to not paying their bill. In an interview on [DATE] at 10:10 am, LVN D said that she bought out of her pocket soap, bodywash, lotion, ink, and paper for the printer. She said if she did not purchase these things the residents would go without. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on [DATE] at 10:15 am, LVN E said that she purchased ink and paper for the printer. She said when a resident was sent out of the facility, they had to print a paper packet to go with them. She said due to the facility not having phone or fax services, she had to use her own cell phone to conduct facility business. She said the facility was unable to receive faxes from doctors and hospitals. She said the residents' families had expressed to her their frustration about not being able to contact the facility or their loved ones. In an interview on [DATE] at 10:50 am, the DON said she was aware the facility did not have hot water for the laundry. She said when a resident goes out of the facility, they had to print out a packet concerning the resident's information to be sent with them and the nurses had been buying the ink and paper for that. If they did not purchase the items, they would not be able to send out a packet the receiving facility was requesting. In an interview with the DON on [DATE] at 10:00 am and a record review of an e-mail dated [DATE] at 11:05 am from the Director of Nursing to the CEO, the DON requested Supplies and Payments: We are nearly out of essential supplies, including toilet paper. Could you confirm when the outstanding bills will be settled so that we can restock as needed? Petty Cash: Do we have an estimated timeline for the release of petty cash? Several team members have been using funds to address immediate building needs. Could you advise on the status of these items? The DON said the CEO never responded to the e-mail. In an interview on [DATE] at 10:45 am, the Dietary Manager stated the residents were budgeted $6 a day for breakfast, lunch, and dinner. She said that amount was not enough to purchase all the food items for the menus. As a result, the facility had to substitute items on the menu. An example for today at lunch, it called for hamburger meat but there wasn't enough money to purchase that, so it was substituted with another item on the menu that was chicken. She said she had purchased coffee, milk, artificial sweetener, and tea bags for the residents. In an interview on [DATE] at 11:00 am, the Laundry Supervisor stated there was no hot water for the laundry. The resident's laundry was being washed in cold water. She said the hot water heater had been out for over a month. She said the washing machine did not have the correct chemicals to sanitize the resident's laundry properly. She said the washing machine had an error code and needed to be serviced. She said the facility had not paid the bill to the servicer and they would not come to fix it. She said staff purchased bleach and laundry detergent as the facility did not provide laundry soap or bleach. She said she had purchased laundry supplies for the residents out of her own pocket. She stated it had been reported, and maintenance was aware. In an interview on [DATE] at 2:00 pm, the local Ombudsman reported it was difficult to contact the facility due to having no phone service. Individual facility staff had to be contacted. The ombudsman stated the facility staff had forwarded emails from the CEO and she stated they appeared demeaning and negative, but no specifics were provided. In an interview on [DATE] at 2:54 pm, the Maintenance Director stated the facility needed a new hot water heater for the laundry. He said the facility could not get anyone to come out and look at the hot water heater due to the facility owing everyone money. He said the washing machine could not be serviced due to an unpaid bill. He said the facility could not order the proper chemicals for the washing machine due to an unpaid bill. He said the CEO was aware. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on [DATE] at 9:30 am, Resident #1's POA expressed her concern about the facility not having an Administrator in the building and questioned as if this caused a delay of Resident #1 being placed on hospice care requested on [DATE]. In an interview with the Activity Director, on [DATE] at 11:23 am, stated she had purchased blow-up calendars for the activity bulletin board out of her own pocket and the facility would reimburse her. She said she purchased a calendar for January and the facility would not reimburse her. She said the facility owed her $30. She said she purchased BINGO winnings for the residents such as coke, candy, and popcorn out of her own pocket. If she did not, the residents would not have any BINGO winnings. In an interview on [DATE] at 12:00 pm, Facility Physician A said she was aware the facility was not paying its bills. She said it made communication very difficult as she could not send or receive faxes from the facility. She had to conduct business on staff's individual cell phones. In an interview on [DATE] at 1:35 pm, CNA F stated she had purchased soap and body wash for the residents so they could have a bath. In an interview with the CEO on [DATE] at 4:20 pm, he said don't worry about the utilities, they will not get shut off. I will not be able to keep up 30-day payments due to all the Medicaid in the facility and them not paying that much. He said he purchased the facility 6 months ago and it takes time to get everything switched over to a new account. He stated he was not going to pay any back service because he was not responsible for anything before, he bought the facility. He said the facility staff had not communicated to him about the food or lack of food, the best he can do is contact his purchase person. He said he was not aware the washing machine did not have hot water and needed to be serviced. The CEO said the Administrator job was posted on a job website. He said no one that had a license has applied. He said there was no interim administrator at the facility. He said the DON and Human Resource Director were running the facility. In an interview with the CEO on [DATE] at 4:55 pm, he stated he signed a new contract for electric vendor. He said the water bill was only 2 months behind and that it is not late enough to be shut off so that was fine. He said the Fire and Security vendor were still within terms and would complete repairs. He said he would get payment sent out tomorrow for the ice machine vendor. He said they had a new pharmacy consultant to start [DATE]. In an interview with the Social Worker on [DATE] at 1:00 pm, she stated for the last 3 to 4 weeks, she had received calls from family members 2 to 3 times per week on her personal cell phone upset and worried due to the facility phone number not working. In an interview on [DATE] at 12:30 pm, the DON said possible negative outcomes of not having an Administrator was the facility was not being run effectively, making sure there were supplies in the building, and QAPI was not being done. In an interview on [DATE] at 10:00 am, the Human Resource Director said the internet was disconnected on [DATE] in the afternoon for non-payment. The facility did not have any internet service from [DATE] to the morning of [DATE]. She stated the facility had insurance on the van and provided an invoice. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on [DATE] at 11:25 am, the Activity Director said she was responsible for taking residents to doctor's appointments but had not taken them in February or March due to the van not having insurance or current tags. In an interview on [DATE] at 12:55 pm, the Dietary Manager said she had to substitute pot roast that was on the menu for chicken due to post roast being over $200. She said she did not have enough money to purchase the required food items on the menu. In an interview on [DATE] at 1:00 pm, LVN D and LVN E stated due to the internet being down, the nurses were not able to access the computer for medication administration. They stated the residents on the Yellow [NAME] Hallway did not have TV service due to the internet being out and the facility did not purchase a hot spot for that hallway. They reported the residents did not have any coffee today and they were going to go purchase some. In an observation on [DATE] at 1:15 pm, the facility van's tag displayed on the front windshield expired on , d+[DATE]. In an interview on [DATE] at 1:30 pm, the DON said due to the facility having no insurance on the van, 3 residents had missed their doctors' appointments. One resident missed a cardiology and nephrology appointment; 2 residents missed an appointment with their primary doctor and 2 residents have been taken to their appointments by their family. The DON said a potential negative outcome would be the residents would not receive the proper treatment they needed. In an interview on [DATE] at 10:16 am, this writer contacted the van insurance company from the invoice provided by the Human Resource Director and was informed the policy had been cancelled and was not active. In an interview on [DATE] at 10:45 am, the Dietician said she was concerned about the food budget and not enough money to cover the menu. She said she was not aware the facility had been substituting the menu as frequently as they were doing. She said the facility should not be having to substitute more than 2 meals a week. In an interview on [DATE] at 1:15 pm, the laundry supervisor said the facility was not using the recommended bleach or detergent for the laundry, and no alkaline was being used. One washing machine was not equipped anymore to receive chemicals and they wash items in that one that doesn't require bleach. She said it had been over 2 years since the washing machines had been serviced. She said as a result the laundry had the potential to not be sanitized properly. In an interview on [DATE] at 8:24 am, Facility Physician B stated it was very difficult to communicate with the facility due to no phone or fax service. He said a resident had an appointment with him yesterday, but it was cancelled. He was not aware it was cancelled due to the facility not being able to transport residents due to having no insurance on the facility van. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	6). Action: Staff will be reimbursed for their out-of-pocket expenses per usual procedures, including submitting reimbursement requests and receipts. The Human Resource Director (HR) will instruct line staff not to purchase items for the facility in the absence of the facility administrator; all purchases will be made by the facility administrator and/or the HR Director after the weekly Thursday conference call. Start Date: [DATE] Completion Date: [DATE] Responsible: Chief Executive Officer (CEO) and Chief Operating Officer (COO), Director of Nursing (DON), Human Resource Director (HR), and Administrator (LNFA) 7). Action: Annual van registration and insurance will be added to the annual maintenance checklist to ensure timely registration renewal; The facility administrator will review the yearly checklist during QAPI to ensure timely review. Start Date: [DATE] Completion Date: [DATE] Responsible: Maintenance Director and Facility Administrator 8). Action: An ad-hoc QAPI meeting will be held, and the facility Medical Director will be notified of the deficient practice and the approved removal plan. Action items will be reviewed monthly during the QAPI meetings for the next 3 months and ongoing as needed. Meeting minutes will be taken and maintained for 12 months. Start Date: [DATE] Completion Date: [DATE] Responsible: Chief Executive Officer (CEO) and Chief Operating Officer (COO), Director of Nursing (DON), Human Resource Director (HR), and Administrator (LNFA). Verification: Record review of receipt payment dated [DATE] to Water Department dated [DATE] for $1,579.21. Record review of receipt payment dated [DATE] reflected $1,141.08 to garbage and waste. Record review of receipt payment dated [DATE] to Water Department for $1,579.21 Record review of receipt dated [DATE] reflected $286.86 for ice machine payment. Observation on [DATE] at 3:46 pm revealed the fire sprinkler system with tag noted to have been serviced and working. (continued on next page)

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	455893	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Care Center of Henrietta	807 W Bois D Arc Henrietta, TX 76365

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an Interview on [DATE] at 11:20am, Resident #1 stated she gets all of her medications as far as she knows and had no concerns. She stated she has her own cell phone so not affected. In an Interview on [DATE] at 11:22am, Resident #9 stated he gets all of his medications and has no concerns with care. In an observation on [DATE] at 11:55am, 9 residents were in the dining room. The menu was followed, and no food concerns were noted. In an observation on [DATE] at 9:20am, the kitchen had 7 days of non-perishable food and 3 days of perishable and no concerns were noted. In an Interview on [DATE] at 3:17pm, Resident # 11 stated she has access to her visitors and them to her and no concerns of anything about her care at the facility. In an Interview on [DATE] at 3:27pm, Resident #13 and Resident #10 stated they have access to their visitors and have no issues or concerns with their care and get their doctor appointments. A record review of the in-service titled Governing Responsibility dated [DATE] and signed by the CEO and COO reflected the importance of paying bills timely and the expectation of them to meet weekly on Thursdays to ensure bills are paid timely. Observation on [DATE] at 12:23pm revealed 9 residents in the dining room with no portion concerns. Food appears palatable and displayed well. Record review of the maintenance checklist on [DATE] at 3:15 pm revealed vehicle registration and insurance renewal was added annually with a next review date of [DATE]th, 2025. Record review of Medication Pass Observations for 5 nurses dated [DATE]-[DATE] for med pass observation by DON reflected medication pass observations were completed by the DON of her nurses. In an interview on [DATE] at 12:16 pm, the COO confirmed she had been in-serviced concerning bills must be paid in a timely manner and she is to meet weekly with the CEO and Human Resource Director weekly to review. In an interview on [DATE] at 1:27 pm, LVN E stated she had received 1:1 instruction from the DON on how to administer medications during an internet outage and how to obtain a copy of the paper MAR if one is not available. She said she had completed 2 in-services regarding medication administration and medication errors. In an interview and record review on [DATE] at 1:59 pm, the Human Resource Director stated she purchased additional data for the hot spots early today and provided a copy of the receipt dated [DATE] that indicated additional data purchased. The Human Resource Director provided the training sheet that was completed with the department heads on the process of communicating supply needs to be completed weekly. Human Resource Director said that 1:1 training with the department heads had been completed and they reviewed the process of communication for supply needs. She said she is to have a meeting weekly, on Thursdays, with the CEO and COO concerning supply needs of the facility. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on [DATE] at 2:13 pm, the Human Resource Director confirmed weekly meetings were to be held with the CEO and COO on Thursdays to discuss billing and concerns. Record review/Observation on [DATE] at 2:45 pm of job website revealed the Administrator's position was posted for a salary up to $50,[AGE] yearly with a sign on bonus. In an interview on [DATE] at 3:37 pm, the Maintenance Director stated he was given the task of monitoring supplies for the laundry weekly. He created a spread sheet weekly for the laundry staff to review needed supplies. Maintenance Director said he had the vehicle insurance and registration task added to his annual checklist. In an interview on [DATE] at 4:00 pm, the DON reported all the resident's representatives had been [TRUNCATED]

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47044 Based on interview and record review, the facility failed to implement appropriate plans of action to correct identified quality deficiencies and to regularly review and analyze data, including data collected under the QAPI program and act on available data to make improvements for one of one facility. The facility failed to follow their Plan of Correction (POC) dated 1/3/25 in utilizing a pool of RNs from neighboring/sister communities to ensure RN coverage at least 8 consecutive hours/day 7 days/week for 28 days since the dated POC. The facility failed to follow their POC to review weekly RN coverage in SOC (Standard of Care meeting) by the Administrator and DON to ensure appropriate RN coverage is arranged and provided by the facility or services of facilities or RN telehealth audio and visual capabilities were arranged. The facility failed to follow their POC to discuss the quality deficiencies in monthly QAPI meetings for 3 months. This failure placed the residents at risk of oversight and management of the residents' healthcare needs and in managing and monitoring of the direct care staff which would ultimately affect resident care. Findings included: Record review of the POC dated 1/3/25 revealed the facility created a pool of Registered Nurses from neighboring/sister communities to ensure the human resources need to provide the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. The POC revealed weekly RN staffing needs would be reviewed weekly in SOC by the Administrator and DON to ensure appropriate RN coverage was arranged or services of facility RN telehealth audio and visual capabilities were arranged. Systematic failures will be discussed monthly in QAPI for 3 months to ensure effectiveness of systematic approaches. In an interview on 02/23/25 at 10:50 am, the DON said she was on medical leave and returned to the facility on [DATE]. She said during the time she was off, there was no RN coverage for the building. She said she only works Monday-Friday so there is no RN in the facility on the weekends, but staff can call her if needed. In an interview dated 3/13/25 at 10:30 am with the Human Resource Director which provided QAPI notes, stated the Medical Director and Administrator did not attend the meeting. The Human Resource Director stated we talked about it [RN coverage] but there is nothing we can do about it. There was no meeting in February. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow-up interview dated 3/15/25 at 2:25pm with the Human Resource Director, she stated the facility did have a pool with their sister facility, but that facility had several RNs quit. The Human Resource Director stated she had RN positions posted on a job website and stated she would provide the postings. These postings were not provided prior to exit. HR stated she monitored the coverage and reported to the CEO and COO. One QAPI meeting was held since 1/3/25 and that was on 1/24/25. The Human Resource Director further stated the February QAPI meeting was cancelled because staff had to cover because COVID was in the building. The March QAPI meeting is scheduled for next week. In an interview dated 3/15/25 at 2:02pm with the DON stated there is no pool of RNs. The SOC was not happening weekly because there is no Administrator. We [facility] used to have telehealth but that was before Thanksgiving. We are encouraged not to use it and staff don't know how to use it . The DON stated during the meeting on 1/24/25 that there was no discussion of RN coverage, and DON has no knowledge of RN positions posted online or anywhere. Record review of the SOC Meeting dated 1/24/25 provided by Human Resource Director as QAPI meeting minutes revealed DON, Human Resource Director, Activity Director, Maintenance Supervisor and Social Worker attended meeting. Meeting minutes revealed Resident Level Quality Measure Report run dated 2/9/25 for period of 1/1/25-1/31/25. No other information. No information regarding RN coverage or next QAPI meeting date. In a record review and interview on 02/23/25 at 10:00 am, the Human Resource Director provided the Nurse Staffing Information from January 1, 2025, to February 21, 2025. It revealed there was no RN coverage for dates of 01/01/25, 01/02/25, 01/03/25, 01/04/25, 01/05/25, 01/06/25, 01/07/25, 01/08/25, 01/09/25, 01/10/25, 01/11/25, 01/12/25, 01/13/25, 01/14/25, 01/15/25, 01/16/25, 01/17/25, 01/18/25, 01/19/25, 01/20/25, 01/26/25, 01/27/25, 02/01/25, 02/02/25, 02/08/25, 02/09/25, 02/15/25, and 02/16/25, 03/01/25 and 03/03/25. The Human Resource Director confirmed there was no RN coverage for the dates. She said the DON was out on medical leave and returned on 01/21/25. The DON works Monday-Friday. There is no RN coverage for the weekends , but staff can call the DON if needed. Record review of Quality Assurance and Improvement Committee policy undated revealed The committee will meet monthly .The committee shall track the progress of any plans of correction. Record review of indeed jobs revealed Administrator and CNA job posting for this facility but no RN posting located.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41871 Based on observation, interview, and record review, the facility failed to handle, store, process, and transport linens in accordance with accepted national standards in order to produce hygienically clean laundry and prevent the spread of infection to the extent possiblefor 1 of 1 washing machines observed for infection control practices. The facility failed to make sure the washing machine had hot water and chemicals to sanitize and clean linens and clothing for residents. This failure could affect the residents in the facility by placing them at risk of possible unsanitary conditions and run the risk of infections. Findings included: In an interview on 02/22/25 at 11:30 pm, the Maintenance Director stated the hot water heater for the laundry did not work and was not able to get it fixed due to the facility owing money to the vendor. The washing machine had an error code, and it needed to be serviced but could not get it serviced due to the past bill . The washing machines did not have the correct chemicals but cannot order them due to a past bill. In an interview on 02/22/25 at 02:10 PM, Housekeeper C stated there was no hot water in the laundry and all laundry was being washed in cold water. She said the washing machine had no chemicals and needed to be serviced. She said staff have purchased bleach and laundry detergent so they could do the resident's laundry, but they were not the required chemicals. She said the laundry had a smell of urine after being washed. In an interview on 02/23/25 at 10:50 am, the DON said she was aware the facility did not have hot water for the laundry. The DON said there have been no reports of residents having skin issues or infections relating to the laundry. The DON was aware staff were purchasing laundry soap and bleach for the washing machine for the the resident's laundry. In an observation on 02/23/25 at 12:23 pm, the linen closet was observed. The linens were stained with dark spots and had a musty odor. The pads smell of urine. In an interview and observation on 02/24/25 at 11:00 am, the Laundry Supervisor stated the facility did not have hot water for the laundry for approximately over a month due to the hot water heater not working. The resident's laundry was being washed in cold water. The laundry supervisor also stated it had been reported to maintenance, and maintenance was aware. She said the washing machine did not have the correct chemicals to sanitize the resident's laundry properly. She said the washing machine had an error code and it needed to be serviced. She said the facility had not paid the bill to the servicer and will not come to fix it. She said staff purchased bleach and laundry soap as the facility had not been providing them. She said the linens smell of urine, especially the pads. Observed and smelled the clean linens, the pads had an odor of urine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 02/24/25 at 2:54 pm, the Maintenance Director stated the facility needed a new hot water heater for the laundry. He said the facility could not get anyone to come out and look at the hot water heater due to the facility owing everyone money. He said the washing machine could not be serviced due to an unpaid bill. He said the facility could not order the proper chemicals for the washing machine due to an unpaid bill. He said that it had been reported to corporate and they were aware of the situation but failed to get it fixed/serviced. In an interview with the CEO on 02/25/25 at 4:20 pm, he said he was not aware the washing machine did not have hot water and needed to be serviced. Review of the facility's Resident List Report, dated 02/22/25, revealed a census of 23 residents.