STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675002	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retama Manor Nursing Center/San Antonio West	636 Cupples Rd San Antonio, TX 78237

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on observation, interviews, and record reviews the facility failed to ensure each resident was treated with respect, dignity, and care for 2 of 8 residents (Resident #18 and Resident #56) observed for resident rights. 1. The facility failed to ensure all residents were served at one table before serving the other tables, allowing all residents to eat at the same time at their respective tables. 2. Residents were served a fried chicken patty instead of fried chicken for 01/26/25 lunch meal. 3. Residents struggled to cut their fried chicken patty with a fork. These failures could place residents at risk of not being treated with dignity and respect. Findings included: Resident # 18 Record review of Resident #18's Admission Record, dated 01/26/25, reflected Resident #18 was an [AGE] year-old initially admitted on [DATE]. It reflected Resident #18 had diagnoses to include dysphagia (difficulty in swallowing), lack of coordination, muscle weakness, cognitive communication deficit, and dementia (group of symptoms affecting memory, thinking and social abilities. Record review of Resident #18's quarterly MDS assessment, dated 10/16/24, reflected Resident #18 had a BIMS of 15 out of 15, indicating intact cognition. Record review of Resident #18's Lunch-Day 15 lunch meal tray ticket, dated 01/28/25, reflected menu to include Fried Chicken. Resident #56 Record review of Resident #56's Admission Record, dated 01/26/25, reflected Resident #56 was a [AGE] year-old initially admitted on [DATE]. It reflected Resident #56 had diagnoses to include depression, anxiety, lack of coordination, pain, and dementia (group of symptoms affecting memory, thinking and social abilities. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #56's quarterly MDS assessment, dated 12/06/24, reflected Resident #56 had a BIMS of 07 out of 15, indicating severe cognitive impairment. Record review of Resident #56's Lunch-Day 15 lunch meal tray ticket, dated 01/28/25, reflected menu to include Fried Chicken. During an interview and observation on 01/26/25 at 12:27 PM, Resident #18 was sitting with another resident. Resident #18 revealed she had not received her lunch meal tray yet. The other resident sitting with Resident #18 was observed to be done with her lunch meal. Resident #18 revealed the other resident always got her meal first and Resident #18 was always waiting on her meal. Resident #18 revealed I want my meal and it bothered her that she still did not have her lunch meal tray. During an interview and observation on 01/26/25 at 12:32 PM, Resident #56 revealed he received a chicken patty but wanted fried chicken as was reflected on his meal tray ticket. He revealed the chicken patty was half burnt, showing the bottom side of his chicken patty appeared to have the color black on some parts. He further revealed the chicken patty was too hard and it would take half a day to cut. Resident #56 was observed cutting his chicken patty with a fork. During an interview and observation on 01/26/25 at 12:35 PM, Resident #18 revealed she can't eat the chicken patty that was served for 01/26/25 lunch. She revealed it was too hard and she could not cut it with her fork. She further revealed they did not receive any knives, so they had to cut their food with either a fork or a spoon. Resident #18 picked up the chicken patty and hit it on her plate, emphasizing how hard the chicken patty was and she needed a knife to cut her foods. Resident #18 revealed she had to ask for an alternative because she was not going to eat the chicken patty. During an interview on 01/26/25 at 12:52 PM, the ADM and DON revealed the facility did not have any knives provided for residents to eat their meals due to safety concerns because they had a lot of residents with behavioral issues. During an interview on 01/28/25 at 04:35 PM, the CDM revealed there were no substitution logs for this month (January 2025). He further revealed they used the substitution log in case they were not able to order what was needed for the menus. The CDM revealed they could not order the fried chicken that was reflected on the 01/26/25 lunch menu. During an interview on 01/28/25 at 06:39 PM, the DON revealed he was not aware if residents at each table should be served first before the next, but it made sense when it could affect the residents' eating. During an interview on 01/29/25 at 04:31 PM, the RD revealed she did not have to sign a substitution log for January 2025. The RD revealed the facility needed to be following the menus and the CDM was working on getting the ordering down. The RD revealed the facility needed to get a substitution log so the RD can make sure it was an acceptable substitution. The RD revealed the facility did not have knives because several residents had behavioral issues, however she understood from the resident's standpoint, it would be difficult for residents to cut foods as needed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/30/25 at 03:15 PM , CNA F revealed some of the residents get upset if they were not served what was on the menu. He revealed it was important to serve all the residents at one table first before moving onto the next table so they could eat together, because residents had feelings and could feel bad. Record review of the facility's policy Resident Rights, revised February 2021, reflected Employees shall treat all residents with kindness, respect, and dignity.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observations, interview and record review the facility failed to ensure the resident has a right to personal privacy and confidentiality of his or her personal and medical records for 3 of 9 (room [ROOM NUMBER], #47 and resident #76) incidences of privacy concerns in that: 1. LVN J did not knock on rooms [ROOM NUMBERS] before entering rooms. 2. LVN Z left her computer open with resident#76's personal information. This could affect and result in resident privacy being violated. The Findings were: 1. Observation on 1/26/2025 at 10:33 AM LVN J went into room [ROOM NUMBER] and did not knock on the door before entering room. Observation on 1/26/25 at 10:00 AM LVN J went into room [ROOM NUMBER] and did not knock on the door before entering room. Interview on 1/26/25 at 10:38 AM with LVN J stated she did not knock on the 2 doors, and she should have knocked before she entered. 2. Observation on 1/26/2025 at 12:11 PM to 12:19 PM revealed LVN Z had her computer screen open revealing Resident #76's confidentiality information . (residents picture, resident name, vitals, age, id number, and medications to be provided). Interview on 1/26/2025 at 1:48 PM with LVN Z stated she forgot to turn the monitor screen off and got busy checking resident lunch trays. Interview on 1/28/2025 at 12:04 PM with ADM and DON, did discuss and stated they will educate staff on the concerns with knocking on the door, and staff leaving the computer screen open to residents' personal information. No other response was provided. Record review of policy, Dignity dated February 2021 Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. 1. Residents are treated with dignity and respect at all times. 7. Staff are expected to knock and request permission before entering resident's rooms. Record review of policy, Confidentiality of Information and Personal Privacy dated October 2017 was documented Our Facility will protect and safeguard resident confidentiality and personal privacy. 1. The facility will safeguard the persona privacy and confidentiality of all resident personal and medical records. 4. access to resident personal and medical records will be limited to authorized staff and business associates.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews the facility failed to ensure residents had a safe, clean, comfortable, and homelike environment, with adequate and comfortable lighting levels in all areas; for 2 of 8 residents (Residents #18 and #37) reviewed for adequate lighting in the dining room. On 1/26/2026 at noon and ongoing until 1/30/2025 the facility's dining rooms had malfunctioning fluorescent lamps and fixtures, which residents #18 and #37 had stated they wished for better lighting during their meals. These failures could negatively impact residents' morale and overall sense of self-esteem. The findings included: A record review of Resident #18's admission record dated 1/30/2025 revealed an admitted [DATE] with diagnosis which included dysphagia (difficulty swallowing), anxiety, and bipolar disorder (a serious mental illness characterized by extreme mood swings.) A record review of Resident #18's quarterly MDS assessment dated [DATE] revealed Resident #18 was an [AGE] year-old female admitted for long term care and assessed with a BIMS score of 15 which indicated intact cognition. Further review revealed Resident #18 could usually understand others, could make herself understood, had adequate vision and hearing. Resident #18 was assessed with the ability to use suitable utensils to bring food and / or liquid to her mouth and swallow food and / or liquid once the meal was placed before her. During the assessment Resident #18 stated she sometimes felt lonely and isolated. Resident #18 was assessed with the need to use a wheelchair and could ambulate with the wheelchair. Resident #18 was assessed as medically complex with anemia (eating a healthy diet might prevent some forms of anemia), and malnutrition. A record review of Resident #18's care plan dated 1/30/2025 revealed, Resident at risk for nutritional problem r/t vitamin D def sic(deficiency), HTN (high blood pressure), CHF (heart failure), CKD (kidney disease) and obese status . Monitor/document/report to MD PRN (as needed) for s/sx (signs and symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, appears concerned during meals. Date Initiated: 08/26/2022 Provide and serve diet as ordered. A record review of Resident #18's physicians' orders dated 1/30/2025 revealed the physician prescribed for Resident #18 to receive mirtazapine (an antidepressant - often prescribed off-label as an appetite stimulant to aid in weight gain for certain populations) 15mg at bedtime for a poor appetite. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #37's admission record dated 1/30/2025 revealed an admitted [DATE] with diagnoses which included bilateral cataracts (both eyes - a condition affecting the eye that causes clouding of the lens. A gradual progression of vision problem, eventually, if not treated, may result in vision loss), depression, and dysphagia (difficulty swallowing). A record review of Resident #37's quarterly MDS assessment dated [DATE] revealed Resident #37 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 15 which indicated intact cognition. Further review revealed Resident #37 could usually make herself understood and could understand others. Resident #37 was assessed with symptoms of little interest or pleasure in doing things? . feeling down, depressed, or hopeless? . yes 2-6 days .over the last 2 weeks Resident #37 was assessed with the ability to use suitable utensils to bring food and / or liquid to her mouth and swallow food and / or liquid once the meal was placed before her. Resident #18 was assessed as medically complex with a diagnosis of malnutrition. During an observation and interview on 1/26/2025 at 12:08 PM Resident #18 and #37 were seated together at one of the dining room tables. The dining room was 1 of 2 which were adjacent to one another. The fluorescent light fixture directly above Resident #18's and #37's table was not illuminated and caused for a dimly lighted area within the dining room. Further observation revealed 4 out of approximately 9 fixtures were not illuminated in the dining rooms. Resident #18 and #37 stated the lights had not worked, for some time now . we don't know how long. Residents #18 and stated she felt a little down and she wished the lights worked and stated, I wish I could see what I am eating. Resident #37 stated, the dark makes me feel down. I would like more light . I want to see my food. During an observation on 1/26/2025 at 12:08 to 12:45 PM the facility's dining rooms had flickering fluorescent lamps due to staff attempting to illuminate the malfunctioning lamps. Admissions coordinator stated the lights were now working because he turned on and off the switches. Observation at the time revealed the malfunctioning lights were illuminated only to malfunction again. The operations manager stated the electrical contractor would be called to repair the malfunctioning lamps. Continued daily intermittent observations from 1/26/2025 to 1/30/2025 revealed the dining rooms continued with malfunctioning lamps. A record review of the facility's policy titled Residents Rights dated February 2021 revealed, Policy Statement Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity;

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on observations, interviews, and record reviews the facility failed to protect the residents right to be free from physical abuse by Resident #83 and #55, for 3 of 13 residents (Residents #55, #61, and #83) reviewed for physical abuse and neglect. 1. On 1/11/2025 on or about 11:00 AM Resident #61 was physically battered by Resident #83, to include a face punch, his hair pulled, and drug by his foot across the floor. 2. On 4/9/2024 Resident #61 entered Resident #55 room and began to use the restroom when Residents #55 and #61 began forcing each other's hands away from one another. 3. On 4/22/2024 Resident #61 was punched in the nose by Resident #55. 4. On 8/12/2024 Resident #61 was punched in the face by Resident #55 when he entered Resident #55's room. An IJ was identified on 1/29/2025. The IJ template was provided to the facility on [DATE] at 3:15 PM. While the IJ was removed on 1/30/2025 at 9:00 PM, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm. These failures placed residents at risk for physical abuse. The findings included: 1. Resident #61 A record review of Resident #61's admission record dated 1/27/2025, revealed an admitted [DATE] with diagnoses which included dementia with moderate agitation (a group of symptoms affecting memory, thinking and social abilities. further review revealed Resident #61 resided in the facility's secured Memory Care Unit (MCU). A record review of Resident #61's annual MDS assessment dated [DATE] revealed Resident #61 was a [AGE] year-old male admitted for long term care and was assessed with a BIMS score of 4 out of a possible 15 which indicated severely impaired cognition. Resident #61 was reviewed for the 6 days prior to the assessment and Resident #61 was assessed with a history of wandering, has the Resident wandered? Behavior of this type occurred 1 to 3 days. does the wandering place the Resident at significant risk of getting to a potentially dangerous place? Yes Resident #61 was diagnosed with cataracts (a gradual progression of vision problem, eventually, if not treated, may result in vision loss.) Further review revealed Resident #61 was 5 foot and 5 inches tall and weighed 129 lbs. A record review of Resident #61's care plan dated 1/29/2025 revealed, Behavioral Complex Care Plan Physically Abusive Behavior, Socially Inappropriate Behavior, Wandering, verbally abusive and/or resisting care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	12/24/24 pacing back/forth ready to go to work attempted to go out-door pushing bar. 1/11/25 Another Resident (Resident #83) entered this Res room. Staff heard yelling other resident was found dragging (Resident #61) by the hair as per CNA, then that resident began to drag Resident (#61) by the legs . revision 1/16/2025 . Resident move to different room. Date Initiated: 01/14/2025 Refer to behavioral health Date Initiated: 08/13/2024 Revision on: 8/14/2024 Separate Residents. Date Initiated: 01/11/2025 . Resident #61 uses anti-anxiety medications r/t agitation. Resident #61 is taking Anti-anxiety meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia, falls, broken hips and legs. Monitor every shift for safety A record review of Resident #61's physicians orders, dated 6/10/2024, revealed the physician prescribed for staff to have Frequent monitoring throughout the shift staff to attempt to anticipate some of residents needs as tolerated. A record review of Incident reports indicated the following: A record review of the facility's incident report dated 4/9/2024 revealed Resident #61 entered Resident #55 room and began to use the restroom when Residents #55 and #61 began forcing each other's hands away from one another. Further review of the report revealed the previous administrator and the previous DON had been notified. A record review of the facility's incident report dated 4/22/2024 revealed the previous DON documented Resident #61 was punched in the nose by Resident #55. Resident #61 was presented to the nurse with a bloody nose after exiting Resident #55's room. Resident #61 took the nurse to Resident #55 room and stated, this is the bathroom, and he won't let me use it. He hit my nose. Resident #55 stated, He came in here to take a shit. I told him to get out. He peed in the corner, so I hit him on the nose. A record review of the facility's incident report dated 8/12/2024 revealed the LVN C documented on 8/12/2024 Resident #61 was punched in the face by Resident #55 when he entered Resident #55's room. Resident #55 stated, I hit him because he came into my room. Resident # 83 A record review of Resident #83's admission record dated 1/30/2025 revealed an admitted [DATE] with diagnoses which included dementia (a group of symptoms affecting memory, thinking and social abilities. In people who have dementia, the symptoms interfere with their daily lives), psychotic disturbance (a cluster of symptoms, not an illness. It's sometimes described as losing touch with reality), mood disturbance, and anxiety. Further review revealed Resident #83 resided in the MCU. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of Resident #83's admission MDS assessment dated [DATE] revealed Resident #83 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 6 out of a possible 15 which indicated severely impaired cognition. Resident #83 was reviewed for the 6 days prior to the assessment and Resident #83 was assessed with a history of behavioral symptoms, physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) . behavior of this type occurred 1 to 3 days. verbal behavioral symptoms directed toward others (e. g., threatening others, screaming at others, cursing at others) . behavior of this type occurred 1 to 3 days. impact on others? Put others at significant risk for physical injury? Yes Further review revealed resident #83 was six foot tall and weighed 179 lbs. A record review of Resident #83's care plan dated 1/29/2025 revealed, Behavioral Complex Care Plan Physically Abusive Behavior, Verbally Abusive Behavior 1/1/25 noted standing in doorway of another resident, both residents with raised voices. 1/11/25 Another Resident went into his room this resident. This resident is kept separated from other resident and redirected as necessary Date Initiated: 11/06/2024 Revision on: 01/28/2025 . Look for alternative placement. Date Initiated: 01/14/2025 Residents were separated. Date Initiated: 01/01/2025 Staff to explain cares to resident prior to and during process of cares. Date Initiated: 11/07/2024 Revision on: 11/14/2024 A record review of Resident #61's provider investigation report dated 1/20/2024 revealed the operations manager documented an incident on 1/11/2025 at 11:00 AM, where Resident #83 physically battered Resident #61. The operations manager documented Resident #83 as the perpetrator and identified CNA A and RN S as witnesses. The operations manager documented, Resident was hit by another Resident, dragging by his hair and his leg per CNA. Resident stated he accidentally walked into wrong room. after interviewing staff and Resident(s) it was found Resident wandered into wrong room and was the cause of the altercation and we moved residents' room to avoid future issues. (Resident #61) is extensive supervision and needs constant redirection due to dementia diagnosis During an observation and interview on 01/26/25 at 3:55 PM revealed the MCU where Resident # 61 was asleep in room [ROOM NUMBER] (which was not his assigned room.) CNA A was the only staff in the MCU. CNA A was alerted by the surveyor that Resident #61 was not in his assigned bedroom. CNA A discovered Resident #61 in another bedroom and redirected him to his bedroom. CNA A stated on 1/11/2025 at 11:00 AM she heard screams from the end of the hall and ran to the sounds and witnessed Resident #83 in his room and had Resident #61 by his hair and was dragging him to the floor. CNA A attempted to separate them but Resident #83 was a large man and CNA A was herself threatened so she ran down the hall, exited the MCU to gather emergency assistance, and upon her return to the MCU, she witnessed Resident #83 had Resident #61 by his foot and drug him out of Resident #83's room and into the hallway. CNA A stated, I am often alone in the MCU, the nurse works this MCU and another hall outside of the MCU. CNA A stated Resident #83 was very aware of his room and becomes violent when anyone was in his room. Resident #61 was very confused and often goes into different rooms and Resident #83 becomes aggressive towards Resident #61. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 1/30/2025 at 5:35 PM RN S stated she was a nurse who worked at the facility as needed and could work the MCU during the 10P-6A shift. RN S stated she had received the in-service for the MCU which included the addition of 2 CNAs would staff the MCU. RN S stated she appreciated the addition of 2 CNAs for the MCU since she was on duty on 1/22/2025 at 11:00 AM when Resident #61 was battered by Resident #83 and CNA A had to leave the residents and the MCU to alert her to the resident-to-resident abuse. RN S stated she was on the adjacent hall providing care when CNA A exited the MCU and called out for help in the MCU. RN S stated she ran after CNA A and entered the MCU to the end of the hall to Resident #83's bedroom and witnessed Resident #83 dragging Resident #63 by his legs out of the room into the hall. RN S stated the residents were separated for safety and assessed head to toe, no injuries were assessed for Resident #83, and Resident #61 was assessed with a right cheek redness, slight swelling, and discoloration. The physician received a report and Resident #61 was supported with x-rays which revealed no deep injuries. RNS stated residents were monitored frequently and ultimately Resident #61 was relocated to a bedroom away from Resident #83's bedroom. During an interview on 1/27/2025 at 4:05 Resident #61's emergency contact stated Resident #61 was a full code and would often visit him. Resident #61's emergency contact stated she often observed the MCU was staffed by 1CNA and 1 nurse and was not aware the nurse would leave the MCU to care for residents outside of the MCU. Resident #61's emergency contact stated she received a report from Resident #61's Representative that Resident #61 was punched in the face by Resident #83 but was not aware Resident #61 was left alone with Resident #83 while the CNA left to get help. During a joint interview on 1/28/2025 at 11:47 AM Resident #61's representative and emergency contact stated they had not received a full report for the Resident-to-Resident aggression on 1/11/2025 when Resident #61 wandered into a different bedroom, I only knew that another Resident had hit Resident #61 in the face and he had received x-rays. Resident #61's representative and emergency contact stated they were unaware the MCU was staffed by one CNA and were unaware Resident #61 was left alone while Resident #83 was beating Resident #61, (Resident #61) is profoundly confused and needs redirection to his bedroom . he often goes to lay down . and needs to be monitored for safety and never left alone During a joint interview on 1/28/2025 at 8:55 AM the DON and the operations manager stated the facility operates 3 shifts: 6:00 AM to 2:00 PM, 2:00 PM to 10:00 PM, and 10:00 PM to 6:00 AM to include the MCU. The operations manager stated she investigated an incident of Resident-to-Resident aggression between Resident #61 and Resident #83 on 1/11/2024 at 11:00 AM when CNA A witnessed Resident #83 pulled Resident #61 out of his room when Resident #61 wandered into the bedroom. The DON stated currently 13 residents resided in the MCU to include Residents #61 and Resident #83. The DON stated the MCU was staffed by 1 CNA and 1 nurse during every shift. The DON stated the nurse was also assigned another set of residents to care for outside of the MCU and stated, she would leave the MCU to care for residents in the C hall. The administrator stated the facility provided for Resident #61's safety, post the aggression incident, by moving Resident #61 to a different bedroom away from Resident #83 and continued with the 1 CNA to monitor and redirect the MCU residents. The operations manager and the DON stated the IDT met Monday - Friday mornings and they were responsible for leading the meeting. The DON and the operations manager stated the previous day's care was reviewed and the team would be responsible for developing and implementing any further care to keep residents healthy and safety. The operations manager stated on 1/13/2025 the IDT met and decided to move Resident #61 to a different bedroom and continue with the level of supervision for the MCU. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/28/2025 at 3:00 PM, the MDS nurse stated she was responsible for updating Residents care plans to include Resident #61's care plan on 01/14/2025. The MDS nurse stated the IDT met during the morning meeting on 01/13/2025 and again on 01/14/2025 and reviewed the aggression incident on 01/11/2025 for Residents #61 and #83 and decided to add interventions for Resident #61 to be moved to a different bedroom and for Resident #83 to be safely discharged to another facility. The MDS nurse stated residents in the MCU had a history of Resident-to-Resident physical aggression and prior to the 01/13/2025 and 01/14/2025 meetings, there were no interventions for monitoring for wandering safety for residents #61 and #83 to include the history of physical aggression between the two. Resident #55 A record review of Resident #55's admission record revealed an admitted [DATE] with diagnoses which included corneal ulcer of the right eye, generalized anxiety disorder, dementia with behavioral disturbance. A record review of Resident #55's annual MDS assessment dated [DATE] revealed Resident #55 was a [AGE] year-old male admitted for long term care and resided in the MCU. Resident #55 was assessed with a BIMS score of 00 which indicated severe cognitive impairment as evidenced by his inability to participate in the assessment. A record review of Resident #55's care plan dated 1/28/2025 revealed, (Resident #55) has a behavioral concern of increased agitation physical and verbal aggression with the possibility of throwing things. 1/8/25: yelled and cursed at SW Date Initiated: 12/22/2022 Revision on: 01/09/2025 Intervene as needed to ensure resident safety. Date Initiated: 12/22/2022 Leave additional activities to keep resident engaged. (psych provider) eval/tx for psychological services. Refer to behavioral health. Date Initiated: 08/13/2024 Revision on: 08/13/2024 . Staff to redirect resident to other activities Date Initiated: 12/22/2022 Revision on: 12/22/2022 2. During an interview and observation on 01/26/25 at 4:00 PM revealed LVN C entered the MCU and to exit the MCU and attended residents in the C-hall. LVN C stated she was assigned to work the MCU and the c-hall (rooms 34-46) which were located outside of the MCU. LVN C stated the MCU was also staffed by 1 CNA, who would stay in the MCU. During an observation and interview on 1/27/2025 at 3:32 PM revealed CNA B exited the MCU, continued observation revealed the MCU was unattended. At 3:54 PM revealed CNA B returned to the MCU. CNA B stated he was the only staff in the MCU and had left the MCU briefly to return a meal tray to the kitchen. CNA B stated he was the CNA for the MCU and there was no nurse until 4:30 PM. CNA B stated the current nurse on duty was the DON and he was not in the MCU. CNA B stated if a Resident had aggression, he would be by himself, he would attempt to separate residents and then leave the MCU to go get help. CNA B stated if a Resident was discovered unresponsive, he would have to leave the unit to ask for help because he would not know who was a full code and/or a DNR. CNA B stated it was routine to be by himself due to the routine schedule which had a nurse to work 2 halls to include the MCU. CNA B stated his concern for aggressive and confused residents was for Resident #61 and Resident #83 history of physical aggression. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with DON and Administrator on 01/28/2025 at 4:10 PM, their plan for keeping residents safe was for staff to monitor wandering residents, separate aggressive residents, and leave the memory care unit to call for help. A record review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated April 2021, revealed, Policy Statement: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The Administrator was notified on 1/29/2025 at 3:15 PM an IJ was identified on 1/29/2025 due to the above failures. The IJ template was provided to the facility on [DATE] at 3:15 PM and was accepted on 1/30/2025 at 9:00 PM. Plan of removal Date 1/29/2025 (the Facility) PLAN OF REMOVAL FOR IMMEDIATE JEOPARDY To Whom it May Concern, Summary of details which leads to outcomes. On 1/29/2025 sic(1/26/2025) annual survey was initiated at (The Facility). On 1/29/2025, a surveyor provided an IJ Template notification that the Survey Agency has determined that the conditions at the center constitute immediate jeopardy to residents' health. The notification of the alleged immediate jeopardy states as follows: F600 Abuse and Neglect The facility neglected to have measures in place to keep residents in the memory care unit free from abuse. Problem On 01/11/2025 at 11 AM, Resident #61 wandered into Resident #83's room on the memory care unit. Resident #83 punched Resident #61 in the face, pulled Resident #61's hair, and dragged Resident #61 across the floor by his foot. Immediate Corrections Implemented for Removal of Immediate Jeopardy. Once the facility was made aware of the deficient practice, the Director of Nursing/ designee immediately ensured a second team member would be staffed in the memory care unit as of 1/28/2025. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility Director of Nursing/designee completed a 100% in-service for nursing staff over ensuring two staff members need to be in the memory care unit at all times, that one staff member needs to remain in memory care unit in the case of emergencies, and utilization of walkie talkies to promote communication between unit and general population. Walkie Talkies will be held by nursing staff member, as emergency communication back up, in the unit and the second by the licensed nurse that is floating between two units. Identification of Others: Residents identified at risk for deficient practice are the resident population residing in the memory care unit. Systemic Changes The Director of Nursing/ designee initiated immediate education with all licensed/certified nursing staff over staffing requirements for memory care unit, that one facility staff member needs to remain in memory care unit in the case of emergencies, and utilization of walkie talkies to promote communication between unit and general population. These educations are at 100% completion as of 1/28/2025. Staff who are on leave or off-site have been notified and provided education via phone call. The Director of Nursing /designee initiated immediate education, by neuropsychologist, with all licensed/certified nursing staff over managing difficult behaviors, de-escalation strategies, and wandering/elopement on 1/29/2025. This education will be at 100% completion by 1/29/2025. Staff who are on leave or off-site have been notified and provided education via phone call. The Director of Nursing/designee initiated immediate education with all facility staff over the Abuse, Neglect, Exploitation or Misappropriation Prevention Program on 1/29/2025. Staff who are on leave or off-site have been notified and provided education via phone call. Administrator/designee will conduct monthly all-staff meetings, beginning on 2/12/25, during monthly in-service a specific aspect of behavioral care will be addressed: focus on de-escalation of behaviors, behavior management, wandering, dementia care and activities. All education and training was sic(were) started on 1/28/2025 and will continue until all nursing staff have received training prior to the start of their work shift. The facility Director of Nursing, Corporate Clinical Director and Administrator met on 1/28/2025 to evaluate the facility's staffing schedules and requirements regarding the memory care unit and general population. All residents have access to behavioral health services. Residents with increased behaviors are identified by staff and provided with comprehensive behavioral health services to include medication management, counseling services, cognitive behavioral therapy, and neuropsych sic(neuropsychic) therapy. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Director of nursing/designee will complete education and training with all licensed/certified nursing staff and newly hired licensed/certified nursing staff over facility's memory care unit staffing requirement. The education will be provided by DON or designee and be kept in the employees' HR file. The Director of nursing/designee will complete Preferences for Activity and Leisure (PAL) Cards for all residents in the memory care unit to assist in managing challenging behaviors and de-escalation strategies such as providing triggers, providing comfort and familiarity, offering calming strategies, encouraging positive redirection, supporting non-verbal communication, building trust and rapport, etc. By integrating PAL Cards into daily care, staff can proactively prevent agitation and respond effectively when challenging behaviors arise, fostering a person-centered care environment. PAL Cards will be completed for all residents in memory care unit by 1/29/2025. All nursing staff will receive education on purpose and utilization of PAL Cards by 1/29/2025. The Administrator, DON, and designee will develop and ensure an ongoing long-term monitoring and oversight system is in place by 1/29/2025 to review and address concerns related to the deficient practices identified in F600. Monitoring will include a system to ensure deficient practice is prevented and residents in the memory care unit will have sufficient supervision. The monitoring and oversight system will gather measurable data for review of patterns or trending. Concerns identified will be provided by the DON or designee to the QAPI committee monthly, for a minimum of 6 months, for the discussion of sustaining compliance or correction of concerns identified. Monitoring The DON or designee will develop a short-term monitoring system for all areas of deficient practice identified for this deficiency. Monitoring will include a system to observe all residents especially in the memory care unit are under appropriate supervision. This monitoring system will begin 1/29/2025. All concerns identified during the monitoring process will be addressed timely and staffing will be adjusted appropriately. The monitoring process, findings, and corrections will be presented to the facility QAPI committee each month for a minimum of 3 months for this plan of correction. The administrator will be responsible for monitoring DON compliance with the system weekly. System compliance will be documented and discussed. Administrator/designee will monitor use of walkie talkies every shift x 7 days then random audit daily x 3 months. Sign out log will be completed every shift to validate staff responsible for carrying and utilization of walkie talkies. The Administrator/ designee will develop or ensure an ongoing long-term monitoring and oversight system is in place by 1/29/2025 to review and address concerns related to the deficient practices identified in F600, to include monitoring of PAL card use and compliance with utilization and updating as appropriate. Clinical Director of Operations will in-service Admin and DON over deficient practice F600 Abuse and Neglect on 1/29/2025. Monitoring will be conducted weekly for 4 weeks to determine if compliance is being sustained. Sustained compliance or corrective actions will be discussed and documented in QAPI Meeting. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Social Services/designee will attend daily meeting Monday - Friday to be made aware of any newly identified behaviors or concerns. Social Services/designee will assure necessary notification to behavioral health services are in place or make necessary appointments to have residents in need seen as soon as possible. The QAPI committee will meet monthly, and facility interdisciplinary team will meet daily to review the ongoing status of the corrections for this deficiency with the purpose to identify, evaluate, plan, implement, and address concerns or deficient practices identified as it relates, or to determine if compliance is being sustained. All corrections or steps taken and identified by QAPI will be documented. Ad Hoc QAPI meeting will be held on 1/29/2025 with the Medical Director, Administrator and Director of Nursing to review and validate the plan of removal. Involvement of Medical Director The Director of Nursing notified the facility's Medical Director, of the Immediate Jeopardy tag on 1/29/2025. The Administrator will be responsible for implementation of ensuring the adequate process regarding staffing requirements for increased supervision and minimize to support accident management. The new process/systems were initiated on 1/29/2025. Please accept this letter as our plan of removal for determination of the alleged Immediate Jeopardy issued 1/29/2025. Plan of Removal Verification Intermittent observations on 1/26/2025, 1/27/2025, 1/28/2025, and 1/29/2025 from 8:00 AM to 10:00 PM revealed 13 residents resided in the MCU to include residents #55, #61, and #83. During an observation and interview on 1/29/2025 at 1:30 PM it was revealed that CNA D and MA E were staffing the MCU. MA E and CNA D stated they were assigned to the MCU and if they needed help, they would stay in the MCU and call via the 2-way radios provided. MA E stated LVN C had the radio while she was out of the MCU providing care for other residents. Observation on 1/30/2025 at 5:25 PM in the memory care unit had 2 CNA's and 1 nurse/CNA. Observation and interview on 1/30/2024 at 5:26 PM revealed LVN R had the other walkie talkie and could use to communicate with the CNAs in the MCU. Observation and interview on 1/30/2025 at 5:24 PM revealed CNA U had a walkie talkie on her, and CNA B stated if one leaves the MCU, they can use the walkie talkie for emergency as well. Dr. x During an observation on 1/29/2025 at 10:40 AM revealed Dr. X provided the in-service topic Understanding Dementia to staff in the facility's living room. During an interview on 01/29/25 at 11:09 AM, Dr. X revealed he conducted an in-service to the facility staff on helping residents with dementia. He revealed some interventions he taught to include getting to know residents, getting to know their triggers, and adjusting resident care accordingly. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of in-service/sign in sheet, dated 1/29/2025, reflected in-service topic Understanding Dementia with Facilitator Dr. X. further review revealed 54-staff signed the document. Observation and interview on 1/30/2025 at 5:24 PM revealed CNA U had a walkie talkie on her, and CNA B stated if one leaves the MCU can use the walkie talkie for emergency as well. During an interview on 1/30/2025 5:29/2025 the DON stated he would hold an all-staff monthly meeting, beginning 2/12/2025, to cover aspects of behavioral care with a focus on de-escalation of behaviors, behavior management, wandering, dementia care and activities. During an interview on 1/30/2025 at 5:38 PM the DON stated all the in-services have been completed for all staff and stated any staff who had not received the in service i.e., new staff, no one would be able to accept a work shift until they received the in service. During an interview on 01/30/25 at 07:00 PM, the Administrator revealed he informed the DON will ensure 2 CNAs will be always staffed back in MCU. They revealed when a staff member did not come in as scheduled, they would make sure to fill this position in. They further revealed they were actively hiring and searching for new staff members to be adequately staffed. Record reviews of facility schedules, from 1/26/2025 to 1/30/2025, revealed the following staff usually worked the following shifts: 6:00 AM - 2:00 PM LVNs RNs: DON ADON LVN C CNAs: CNA G CNA F CNA A MA E CNA H CNA I 2:00 PM - 10:00 PM (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LVN J RN K LVN L LVN W CNAs CNA B CNA M CNA N CNA O CNA P CNA Q 10:00 PM to 6:00 AM Nurses LVN R RN S CNAs CNA T CNA U During an observation on 1/30/2025 at 1:55 PM of the MCU revealed CNA B and CNA U staffed the MCU. It was observed CNA B had on his person the 2-way radio and RN K had the other 2-way radio while she documented at the nurse's station located outside of the MCU. Record review of Resident - to Resident Altercations (2022) and unmanageable residents (2010) policy, in-service, dated 1/11/2025, indicated there is to be 2 CNA's on A hall at all times. If there is an emergency, 1 aide needs to always stay with the resident /residents, while the other aide goes to help, there will be a walkie talkie to communicate with A hall nurse and A hall CNAs in case of emergency. The Walkie talkie needs to always stay with the employee during their shift. Walkie talkies will be checked every shift to ensure they are working properly. There will be a walkie talkie log to be initialed by nurses and CNA documenting they are working properly every shift signed by 53 staff, to include CNA A, CNA B, LVN C, CNA D, and MA E. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of the facility's in- service dated 1/29/2025 titled Abuse and Neglect had 89 staff signatures, to include CNA A, CNA B, LVN C, CNA D, and MA E. A record review of the facility's in- service dated 1/29/2025 titled Understanding Dementia had 44 staff signatures, to include CNA A, CNA B, LVN C, CNA D, and MA E. A record review of the facility's in-service dated 1/29/2025 titled PAL (preference for activity and leisure) had 28 staff signatures. Observation on 1/30/2025 at 7:03 PM revealed the MCU nurse station where the PAL (preference for activity and leisure) binder was located. The PAL (preference for activity and leisure) binder revealed 12 residents had their preferences, likes, dislikes, and plan for redirections and included triggers for behaviors. A Record review of the undated PAL for Resident #55 revealed, Resident is a smoker, likes to eat in dining room. A Record review of the undated PAL for Resident #61 revealed, he has been married [AGE] years. He worked as a driver. He has 2 children. A Record review of the undated PAL for Resident #83 revealed, he was a body work. In jail for [AGE] years causing him to struggle with confinement and others in his space. During an interview on 1/30/2025 at 1:58 PM LVN C stated she had the PAL documents in a binder kept at the nurse station which aided in preferences and redirections for residents. A record review of the facility's in-service dated 1/29/2025 titled monitoring weekly x4 weeks to determine compliance is being sustained had 2 staff signatures to include the DON. During an interview on 1/30/2025 at 05:34 PM the DON stated he received the in service from the regional operations manager on 1/28/2025 to include the new policy to have 2 CNA staff in the MCU during all 3 shifts, to provide the MCU nurse and 1 CNA each a 2-way radio to facilit [TRUNCATED]

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on interview and record reviews the facility failed to ensure implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 8 (Resident #5) residents in that: Resident #5's code status in chart did not match the care plan. This failure could affect residents by not having their end of life met. The Findings were: Record review of Resident #5's Admission Record dated 1/29/2025 was documented she was admitted on [DATE], readmitted on [DATE] with diagnoses of diabetes II (a chronic condition where the body does not use insulin effectively or does not produce enough insulin.), cognitive communications disorder. Further review revealed the resident had an advanced directive of DNR. Record review of Resident #5's consolidated physician orders for January 2025 documented an order for full code (resuscitate). Record review of Resident #5's significant change MDS dated [DATE] was documented her BIMS score was 13 out of 15 (cognitively intact). Record review of Resident #5's psychosocial assessment dated [DATE] was documented she was a full code. Record review of Resident #5's care plan dated 12/12/2024 was documented she was a DNR. Interventions were following facility protocol for identification of code status, and review code status quarterly. Interview on 1/27/2025 at 2:01 PM with Resident #5 stated she wanted to be a Full Code. Interview on 1/29/2025 at 12:24 PM with SW revealed she was hired on 11/2/2024 and confirmed Resident #5's the care plan did not match her order or Admission Record. The SW stated she will check with the nurses to put in resident order. The SW stated she would ask the residents upon admission and quarterly assessments about their advanced directives. Record review of Policy for care plan, Comprehensive Person-Centered dated March 2022 was documented, The Comprehensive Care Plan: includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident highest practicable physical, mental, and psychosocial wellbeing, Include the resident stated goals upon admission and desired outcomes.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observations, interviews and record reviews the facility failed to ensure and provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 5 of 8 (Residents #5, #22, #45, #67, #79) residents in that: 1.Resident #5 stayed in bed and had not observed activities program and activity assessment was not up to date. 2.Resident #22 she called bingo/loteria (Mexican bingo) and tried to get some activities for the other residents, since we don't have a full time Activity Director, since November 2024. The Activity Assessment was not up to date. 3. Resident #45 was bed bound resident with no in room activities. Activity assessment was blank. 4.Resident #67 had activities to do. The Activity Assessment was not up to date. 5. The Activity Calendar did not match the Activity for that hour in the facility. 6. Resident #79 stayed in bed and did not have his choice of activity (watching TV) set up. These failures could place residents at risk of boredom, increased behaviors, and decrease quality of life. The Findings were: 1.Record review of Resident #5's Admission Record dated 1/29/2025 documented she was admitted on [DATE], readmitted on [DATE] with diagnoses of cognitive communications disorder and lack of coordination. Record review of Resident #5's consolidated physician orders for January 2025 was documented she may participate in activities as tolerated. Record review of Resident #5's significant change MDS dated [DATE] documented her BIMS score was 13 out of 15 (cognitively intact). She wore corrective lenses and, sometimes requires someone to help to read instructions or other written material form doctor or pharmacy. Activities important for her to have books, newspaper, magazines music, around animals, do her favorite activities, go outside to get fresh air when weather is good, and participate in religions activities. She required use of manual wheelchair. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retama Manor Nursing Center/San Antonio West	636 Cupples Rd San Antonio, TX 78237

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's care plan dated 12/12/2024 was documented will encourage/assist with environmental acclimation and encourage socialization, recreational activity participation, room personalization, and routine development, Encourage activity/exercises and activity tolerance and ambulation. Record review of Resident #5's Activity assessment dated [DATE] documented at Admission, she was able to read and write, likes to participate in religious activities, music, trips, wheeling outdoors, TV, conversing, and preferred activity in own room. Observation on 1/26/2025 at 3:02 PM in Resident #5's room revealed she was lying in bed with covers over her and watching television. no other in room activity. Observation on 1/27/2025 at 2:01 PM in Resident #5's room revealed was lying in bed covered with blankets and watching television. no other in room activity. Observation on 1/28/2025 at 11:14 AM in Resident #5's room revealed was lying in bed covered with blankets and watching television. no other in room activity.9 Observation on 1/29/2025 at 2:52 PM in Resident #5's room revealed was lying in bed covered with blankets and watching television. no other in room activity. Interview on 1/28/202 at 11:15 AM with Resident #5 stated she no staff come to conduct in room activities with her and she only watches television. 2.Record review of Resident #22's Admission Record dated 1/29/2025 documented she was admitted on [DATE], readmitted on [DATE] with muscle spasm, mild cognitive impairment, generalized anxiety, bipolar (a chronic mental health condition characterized by extreme shifts in mood, energy, and activity levels), and lack of coordination. Record review of Resident #22's consolidated physician orders for January 2025 was documented she may participate in activities as tolerated. Record review of Resident #22's Quarterly MDS dated [DATE] documented her BIMS score was 15 out of 15 (cognitively intact), no devices needed to ambulate, and had pain occasionally. Record review of Resident #22's Quarterly MDS dated [DATE] documented activity-very important to listen to music, be around animals, keep up with news, do things with group of people, go outside to get fresh air when the weather is good, participate in religious activities. Record review of Resident #22's care plan dated 1/22/2025 was documented she was dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits due to forgetfulness and needs reminders, she prefers activities such as gardening, cooking and music. Record review of the Care plan was documented for her behaviors her interventions was staff to redirect resident to other activities, and for her muscle spasm intervention was to participate in daily activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #22's Activity assessment dated [DATE] was documented she walked daily to group activities, she engages in trivia table games, board games, outing, church, pet therapy, music and entertainment assist with passing out activities. Interview on 1/27/2025 at 2:35 PM Resident #22 stated the facility had not had an Activity Director for a few months and the prior Activity Director comes when she can. Resident #22 stated she announced Bingo and some vendors come for activity program but were not at facility all day. Resident #22 stated she tried to gather resident for Activities, so it would not be boring. She stated they do not have a structured Activity program at the facility. Resident #22 stated the vendors for Activities come for an hour a day. 3.Record review of Resident #45's Admission Record was dated 1/28/2025 she was admitted on [DATE], readmitted on [DATE] with diagnoses of hemiplegia and hemiparesis (neurological conditions that cause weakness or paralysis on one side of the body, , dementia) (a syndrome characterized by a progressive decline in cognitive functions, such as memory, thinking, reasoning, and problem-solving, that interferes with daily life and activities), muscle weakness, cognitive communication deficit, need assistance with personal care, and adult failure to thrive. Record review of Resident #45's consolidated physician orders for January 2025 was documented she may participate in activities as tolerated. Record review of Resident #45's Significant change MDS dated [DATE] was documented her BIMS score was 3 out of 15 (severely impaired), had ability to understand, very important for activities was to have books, to listen to music, be around animals, keep up with news, do things with group of people, go outside to get fresh air when the weather was good, and participate in religious activities. Resident #45 was documented she had upper extremity impairment on both sides' lower extremity impairment on one side, she was dependent on oral care, showers, dressing, personal hygiene, she was always incontinent, she used a wheelchair to mobilize in the facility, and required a feeding tube to eat. Record review of Resident #45's care plan dated 1/24/2025 was documented she is dependent on staff for activities, cognition stimulation, social interaction related to cognitive deficits .Interventions she required assistance with activity functions and encourage activity exercises. Record review of Resident #45's Activity assessment dated [DATE] was blank. Observation and an attempted interview on 1/26/2025 at 2:21 PM Resident # 45 was sleeping in bed, covered by sheet, no music or TV on. Resident #45 was not interviewable. Observation on 1/26/2025 at 4:24 PM Resident # 45 was sleeping in bed, covered by sheet, no music or TV on. Observations on 1/27/2025 at 5:02 PM Resident # 45 was sleeping in bed, covered by sheet, no music or TV on. Observation on 1/28/25 at 9:34 AM Resident # 45 revealed she awake, was on laying on her back, no music or TV on. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 1/29/2025 at 10:53 AM in Resident #45's room revealed she was laying down with a blanket on her, no TV or music. 4.Record review of Resident # 67's Admission Record dated 1/27/2025 was documented she was admitted on [DATE], readmitted on [DATE] with diagnoses of muscle weakness, pain, lack of coordination, need for assistance with personal care, and cognitive communication deficit. Record review of Resident # 67's consolidated physician orders for January 2025 was documented she may participate in activities as tolerated. Record review of Resident # 67's Quarterly MDS dated ,d+[DATE]//2024 was documented her BIMS score was 15 out of 15 (cognitively intact). Record review of Resident #67's Annual MDS dated [DATE] was documented was very important to listen to music, do things with group of people, to do her favorite activity, and participate in religious activities. Record review of Resident # 67's care plan dated 1/30/2025 was documented for Activity-will encourage/assist with environmental acclimation and encourage socialization, recreational activity participation, room personalization, and routine development, encourage activities. Record review of Resident # 67's Activity assessment dated [DATE] was documented Quarterly she uses wheelchair to attend activities, she attends and participates in all group activities, social outings, music entertainment, yard games, board games, church, and crafts. Observation on 1/26/2025 at 1:55 PM Resident #67's was laying down on her bed watching TV. Interview on 1/26/2025 at 1:57 PM Resident #67 stated the Activity Director was not here anymore, so residents did not have any activities, just watch tv, no church today (Sunday), no activities today and it was different now. Resident #67 stated she used to like to do art and crafts, paint, and crafts for Holidays. Resident #67 stated they had not had an Activity Director for 2-3 months. Observation on 1/27/2025 at 1:11 PM Resident #67 was sitting on w/c and was watching TV. Observation on 1/28/2025 at 11:30 AM Resident #67 was sitting on w/c and was watching TV and looking outside her window. Observation on 01/29/25 at 10:20 AM Resident #67's was sitting in her w/c in the main dining room/activity room revealed she was watching TV. Interview on 1/29/2025 at 10:24 AM Resident #67 stated no arts and crafts today, and the activity calendar was not correct. 5. Record Review of the Large Activity Calendar that was posted in the area of the main dining room/Activity room revealed the following: *1/28/2025 at 10:00 AM Daily Stretches (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*1/28/2025 at 4:30 PM Hand hygiene. *1/29/2025 at 10:00 AM Arts and crafts. *1/30/2025 at Bingo Observation on 1/28/25 at 10:17 AM in the dining room revealed residents' activity was loteria and Resident #22 was in charge. Observation on 1/28/2025 at 4:33 PM in main dining area no hand hygiene activity. Observation on 1/29/2025 at 10:22 AM in the dining area no arts and crafts in main Dining Room/Activity room. Interview on 1/29/2025 at 10:23 AM with SW confirmed the residents were not doing arts and crafts right now and they are watching TV. The SW stated all staff pitch in for resident activities, 2 vendors come visit daily, and responded they come for a while. The SW stated they did not have a lot of activities; they have no activity director, and an Activity Director has been hired and started [DATE]th. Observations on 1/30/2025 at 10:30 AM in main dining area no bingo. 6. Record review of Resident #79's Admission Record, dated 01/27/25, reflected Resident #79 was a [AGE] year-old initially admitted on [DATE]. It reflected Resident #79 had diagnoses to include acquired absence of right leg above knee, expressive language disorder, anxiety disorder, and depression. Record review of Resident #79's quarterly MDS assessment, dated 12/14/24, reflected Resident #79 had a BIMS of 08 out of 15, indicating moderate cognitive impairment. Record review of Resident #79's care plan, last reviewed 01/03/25, reflected focus At risk for falls related to surgical incisions Right BKA .medication diuretic, pain, hypotension with intervention Activity Programming-exercises, TV programs, revised 09/16/24. During an interview and observation on 01/26/25 at 03:57 PM, Resident #79 revealed he wanted to watch TV because he was bored in his room. Resident #79 was observed to only have his radio playing and he had no other activities to do in his room. He revealed he would like to watch TV because he was stuck in bed. During an interview and observation on 01/28/25 at 09:20AM, Resident #79 revealed he was bored and wanted to watch television. He further revealed he was told the remote did not work so they did not put the television on for him. It was observed Resident #79's TV was not on. During an interview and observation on 01/30/25 at 11:09 AM, Resident #79 revealed he wanted to read a newspaper or something because he did not get to do any activities. He further revealed he has had no help with turning his television on. It was observed Resident #79's TV was not on. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/30/25 at 03:03 PM, CNA F revealed Resident #79's TV was not working. CNA F revealed he put Resident #79 in front of the TV in the public area at times. CNA F further revealed he had never seen Resident #79's TV on and assumed the TV was not working. CNA F further revealed the TV would help residents to stimulate their mind, especially for resident with psychological issues. During an observation and interview on 01/30/25 at 03:40 PM, CNA F revealed the TV was working and he borrowed a remote from another resident to turn on Resident #79's TV. Interview on 1/26/2025 at 5:30PM with prn Activity Director (prior/prn Activity Director) stated she was prn (as needed) Activity Director and comes in and does activities with Residents when she can. The prior/prn Activity Director stated she calls different vendors from her house and comes to facility to do some activities, when she can. Interview on 1/27/2025 at 4:07 PM with Ombudsman AC stated the previous Activity Director left in November 20024. Interview on 1/272025 at 2:45 PM with Resident Council group stated they use to vote on council to see which restaurant they wanted to go to each month. The Resident Council group stated they do not go to restaurants anymore, since they do not have anyone to take them. Resident #22 stated she announced on intercom bingo/loteria and some vendors come but only were at the facility for 1 hour. Residents stated they had to figure out what to do as an activity for the day and felt like we are in limbo. Residents stated they color, paint, and form small group to do board games and etc. Interview on 1/30/2025 at 10:46 AM with ADM discussed the concern with no Activity Director, in room activities, have not observed activities that match the activity calendar, requested activity calendar for this month. No response. ADM stated no full-time Activity Director and were looking to hire one soon. ADM did not provide the in-room activity calendar before we exited and the Activity policy. Record review of the job description for Director of Activities (no date) was documented The primary purpose of the position is to plan, organize, and direct a program of activities which provide opportunities for entertainment, exercise, relaxation, and expression and fulfills basic psychology, social and spiritual needs which will be available to all residents of the facility while delivering on the facilities values of wellness, compassion, customer experience and company results. Maintain all activity related records required by regulations and Medical Records Department-activity assessment, progress notes and discharge summary. Activity Calendar Duties include, plan, develop, organize, implement, evaluate and direct the activity programs of the facility, oversee day t day activities of resident in the facility. Record review of the admission policy (no date) was documented, exhibit 2 items and services included in the daily Medicaid rate-Activities, participation in a group setting and on an individual basis, as selected by the resident. 48366

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 26869 Based on observations, interviews and record review the facility failed to ensure the activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- Is licensed or registered, if applicable, by the State in which practicing; and has completed a training course approved by the State for 1 of 1 facility in that: Operations Manager stated no full time Activity Director. No full time Activity Director since November 2024. This failure could result residents not having activities while residing in the facility. The Findings were: Interview on 1/26/2025 at 5:30PM with prn Activity Director (prn Activity Director) stated she was prn (as needed) Activity Director an comes in and does activities with Residents when she can. The prn Activity Director stated she calls different vendors from her house and comes to facility to do some activities, when she can. Interviews with the Resident Council stated they did not have an Activity Director and they try to figure out what to do for the day. Resident council stated they left us in limbo with no Activity Director. Interview on 1/27/2025 at 2:35 PM Resident #22 stated the facility had not had an Activity Director for a few months and the prior Activity Director comes when she can. Resident #22 stated she announces Bingo and some vendors come for activity program but were not at facility all day. Resident #22 stated she tries to gather resident for Activities, so it won't be boring and do not have a structured Activity program at the facility. Resident #22 stated the vendors for Activities come for an hour a day. Interview on 1/27/2025 at 4:07 PM with Ombudsman AC stated the previous Activity Director left in November 2024. Interview on 1/27/2025 at 5 PM the Operations Manager stated they did not have a full time Activity Director and was in the process of hiring an Activity Director. The Operations manager stated they had not had an Activity Director for a few months. Interview on 1/29/2025 at 3:14 PM CNA F stated the prior Activity Director had not been full time since November 2024. CNA F stated since the Activity Director had not been at the facility, it had not been the same, some residents gather themselves to play bingo, watch TV, color and church group comes and vendors come to visit for a few hours a day. (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the job description for Director of Activities (no date) was documented The primary purpose of the position is to plan, organize, and direct a program of activities which provide opportunities for entertainment, exercise, relaxation, and expression and fulfills basic psychology, social and spiritual needs which will be available to all residents of the facility while delivering on the facilities values of wellness, compassion, customer experience and company results. Maintain all activity related records required by regulations and Medical Records Department-activity assessment, progress notes and discharge summary. Activity Calendar Duties include, plan, develop, organize, implement, evaluate and direct the activity programs of the facility, oversee day to day activities of resident in the facility. Record review of the admission policy (no date) was documented, exhibit 2 items and services included in the daily Medicaid Rate-Activities, participation in a group setting and on an individual basis, as selected by the resident.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observation, interview and record review the facility failed to ensure a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection for 3 of 8 (Resident #67, #5 and #45) residents in that: 1. Resident #67 had a pressure ulcer on her heel and was not observed offloading her heels. 2. Resident #5 had a pressure ulcer on her heel and was not observed offloading her heels. 3. Resident #45 was not turned every 2 hours by staff. This could affect all residents with pressure ulcers and could result in wounds not healing. The Finding were: 1.Record review of Resident # 67's Admission Record dated 1/27/2025 was documented she was admitted on [DATE], readmitted on [DATE] with diagnoses of diabetes II (a chronic condition where the body does not use insulin effectively or does not produce enough insulin.), and disorder of skin. Record review of Resident # 67's consolidated physician orders for January 2025 was documented offloading boots to promote wound healing every shift for wound healing and had an unstageable to right heel paint with betadine daily as needed or sound healing if soiled or removed and every shift for wound healing. Record review of Resident # 67's Quarterly MDS dated ,d+[DATE]//2024 was documented her BIMS score was 15 out of 15 (cognitively intact). Resident #67's Quarterly MDS Skin condition was documented resident at risk for developing pressure ulcers/injuries). Record review of Resident #67's Annual MDS dated [DATE] was documented she was a risk for developing pressure ulcers, and unstageable pressure ulcer. Record review of Resident # 67's care plan dated 1/30/2025 was documented potential for pressure ulcer development related to disease process, interventions wear heel protectors while in bed. Record review of Resident #67's wound care assessment dated [DATE] was documented she had a right heel, unstageable pressure injury, clean with betadine daily open to air and offloading boot and elevate. Observation on 1/26/2025 at 2:14 PM in Resident #67's room revealed she was laying down on her bed, with no offloading boots on her heels. Observation on 1/27/2025 at 1:11 PM in Resident #67's room revealed she was sitting on her w/c with no offloading boots on her heels. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 1/28/2025 at 11:30 AM in Resident #67's room revealed she was lying in bed over her, and her feet/heels were not offloaded. Interview on 1/28/2205 at 11:32 AM with LVN AB, wound care nurse, in Resident #67's room stated she did not have her offloading booties on the resident to offload her heels while in bed. LVN AB stated it was important to offload Resident #67's heels to prevent infection and wound getting worse. LVN AB stated Resident #67 had an unstageable wound on her right heel, and treatment was betadine and leave open to air. 2. Record review of Resident #5's Admission Record dated 1/29/2025 was documented she was admitted on [DATE], readmitted on [DATE] with diagnoses of diabetes II (a chronic condition where the body does not use insulin effectively or does not produce enough insulin.), cognitive communications disorder, difficulty walking, need for assistance with personal care, dementia (a syndrome characterized by a progressive decline in cognitive functions, such as memory, thinking, reasoning, and problem-solving, that interferes with daily life and activities), and had lack of coordination. Record review of Resident #5's consolidated physician orders for January 2025 was documented to offloading boots every shift for prevention of breakdown. Record review of Resident #5's significant change MDS dated [DATE] was documented her BIMS score was 13 out of 15 (cognitively intact), she was at risk for developing pressure ulcers/injuries, and she required use of manual wheelchair. Record review of Resident #5's care plan dated 12/12/2024 was documented pressure ulcer or potential for pressure ulcer development related to disease process. Resident #5's goal was to have intact skin, free of redness, blisters or decollation by/through review dated. Resident #5s interventions was to have skin assessments as ordered, and treatments as ordered. Resident #5 had skin integrity non pressure related to excoriation to sacrum. Observation on 1/28/2025 at 11:50 AM with Resident #5 was lying in bed, with no heel protectors on. Interview on 1/28/2025 at 11:54 AM with CNA H stated she took Resident # 5 back to bed, changed her, but did not put her heel protector booties on. The she left to do another task. Interview on 1/28/2025 at 12:04 PM with ADM and DON, they stated they would educate staff on the concerns with residents receiving treatment for pressure ulcers, such as heel protectors. 3. Record review of Resident #45's Admission Record was dated 1/28/2025 she was admitted on [DATE], readmitted on [DATE] with diagnoses of hemiplegia and hemiparesis (neurological conditions that cause weakness or paralysis on one side of the body, muscle weakness, need assistance with personal care, and adult failure to thrive. Record review of Resident #45's consolidated physician orders for January 2025 documented were resident to be turned every 2 hours. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #45's Significant change MDS dated [DATE] documented her BIMS score was 3 out of 15 (severely impaired),.Resident #45 had upper extremity impairment on both sides lower extremity impairment on one side, she was dependent on oral care, showers, dressing, personal hygiene, she was always incontinent, she used a wheelchair to mobilize in the facility, and required a feeding tube to eat. Record review of Resident #45's care plan dated 1/24/2025 documented she had pressure ulcer or potential for pressure ulcer development related to disease process, immobility, and stroke. Resident #45's interventions were needing assistance to turn/reposition at least every 2 hours, more often as needed, or requested. Observation on 1/26/2025 at 2:24 PM Resident #45 was laying in her bed on her right side. Observation on 1/26/2025 at 4:27 PM Resident #45 was laying in her bed on her right side. Interview on 1/26/2025 at 4:32 PM LVN J stated Resident #45 had not been moved/turned in bed. Observation on 1/28/2025 at 9:34 AM Resident # 45 revealed she was on laying on her back. Observation on 1/28/2025 at 11:46 AM Resident # 45 revealed she was on laying on her back. Interview on 1/28/2025 at 11:49 AM LVN Z stated Resident # 45 was laying on her back. LVN Z stated residents were supposed to be repositioned every 2 hours. LVN Z stated she was not sure why the CNA's have not repositioned Resident # 45. LVN Z stated she would reposition Resident # 45 now. Interview on 1/28/225 at 12:28 PM the MDS/LVN stated residents that were bed bound, should be repositioned at least every 2 hours and as needed. Interview on 1/28/2025 at 12:04 PM the ADM and DON, stated they would educate staff on the concerns with repositioning residents while in bed. The DON stated she expected staff turn and reposition bed bound resident every 2 hours. Record review of policy, repositioning dated May 2013 documented, The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individual care plan for repositioning, to promote comfort for all bed or chair bound resident and to prevent skin breakdown, promote circulation and provide pressure relief for residents. Preperation-1. Review the residents care plan to evaluate for any special needs of the resident. General Gudiliens-1. Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of policy, Prevention of Pressure Injuries dated April 2020 was documented The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Preparation -Review the residents care plan and identify the risk factors as well as the intervention designed to reduce or eliminate those considered modifiable. Skin Assessment- 3. Inspect the skin on a daily basis when performing or assisting with personal care of ADL and full skin assessment weekly c. reposition resident as indicated on care plan. Prevention -skin care 6. Do not rub to otherwise cause friction on skin that is at risk for pressure injuries. Mobily/Repositioning -1. Reposition all resident with or at risk of pressure injuries on an individualized schedule. 2 .provided support devise and assistance as needed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on observation, interview, and record review, the facility failed to ensure the each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 5 resident wander guards (Resident #84) reviewed for accident hazards and supervision, in that: The facility did not ensure Resident #84's wander guard (a technology designed to prevent eloping from a facility) was working properly. This failure could place the residents at risk for elopement. Findings included: Record review of Resident #84's care plan, last reviewed 11/20/24, reflected a [AGE] year-old resident admitted [DATE]. It reflected Resident #84 had diagnoses to include need for assistance with personal care, muscle weakness, history of falling, cognitive communication deficit, lack of coordination, and difficulty walking. [Resident #84] is an elopement risk/wanderer as evidenced by impaired safety awareness, wanders aimlessly with intervention Wandergaurd as ordered, dated 09/27/24. Record review of Resident #84's January MAR reflected a doctor's order of [Wander] guard visually check electronic monitoring device every shift to Right Ankle ., with start date 09/25/24, and DEVICE: WANDER GUARD, CHECK VIA ELECTRONIC MACHINE EVERY DAY DUE TO ELOPEMENT RISK every day shift, with start date 01/28/25. Record review of Logbook documentation Resident Monitoring Systems: Check operation of door monitor and patient wandering system reflected Resident #84's wander guard was operating on 01/22/25 and 01/29/25 and the wander guards were checked weekly. During an observation and interview on 01/27/2025 at 10:50 AM revealed Resident #24 wore a wander guard anklet and approached the exit door which led to the fenced outdoor area and smoking patio. Upon attempting to exit through the door, the door locked and alarmed. Further observation revealed the admissions coordinator assisted Resident #24 exit to the patio with supervision. During an observation and interview on 01/27/2025 at 11:00 AM, Resident #84 went out of the patio exit door, leading into a fenced outdoor area, which had a functioning wander guard alarm however when she exited the door the alarm did not sound and or alert. It was observed CNA F witnessed and stated the wander guard should have alarmed. Staff members were present both inside and outside of the exit door leading into the fenced area. During an interview on 01/30/25 at 02:43 PM, the DON revealed Resident #84's wander guard was working prior to survey. He further revealed the wander guard may have stopped working overnight. The DON further revealed he was not aware as to why the wander guard was not working. The DON revealed the nursing staff were visually checking Resident #84's wander guard daily. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/30/25 at 03:06 PM, CNA F revealed he was present when Resident #84's wander guard was not working. CNA F further revealed he went to multiple doors to check Resident #84's wander guard and it did not work. CNA F further revealed the wander guards should be checked daily and apparently it was not checked because it was not working. He revealed the nurses checked the wander guards. During an interview on 01/30/25 at 04:00 PM, the DON revealed Resident #84's wander guard did not work sometime between 01/22/25 and 01/29/25 but could not pinpoint what date it stopped working. He revealed it was important to make sure these devices worked to keep the residents safe inside the building. He further revealed the residents with wander guards were at high risk for elopements, so they did not want these residents to elope. Record review of facility document Wanderguards Alarms, undated, reflected CHECK FOR PROPER FUNCTION: Wanderguard alarms are located on resident wrist, ankle . CHART: In eMAR chart proper function and visual placement

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on interviews, and record reviews the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicated otherwise for 1 of 8 residents (Resident #71) reviewed for nutrition. The facility failed to follow Resident #71's care plan for weighing Resident #71 weekly and failed to follow the facility's policy for weight assessment and intervention when Resident #71 had a significant weight loss. These failures could place residents at risk for malnourishment, weight loss, skin breakdown, and decreased quality of life. Findings included: Record review of Resident #71's Admission Record, dated 01/26/25, reflected Resident #71 was a [AGE] year-old initially admitted on [DATE]. It reflected Resident #71 had diagnoses to include depression, vitamin D deficiency, dysphagia, deficiency of other vitamins, vitamin B12 deficiency, iron deficiency, and pressure ulcer of other site (stage 3). Record review of Resident #71's quarterly MDS assessment, dated 11/17/24, reflected Resident #71 had a BIMS score of 15 out of 15, indicating intact cognition. Record review of Resident #71's care plan reflected [Resident #71] at risk for nutritional problem or potential nutritional problem r/t pressure ulcer, revised 01/06/25 with interventions to include Continue weekly weights, dated 11/01/24, and RD to evaluate and make diet change recommendations PRN., dated 08/09/24. Record review of Resident #71's weight history, accessed 01/26/25, reflected no weight for January 2025, weight for 12/23/24 (192 pounds), and weight for 12/17/24 (203.9 pounds). This reflected a weight loss of 11. 9 pounds (-5.8%) in 6 days, indicating a significant weight loss. Record review of Resident #71's weight summary, accessed 01/29/25, reflected 12/03/24 weight (203 pounds) and 01/06/25 weight (193 pounds). This reflected a weight loss of 10 pounds (-4.9%) in 1 month, indicating a significant weight loss. Record review of the nutritional assessments in PCC reflected no nutritional assessments done in December 2024 or January 2025 for Resident #71. During an interview on 01/26/25 at 12:05 PM, Resident #71 revealed he had weight loss but felt like he was back to around 205 pounds. He revealed he would like to stay at 205 pounds and did not want to lose any weight. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/29/25 at 10:35 AM, Doctor AA revealed he expected the facility to contact the Registered Dietitian about weight loss and he would follow RD recommendations for residents with weight loss. During an interview on 01/29/25 at 12:25 PM, LVN AB revealed Resident #71 had no nutritional interventions in the past 3 months. She revealed the last nutritional intervention for Resident #71 was 10/17/24. During an interview on 01/29/25 at 04:10 PM, the RD revealed LVN AB and her spoke about Resident #71 on Monday 01/27/25. She revealed 2 of the 3 wounds for Resident #71 were intact and 1 of 3 was stable. She revealed Resident #71 needed extra protein and calories for wound healing. She revealed residents were assessed when they had significant weight loss. The RD confirmed there was a weight loss between December and January of 10 pounds, but Resident #71's weight was stable for the last 3 weeks in December. The RD revealed there was a significant weight loss for one month and she did not do a significant weight note for him. The RD revealed they had tried different nutritional interventions with no success, but further revealed she could try more interventions like have the CDM visit Resident #71 for a preference update. Record Review of the facility's policy Weight Assessment and Intervention, revised March 2022, reflected Weight Assessment 2. Weights are recorded in each unit's weight record chart and in the individual's medical record . 4. The threshold for significant unplanned and undesired weight loss will be based on the following criteria a. 1 month-5% weight loss is significant .Care Planning 1. Care planning for weight loss or impaired nutrition is a multidisciplinary effort . Interventions 1. Interventions for undesirable weight loss are based on careful consideration .

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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** 41937 Based on observations, interviews, and record reviews, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each Resident, for 8 of 16 residents (Residents #5, 20, #27, #38, #68, #69, #81, and #85) reviewed for pharmacy services. 1. On [DATE] Medication Aide E administered late medications to Resident #20 at 10:49 AM: a. Acetaminophen 325mg, (Tylenol) late by 1 hour and 49 minutes. b. Levetiracetam 500mg (a medication to treat seizures) late by 1 hour and 49 minutes. 2. On [DATE] Medication Aide E administered late medications to Resident #27 at 9:20 AM: a. Carvedilol 12.5mg (used to treat high blood pressure) late by 20 minutes. b. Divalproex 125mg (used to treat schizophrenia) late by 20 minutes. 3. On [DATE] Medication Aide E administered late medications to Resident #38 at 10:51 AM: a. Famotidine 20mg (used to reduce stomach acid) late by 1 hour and 51 minutes. b. Docusate (a stool softener) 100mg late by 1 hour and 51 minutes. c. Lamotrigine 100mg (used to prevent seizures) late by 1 hour and 51 minutes. d. Sodium chloride 1gr (salt used to treat muscle weakness) late by 51 minutes. 4. On [DATE] Medication Aide E administered late medications to Resident #68 at 10:23 AM: a. Metformin 1000mg (used to treat diabetes) late by 1 hour and 23 minutes. 5. On [DATE] Medication Aide E administered late medications to Resident #69 at 9:45 AM: a. Bactrim 800mg / 160mg (a combination of 2 antibiotics; sulfamethoxazole and trimethoprim) late by 45 minutes. 6. An inspection on [DATE] of the facility's treatment nurse medication cart revealed expired insulins for Residents #5, #81, and #85 as evidenced by the following: a. Resident #5's liraglutide (an anti-diabetic medication used to treat type 2 diabetes, and chronic obesity) subcutaneous (under the skin) solution pen-injector was stored unrefrigerated, and available for administration, in the cart and was expired by 19 days. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Resident #81's 3 injection vials of insulin lispro 100u/ml, were available for administration, stored unrefrigerated, unlabeled with an expiration date, and were expired by as much as 59 days. c. Resident #85's 1 injection vial of insulin lispro 100u/ml, was available for administration, stored unrefrigerated, labeled with an expiration date of ,d+[DATE], and was expired by 45 days. These deficient practices placed residents at risk for not receiving the therapeutic effects of their prescribed medications. The findings included: During an observation and interview on [DATE] at 9:49 AM revealed MA E preparing and administering medications for residents within the facility. Further review revealed MA E's computer electronic medical record display demonstrated MA E's assigned residents were highlighted in red. MA E stated she was late administering medications, specifically for Residents #20, 27, #38, #68, and #69. MA E stated her direct supervisor was the DON and she had not reported the late medication administration. Continued observation revealed she continued to administer medications to residents. 1. A record review of Resident #20's admission record dated [DATE], revealed an admitted [DATE] with diagnoses which included vascular dementia (parts of the brain are damaged due to a stroke) and convulsions (an electrical storm in the brain AKA seizures.) A record review of Resident #20's quarterly MDS assessment dated [DATE] revealed Resident #20 was a [AGE] year-old male admitted for long term care and assessed a BIMS score of 5 out of a possible 15 which indicated severely impaired cognition. A record review of Resident #20's care plan dated [DATE] revealed, (Resident #20) has a seizure disorder r/t (related to) Stroke Date Initiated: [DATE] . Give medications as ordered. Observe/document for effectiveness and side effects. A record review of Resident #20's physicians' orders revealed the physician prescribed for Resident #20 to receive levetiracetam 500mg twice a day at 8:00 AM and at 4:00 PM and acetaminophen 325mg three times a day at 8:00 AM, noon, and at 4:00 PM. A record review of the facility's Medication Admin Audit Report dated [DATE] revealed MA E, on [DATE], administered Resident #20 his acetaminophen 325mg and his levetiracetam 500mg at 10:49 AM late by 1 hour and 49 minutes. 2. A record review of Resident #27's admission record dated [DATE] revealed an admitted [DATE] with diagnoses which included hypertension (high blood pressure) and schizophrenia (a chronic, severe mental disorder that affects the way a person thinks, acts, expresses emotions, perceives reality, and relates to others.) A record review of Resident #27's Quarterly MDS assessment dated [DATE] revealed Resident #27 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 15 which indicated intact cognition. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #27's care plan dated [DATE] revealed, (Resident #27) has Hx (history) of hallucinations. (Resident #27) states that this voice tells him bad things, including not to smoke, tells him he is overweight. Mr. Rico calls this voice/voices the devil . Administer medications as ordered Date Initiated: [DATE] A record review of Resident #27's physicians orders dated [DATE] revealed the physician prescribed for Resident #27 to receive carvedilol 12.5mg and divalproex 125mg twice a day at 8:00 AM and again at 4:00 PM. A record review of the facility's Medication Admin Audit Report dated [DATE] revealed MA E, on [DATE], administered Resident #27 his carvedilol 12.5mg and divalproex 125mg at 9:20 AM late by 20 minutes. 3. A record review of Resident #38's Admission record dated [DATE] revealed an admitted [DATE] with diagnoses which included epilepsy (a brain disease where nerve cells don't signal properly, which causes seizures. Seizures are uncontrolled bursts of electrical activities that change sensations, behaviors, awareness, and muscle movements), Gastroesophageal reflux disease (AKA GERD, occurs when stomach acid frequently flows back into the esophagus, leading to irritation and discomfort), constipation, and muscle weakness. A record review of Resident #38's Quarterly MDS assessment dated [DATE] revealed Resident #38 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 15 which indicated intact cognition. A record review of Resident #38's care plan dated [DATE] revealed, (Resident #38) has behavioral concern of insisting medications be given at a certain time and becoming angry when medications are not being given exactly when requested. (Resident #38) has been made aware of and educated on medication administration window . A record review of Resident #38's physicians' orders dated [DATE] revealed the physician prescribed for Resident #38 to receive famotidine 20mg and docusate 100mg twice a day at 8:00 AM and again at 4:00 PM. Lamotrigine 100mg at 8:00 AM and again at 6:00 PM. Sodium chloride 1gr twice a day at 9:00 AM and again at 5:00 PM. A record review of the facility's Medication Admin Audit Report dated [DATE] revealed MA E, on [DATE], at 10:51 AM, administered Resident #38 his famotidine 20mg, docusate 100mg, lamotrigine 100mg late by 1 hour and 51 minutes and sodium chloride 1gr late by 51 minutes. 4. A record review of Resident #68's admission record dated [DATE] revealed an admitted [DATE] with diagnoses which included diabetes type 2. A record review of Resident #68's quarterly MDS assessment dated [DATE] revealed Resident #68 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 6 out of a possible 15 which indicated severely impaired cognition. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #68's care plan dated [DATE] revealed, (Resident #68) has impaired cognitive function/dementia or impaired thought processes r/t Dementia, Disease Process diabetes, . Administer meds as ordered. Date Initiated: [DATE] A record review of Resident #68's physicians' orders dated [DATE] revealed the physician prescribed for Resident #68 to receive metformin 1000mg twice a day at 8:00 Am and again at 4:00 PM. A record review of the facility's Medication Admin Audit Report dated [DATE] revealed MA E, on [DATE], at 10:23 AM, administered Resident #68 his Metformin 1000mg late by 1 hour and 23 minutes. 5. A record review of Resident #69's admission record dated [DATE] revealed an admitted [DATE] with diagnoses which included a urinary tract infection. A record review of Resident #69's quarterly MDS assessment dated [DATE] revealed Resident #69 was an [AGE] year-old male admitted for long term care and assessed with a BIMS score of 3 out a possible 15 which indicated severely impaired cognition. A record review of Resident #69's care plan date [DATE] revealed, Urinary Tract Infection, potential or actual r/t Diagnosis of BPH, Diagnosis of Urinary retention, Use of indwelling catheter dx (diagnosis) ESBL UTI (extended spectrum beta-lactamase urinary tract infection. ESBL-producing bacteria can't be killed by many of the antibiotics that doctors use to treat infections), Date Initiated: [DATE] . Antibiotic per MD (medical doctor) order x 5days. Date Initiated: [DATE] A record review of Resident #69's physicians orders dated [DATE] revealed the physician prescribed for Resident #69 to receive Bactrim 800mg / 160mg (a combination of 2 antibiotics; sulfamethoxazole and trimethoprim) twice a day at 8:00 AM and again at 8:00 PM. A record review of the facility's Medication Admin Audit Report dated [DATE] revealed MA E, on [DATE], at 9:45 AM, administered Resident #69 his Bactrim 800mg / 160mg late by 45 minutes. During a joint interview on [DATE] at 4:04 PM with the operations manager and the DON, the DON stated the expectation was for the medications to be administered with in 1 hour of the prescribed time. The DON stated his expectation was for MA E to have reported the potential late medication administration and MA E had not reported the late medication administration. 6. A record review of Resident #5's admission record dated [DATE], revealed an admitted [DATE] with diagnoses which included type II diabetes (a long-term condition which results in too much sugar circulating in the blood. High blood sugar levels can lead to disorders of the circulatory, nervous, and immune systems.) A record review of Resident #5's Quarterly MDS assessment dated [DATE] revealed Resident #5 was a [AGE] year-old female admitted for long term care and assessed with a memory problem, Moderately impaired - decisions poor; cues / supervision required A record review of Resident #5's care plan dated [DATE] revealed, Alteration in Blood Glucose due to hyper/hypoglycemia dx. DMII, . Date Initiated: [DATE] . Administer medications as ordered Date Initiated: [DATE] (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #5's physicians' orders dated [DATE] revealed the physician prescribed for Resident#5 to receive liraglutide 18mg/3ml, 1.2mg injected under the skin daily at 8:00 AM. During an observation and interview on [DATE] at 10:30 AM revealed LVN Z attending the nurse treatment cart on the facility's D-hall and was preparing to administer insulins prior to the noon meal. LVN Z demonstrated the insulin stored on the unrefrigerated cart and revealed an insulin injection pen for Resident #5. The pen was labeled, liraglutide injection (Resident #5) 18mg/3ml, . date opened [DATE] .exp. [DATE] . discard pen 30 days after first use LVN Z stated she would not use the insulin pen because it was expired and would immediately discard the injection pen. A record review of Resident #81's admission record dated [DATE] revealed an admitted [DATE] with diagnosis which included type II diabetes. A record review Resident #81's quarterly MDS assessment dated [DATE] revealed Resident #81 was a [AGE] year-old female assessed with a BIMS score of 14 out of a possible 15 which indicated intact cognition. A record review of Resident #81's care plan dated [DATE] revealed, Potential for complication hypo hyperglycemia r/t DMII. Date Initiated: [DATE] . Medications/blood sugar check as ordered and as needed. Date Initiated: [DATE] A record review of Resident #81's physicians' orders dated [DATE] revealed the physician prescribed for Resident #81 to receive insulin lispro 4 times a day at 6:30 AM, 11:30 AM, 4:30 PM, and at 8:00 PM, insulin lispro 100u/ml inject per sliding scale: if ,d+[DATE] = 0; 151 - 250 = 2; . ,d+[DATE] = 14 . subcutaneously before meals and at bedtime for diabetes A record review of Resident #85's admission record dated [DATE] revealed an admitted [DATE] with diagnoses which included type II diabetes. A record review of Resident #85's quarterly MDS assessment dated [DATE] revealed Resident #85 was a [AGE] year-old female admitted for long term care and assessed with a memory care problem, Severely impaired - never / rarely made decisions A record review of Resident #85's physicians' orders dated [DATE] revealed the physician prescribed for Resident #85 to receive insulin lispro three times a day at 6:30 AM, 11:30 AM, and at 4:30 PM, (insulin lispro) subcutaneously solution pen injector 100u/ml inject 10 unit subcutaneously before meals for diabetes During an observation and interview on [DATE] at 10:30 AM LVN Z demonstrated the insulin stored on the unrefrigerated cart and revealed a plastic bag which contained 4 insulin injection pen refill vials. The bag was labeled, (Resident #81) (the facility) (insulin lispro) 100u/ml cartridge qty: 15, [DATE] . refrigerate Observation of the 4 vials revealed: 1. 3ml glass vial insulin lispro 100u/3ml labeled with Resident #81's name, dated with an open date of [DATE], observed ,d+[DATE]'s full. 2. 3ml glass vial insulin lispro 100u/3ml labeled (Resident #81) [DATE] observed full. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retama Manor Nursing Center/San Antonio West	636 Cupples Rd San Antonio, TX 78237

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. 3ml glass vial insulin lispro 100u/3ml unlabeled with a resident's name, dated with an open date , d+[DATE] (no year), observed full. 4. 3ml glass vial insulin lispro 100u/3ml labeled with Resident #85's name, undated, no open date noted, observed ,d+[DATE] full. LVN Z stated the vials were stored unrefrigerated, in a bag labeled Resident #81, however, LVN Z could not state who the insulin vials were intended for and could not state the date the vials were unrefrigerated. LVN Z stated she would discard the vials because they were unsafe to use. During an interview on [DATE] at 1:10 PM the DON stated the expectations and trainings for nurses who administer insulin was for the insulin to be labeled with an opened date and a dispose of date, to include a use span of 28 days. The DON stated all insulins older than 28 days and or unlabeled insulins should be discarded. The DON stated the risk for harm would be residents may not receive the therapeutic effects of their prescribed medications. A policy regarding medication administration was requested on [DATE] at 10:00 AM and as of [DATE] was not provided; however, a policy titled Documentation of Medication Administration was provided. A record review of the policy revealed no policy for timely medication administration. A record review of the Institute for Safe Medication Practices website titled ISMP Acute Care Guidelines for Timely Administration of Scheduled Medication ismp-hosp-temp-MASTER.qxd accessed [DATE] revealed, Medications administered more frequently than daily but not more frequently than every 4 hours (e.g., BID, TID, q4h, q6h) Administer these medications within 1 hour before or after the scheduled time. A record review of the lirglutide manufactures website titled, Victoza (liraglutide) injection, Important Information accessed [DATE], https://www.victoza.com/faq.html, revealed, Instructions for Use? You can use your Victoza pen for up to 30 days after you use it the first time. First Time Use for Each New Pen. How should I store Victoza? Before use: o Store your new, unused Victoza pen in the refrigerator between 36 F to 46 F (2 C to 8 C). o If Victoza is stored outside of refrigeration (by mistake) prior to first use, it should be used or thrown away within 30 days. Pen in use: o Use a Victoza pen for only 30 days. Throw away a used Victoza pen 30 days after you start using it, even if some medicine is left in the pen. o Store your Victoza pen at room temperature between 59 F to 86 F (15 C to 30 C), or in a refrigerator between 36 F to 46 F (2 C to 8 C). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the insulin lispro manufactures website titled [NAME].com/ck/a?!&&p=88304c2b6b2aae023b9ebee38f5cae217a125895e1f0391c2809d0dd502d8becJmltdHM9MTc0MDA5NjAwMA&ptn=3&ver=2&hsh=4&fclid=1aed91e9-b39d-6b[DATE]b27c6a4d&psq=lispro+kwikpen+instructions&u=a1aHR0cHM6Ly9waS5saWxseS5jb20vdXMvaHVtYWxvZy1rd2lrcGVuLXVtLnBkZg&ntb=1, accessed [DATE], revealed, INSTRUCTIONS FOR USE HUMALOG ([NAME]-ma-log) (insulin lispro) injection, for subcutaneous use revealed, Do not use past the expiration date printed on the Label or for more than 28 days after you first start using. Store unused insulin in the refrigerator at 36 F to 46 F (2 C to 8 C). o Do not freeze your insulin. Do not use if it has been frozen. o Unused insulin may be used until the expiration date printed on the Label, if it has been kept in the refrigerator. In-use: o Store the insulin you are currently using at room temperature [up to 86 F (30 C)]. Keep away from heat and light. o Throw away the HUMALOG insulin you are using after 28 days, even if it still has insulin left in it. A record review of the facility's policy titled, Medication Labeling and Storage dated February 2023, revealed, The facility stores all medications and biologicals and locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to the keys. Policy interpretation and implementation: medication storage; . compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trains or carts used to transport such items are not left unattended if open or otherwise potentially available to others. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. H residence medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured location. medication labeling; labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. The medication label includes, at a minimum: the medication name, prescribed dose, strength, expiration date, when applicable, residents name, route of administration, and appropriate instructions and precautions. multi dose vials that have been opened or accessed (for example needle punctured) are gated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. Multi dose vials that are not opened or accessed are discarded according to the manufacturer's expiration date.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews, the facility failed to ensure a medication error rate below 5%, for 25 medication administration opportunities with 4 errors resulting in a 16% medication error rate, for 1 of 8 residents (Resident #62) reviewed for medication administration. 1. Medication Aide E administered Resident #62 his medication doxazosin (a medication to treat high blood pressure) 1 hour and 28 minutes late and his hydralazine (a medication to treat high blood pressure), carvedilol (used to treat heart failure with high blood pressure), and furosemide (used to treat swelling due to heart failure) late by 58 minutes. These failures placed residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. The findings included: A record review of Resident #62's admission record dated 1/30/2025 revealed an admitted [DATE] with diagnoses which included hypertensive chronic kidney disease with end stage kidney disease (kidney disease complicated by high blood pressure, a person at this stage would need a kidney transplant or dialysis to stay alive.) A record review of Resident #62's discharge assessment - return anticipated MDS dated [DATE] revealed Resident #62 was a [AGE] year-old male admitted for support with dialysis off-site therapy (a treatment for individuals whose kidneys are failing, by mechanical filtering waste and excess fluid from the blood.) A record review of Resident #62's care plan dated 1/30/2025 revealed, Potential for complications r/t Renal Failure with dialysis . Medications as ordered by physician . Potential for altered tissue perfusion r/t Hypertension . Medications as ordered. Date Initiated: 05/21/2023 A record review of Resident #62's physicians orders dated January 2025 revealed the physician prescribed for Resident #62 to receive the following medications: Doxazosin an oral Tablet, 4mg, give 1 tablet by mouth one time a day at 7:30 AM for high blood pressure. Hydralazine an oral Tablet, 50mg, give 1 tablet by mouth two times a day, at 8:00 AM and again at 4:00 PM, for high blood pressure. Carvedilol an oral Tablet, 12.5mg, give 1 tablet by mouth two times a day at 8:00 AM and again at 4:00 PM for high blood pressure. Furosemide an oral Tablet, 80mg, give 1 tablet by mouth two times a day at 8:00 AM and again at 4:00 PM for swelling. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 1/28/2025 at 9:49 AM revealed MA E preparing and administering medications for residents within the facility. Further review revealed MA E's computer electronic medical record display which demonstrated her assigned residents highlighted in red. MA E stated she was late administering medications. MA E stated her direct supervisor was the DON and she had not reported the late medication administration. Continued observation revealed she continued to administer medications to residents. During an observation on 1/28/2025 at 9:58 AM revealed Medication Aide E (MA E) prepared and administered Resident #62's medications, to include: Doxazosin an oral Tablet, 4mg, scheduled for administration at 7:30 AM late by 1 hour and 28 minutes. Hydralazine an oral Tablet, 50mg, scheduled for administration at 8:00 AM late by 58 minutes. Carvedilol an oral Tablet, 12.5mg, scheduled for administration at 8:00 AM late by 58 minutes. Furosemide an oral Tablet, 80mg, scheduled for administration at 8:00 AM late by 58 minutes. During a joint interview on 1/29/2025 at 4:04 PM with the operations manager and the DON, the DON stated the expectation was for the medications to be administered within 1 hour of the prescribed time. The DON stated his expectation was for MA E to have reported the potential late medication administration and MA E had not reported the late medication administration. A policy regarding medication administration was requested from the administrator on 1/28/2025 at 10:00 AM and as of 1/30/2025 was not provided; however, a policy titled Documentation of Medication Administration was provided. A record review of the policy revealed no policy for timely medication administration. A record review of the Institute for Safe Medication Practices website titled ISMP Acute Care Guidelines for Timely Administration of Scheduled Medication ismp-hosp-temp-MASTER.qxd accessed 2/4/2025 revealed, Medications administered more frequently than daily but not more frequently than every 4 hours (e.g., BID, TID, q4h, q6h) Administer these medications within 1 hour before or after the scheduled time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews the facility failed to have drugs and biologicals used in the facility labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable; and the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls, for 1 of 1 nurse medication carts reviewed for security and supervision and for 3 of 8 residents (Residents #5, #81, and #85) reviewed for safe storage of insulins. 1. On [DATE] at 6:06 PM LVN J attended the nurse medication cart on the facility's D-hall and left the medication cart unsupervised and unlocked for 7 minutes while she left and provided care for a Resident. LVN J was out of line-of-sight with the nurse medication cart. 2. An inspection on [DATE] of the facility's treatment nurse medication cart revealed expired insulins for Residents #5, #81, and #85 as evidenced by the following: a. Resident #5's liraglutide (an anti-diabetic medication used to treat type 2 diabetes, and chronic obesity) subcutaneous (under the skin) solution pen-injector was stored unrefrigerated, and available for administration, in the cart and was expired by 19 days. b. Resident #81's 3 injection vials of insulin lispro 100u/ml, were available for administration, stored unrefrigerated, unlabeled with an expiration date, and were expired by as much as 59 days. c. Resident #85's 1 injection vial of insulin lispro 100u/ml, was available for administration, stored unrefrigerated, labeled with an expiration date of ,d+[DATE], and was expired by 45 days. These failures could place residents at risk for harm by not receiving the therapeutic effects of their insulins. The findings included: During an observation and interview on [DATE] at 6:06 PM revealed LVN J attended the nurse medication cart on the facility's D-hall and left the medication cart unsupervised and unlocked for 7 minutes while she left and provided care for a Resident. LVN J was out of line-of-sight with the nurse medication cart. Further observation revealed LVN J to return to the cart on [DATE] at 6:13 PM and stated she had left the cart unlocked and apologized as she locked the cart. 1. A record review of Resident #5's admission record dated [DATE], revealed an admitted [DATE] with diagnoses which included type II diabetes (a long-term condition which results in too much sugar circulating in the blood. High blood sugar levels can lead to disorders of the circulatory, nervous, and immune systems.) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #5's Quarterly MDS assessment dated [DATE] revealed Resident #5 was a [AGE] year-old female admitted for long term care and assessed with a memory problem, Moderately impaired - decisions poor; cues / supervision required A record review of Resident #5's care plan dated [DATE] revealed, Alteration in Blood Glucose due to hyper/hypoglycemia dx. DMII, . Date Initiated: [DATE] . Administer medications as ordered Date Initiated: [DATE] A record review of Resident #5's physicians' orders dated [DATE] revealed the physician prescribed for Resident#5 to receive liraglutide 18mg/3ml, 1.2mg injected under the skin daily at 8:00 AM. During an observation and interview on [DATE] at 10:30 AM revealed LVN Z attending the nurse treatment cart on the facility's D-hall and was preparing to administer insulins prior to the noon meal. LVN Z demonstrated the insulin stored on the unrefrigerated cart and revealed an insulin injection pen for Resident #5. The pen was labeled, liraglutide injection (Resident #5) 18mg/3ml, . date opened [DATE] .exp. [DATE] . discard pen 30 days after first use LVN Z stated she would not use the insulin pen because it was expired and would immediately discard the injection pen. 2. A record review of Resident #81's admission record dated [DATE] revealed an admitted [DATE] with diagnosis which included type II diabetes. A record review Resident #81's quarterly MDS assessment dated [DATE] revealed Resident #81 was a [AGE] year-old female assessed with a BIMS score of 14 out of a possible 15 which indicated intact cognition. A record review of Resident #81's care plan dated [DATE] revealed, Potential for complication hypo hyperglycemia r/t DMII. Date Initiated: [DATE] . Medications/blood sugar check as ordered and as needed. Date Initiated: [DATE] A record review of Resident #81's physicians' orders dated [DATE] revealed the physician prescribed for Resident #81 to receive insulin lispro 4 times a day at 6:30 AM, 11:30 AM, 4:30 PM, and at 8:00 PM, insulin lispro 100u/ml inject per sliding scale: if ,d+[DATE] = 0; 151 - 250 = 2; . ,d+[DATE] = 14 . subcutaneously before meals and at bedtime for diabetes 3. A record review of Resident #85's admission record dated [DATE] revealed an admitted [DATE] with diagnoses which included type II diabetes. A record review of Resident #85's quarterly MDS assessment dated [DATE] revealed Resident #85 was a [AGE] year-old female admitted for long term care and assessed with a memory care problem, Severely impaired - never / rarely made decisions A record review of Resident #85's physicians' orders dated [DATE] revealed the physician prescribed for Resident #85 to receive insulin lispro three times a day at 6:30 AM, 11:30 AM, and at 4:30 PM, (insulin lispro) subcutaneously solution pen injector 100u/ml inject 10 unit subcutaneously before meals for diabetes (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on [DATE] at 10:30 AM LVN Z demonstrated the insulin stored on the unrefrigerated cart and revealed a plastic bag which contained 4 insulin injection pen refill vials. The bag was labeled, (Resident #81) (the facility) (insulin lispro) 100u/ml cartridge qty: 15, [DATE] . refrigerate Observation of the 4 vials revealed: 1. 3ml glass vial insulin lispro 100u/3ml labeled with Resident #81's name, dated with an open date of [DATE], observed ,d+[DATE]'s full. 2. 3ml glass vial insulin lispro 100u/3ml labeled (Resident #81) [DATE] observed full. 3. 3ml glass vial insulin lispro 100u/3ml unlabeled with a resident's name, dated with an open date , d+[DATE] (no year), observed full. 4. 3ml glass vial insulin lispro 100u/3ml labeled with Resident #85's name, undated, no open date noted, observed ,d+[DATE] full. LVN Z stated the vials were stored unrefrigerated, in a bag labeled Resident #81, however, LVN Z could not state who the insulin vials were intended for and could not state the date the vials were unrefrigerated. LVN Z stated she would discard the vials because they were unsafe to use. During an interview on [DATE] at 1:10 PM the DON stated the expectations and trainings for nurses who administer medications to residents was for the medication cart to be locked anytime the nurse was away from the cart. The DON stated it was the individual nurse's responsibility to lock the cart anytime they left the cart unattended. A record review of the facility's policy titled, Medication Labeling and Storage dated February 2023, revealed, The facility stores all medications and biologicals and locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to the keys. Policy interpretation and implementation: medication storage; . compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trains or carts used to transport such items are not left unattended if open or otherwise potentially available to others. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. H residence medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured location. medication labeling; labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. The medication label includes, at a minimum: the medication name, prescribed dose, strength, expiration date, when applicable, residents name, route of administration, and appropriate instructions and precautions. multi dose vials that have been opened or accessed (for example needle punctured) are gated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. Multi dose vials that are not opened or accessed are discarded according to the manufacturer's expiration date.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 48366 Based on observation, interview, and record review, the facility failed to follow menus for 1 of 2 resident meals (dinner meal on 01/28/25) reviewed for menus in that: The facility failed to follow the menu for residents on soft bite sized and minced moist diets for the dinner meal on 01/28/25. This failure could place residents who consume food prepared by the facility kitchen at risk of not having their nutritional needs met and/or weight loss. The findings included: Record review of Week 3 Menu reflected Tuesday (Day 17) Dinner included Tomato Basil Soup and Pimento Cheese Sandwich. Record review of the recipes for Pimento Cheese Sandwich, undated, for the textures minced and moist and soft bite sized reflected recipe directions to include Grind 2 slice of bread 4-6 seconds to mince. Place prepared bread crumbs in a bowl and spray with vegetable pan spray until a more cohesive texture is achieved. Divide the prepared bread crumbs placing half of the crumbs as the first layer. Top with the #8 dip pimento cheese. Top with the other half of the minced prepared bread crumbs. Record review of the recipes for Tomato Basil Soup, undated, for the textures minced and moist and soft bite sized reflected the soup should have been pureed. During an observation of 01/28/25 dinner sample meal tray at 05:15 PM, the dinner for soft bite sized and minced and moist had a full pimiento cheese sandwich and a non-pureed tomato basil soup. During an interview on 01/28/25 at 05:24PM, RN K revealed the nursing staff oversaw checking the meal trays after they left the kitchen, to ensure they were the foods listed on the tray ticket. She revealed if there was a discrepancy, they would go to the kitchen to let them know. RN K revealed she questioned if a sandwich was okay for soft and bite sized and was told okay. During an interview on 01/29/25 at 11:45 AM, the CDM revealed they did not puree the tomato basil soup to its proper consistency. He further revealed the pimento cheese sandwich was not ground according to the recipe. He revealed it was important to follow the diet textures because residents could choke. During an interview on 01/29/25 at 04:31 PM, the RD revealed residents should not be getting regular sandwiches if on minced and moist or soft and bite sized diets. The RD revealed if a resident received a sandwich on these diets, it was a choking hazard. The RD revealed the speech therapist and her educated on these textures. She revealed this in-service was done with nursing and dietary staff about 6 months ago. She further revealed she needed to do another in-service because it has been a long time and there had been a lot of new staff, nursing and dietary. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/30/25 at 03:11 PM, CNA F revealed when the food trays came out of the kitchen, if the tray ticket was different, he would tell the nurse and then dietary. He further revealed soft bite sized diet was chopped up and he was familiar with the minced and moist texture. He revealed sandwiches should be chopped up. He further revealed a resident could choke if they were served a diet with a different texture than what they could have. During an interview on 01/30/25 at 03:50 PM, [NAME] AD and [NAME] AE revealed soft bite sized and minced and moist diet were new diets they were following in the kitchen. [NAME] AE revealed he did not follow the recipes for soft bite sized and minced and moist diet on 01/28/25 dinner and did not know the food textures. They further revealed it was important to follow recipes for the residents' safety. During an interview on 01/28/25 at 06:39 PM, the DON revealed it was important to serve diets as prescribed to avoid any choking hazards. The DON revealed the nursing staff was trained on these diet textures, but he could not recall when this training was. Record review of facility's policy, undated, Standardized Recipes reflected, Standardized recipes shall be developed and used in the preparation of foods.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48366 Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed, in that: 1. In a refrigerator, there were 2 bags of salad, 1 dated 01/25 and one not dated, and 1 bag of ham, dated 01/17, that did not reflect a discard date. 2. The facility's documents Three Compartment Sink Log and Milk Refrigerator Temperature Log for January 2025 reflected no entries were documented January 22-January 24. 3. Dietary Aide AG had a facial piercing and parts of her hair exposed while working in the kitchen. These failures could place residents who consumed meals and/or snacks prepared in the facility kitchen in danger of food-borne illness. The findings were: 1. During observation on 01/26/25 at 10:52 AM, there were 2 bags of salad, 1 dated 01/25 and one not dated, and 1 bag of ham, dated 01/17, that did not reflect a discard date. During an interview on 01/26/25 at 01:03 PM, the CDM revealed the salad bags and the bag of ham in the refrigerator did not have a discard date, so he threw these foods away to ensure foods from the kitchen were safe to eat. He further revealed he was not aware of who did this and he oversaw this process. 2. Record review, during initial kitchen tour on 01/26/25 at 10:52 AM, of facility's document, Milk Refrigerator Temperature Log for January 2025 reflected no temperatures were documented January 22-January 24 in the AM and PM. Record review, during initial kitchen tour on 01/26/25 at 10:52 AM, of facility's document, Three Compartment Sink Log for January 2025 reflected no wash temperatures or PPM were documented January 22-January 24 in the AM and PM. During an interview with [NAME] AF, during initial kitchen tour on 01/26/25 at 10:52 AM, she revealed there were missing days on the Milk Refrigerator Temperature Log and the Three Compartment Sink Log. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/26/25 at 01:03 PM, the CDM confirmed Milk Refrigerator Temperature Log, dated January 2025, and Three Compartment Sink Log, dated January 2025, had no entries documented January 22- January 24 in the AM and PM. The CDM revealed it was important to follow the dishwashing guidelines to kill germs. He revealed he trusted his AM staff members checked temperatures, but he was unaware about his PM staff. He further revealed the log had blank spaces and he expected these logs to be filled completely. He revealed these deficiencies could cause food borne illnesses. 3. During an interview and observation on 01/26/25 at 01:03 PM, it was observed that Dietary Aide AG, while preparing for lunch on 01/26/25, had a facial piercing (located on her bottom lip) and her hair net did not cover the bottom half of her hair. The CDM revealed he had to work on training about dress code with the kitchen staff as there were issues with them following the dress code, but he was going to start the training soon. During an interview on 01/29/25 at 04:31 PM, the RD revealed it was important to label and date food products to make sure they were serving food safely. The RD further revealed that completing logs in the kitchen, like temperatures and dishwashing logs, prevented food borne illness. Record review of facility's policy Food Preparation and Service, revised November 2022, reflected Food Preparation, Cooking, and Holding Time/Temperatures . 1. The danger zone for food temperatures is above 41 *F and below 135 *F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness . Food Distribution and Service . 1. Proper hot and cold temperatures are maintained during food distribution and service . 8. Food and nutrition services staff wear hair restraints (hair net) so that hair does not contact food. 9 . Jewelry is worn minimally, and hand jewelry is covered with gloves . 15. All food service equipment and utensils will be sanitized according to current guidelines and manufacturers' recommendations. Record review of facility's policy Refrigerators and Freezers, revised November 2022, reflected 2. Monthly tracking sheets for all refrigerators and freezers are posted to record temperatures . 4. Food service supervisors or designated employees check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening . 7. All food is appropriately dated to ensure proper rotation by expiration dates . Use by dates are completed with expiration dates on all prepared food in refrigerators . 9. Supervisors are responsible for ensuring food items in pantry, refrigerators, and freezers are not past use by or expiration dates. Record Review of U.S. Food and Drug Administration's 2022 Food Code reflected, 2-303 Jewelry 2-303.11 Prohibition. Except for a plain ring such as a wedding band, while preparing FOOD, FOOD EMPLOYEES may not wear jewelry . Record Review of U.S. Food and Drug Administration's 2022 Food Code reflected, 2-302.12 Food Storage Containers, Identified with Common Name of Food . working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT . shall be identified with the common name of the FOOD. Record Review of U.S. Food and Drug Administration's 2022 Food Code reflected, 3-307 Preventing Contamination from Other Sources 3-307.11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301-3-306. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of U.S. Food and Drug Administration's 2022 Food Code reflected, 3-5 Limitation of Growth of Organisms of Public Health Concern 3-501 Temperature and Time Control 3-501.12 Time/Temperature Control for Safety Food, Slacking . (A) Under refrigeration that maintains the FOOD temperature at 5*C (41*F) or less . 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) . READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections; Standard and transmission-based precautions to be followed to prevent spread of infections; for 3 of 8 residents (Residents #45 and #69) and 3 of 3 staff (MA E, DON, LVN J) reviewed for infection prevention with Enhanced Barrier Precautions. 1. Resident #69 was diagnosed with a urinary tract infection (UTI), assessed with the need for infection prevention enhanced barrier precautions (EBP), and on 1/26/2025 at 11:52 AM the DON wore 1 glove for personal protective equipment (PPE) while attempting to administer an intravenous access for Resident #69. 2. Resident #69 was diagnosed with a urinary tract infection (UTI), assessed with the need for infection prevention enhanced barrier precautions, and on 1/28/2025 at 9:36 AM Medication Aide E (MA E) did not wear PPE while administering medications to Resident #69. 3. Resident #45 was prescribed a gastric tube (g-tube; a surgically placed device used to give direct access to the stomach for supplemental feeding, hydration, or medicine), assessed with a need for infection prevention enhanced barrier precautions, and on 1/28/2025 did not wear EBP PPE and administered medications via Resident #45's g-tube. These failures could place residents at risk for harm by cross contamination infections. The findings included: 1. A record review of Resident #69's admission record dated 1/30/2025 revealed an admitted [DATE] with diagnosis which included a urinary tract infection. A record review of Resident #69's quarterly MDS assessment dated [DATE] revealed Resident #69 was an [AGE] year-old male admitted for long term care and assessed with a BIMS score of 3 out a possible 15 which indicated severely impaired cognition. A record review of Resident #69's care plan dated 1/30/2025 revealed, Urinary Tract Infection, potential or actual r/t Diagnosis of BPH, Diagnosis of Urinary retention, Use of indwelling catheter dx (diagnosis) ESBL UTI (extended spectrum beta-lactamase urinary tract infection. ESBL-producing bacteria can't be killed by many of the antibiotics that doctors use to treat infections), Date Initiated: 01/22/2025 . Antibiotic per MD (medical doctor) order x 5days. Date Initiated: 01/26/2025 A record review of Resident #69's physicians orders dated 1/26/2025 revealed the physician prescribed for Resident #69 to receive meropenem (an intravenous antibiotic used to treat a variety of bacterial infections) Intravenous Solution, Use 500mg intravenously every 6 hours for ESBL UTI (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 1/26/2025 at 11:52 AM revealed Resident #69's room which presented with EBP signage and a PPE supply cabinet at the room entry. Further observation revealed the DON in Resident #69's room, attempting to start an intravenous (IV) access. Further review revealed the DON wore a glove on his right hand as the lone PPE. The DON stated Resident #69 was diagnosed with a UTI and was prescribed intravenous antibiotics, He (Resident #69) had a midline (an intravenous access) he pulled it out and he is refusing the IV. 2. During an observation and interview on 1/28/2025 at 9:36 AM revealed Medication Aide E was in Resident #69's room and had administered medication to Resident #69. MA E stated Resident #69 was diagnosed with a UTI and had a need for infection control EBP's and had PPE supplies as well as signage at his room entry. MA E stated she should have worn EBP PPE and had not. 3. A record review of Resident #45's admission record, dated 12/25/2024, revealed an admitted [DATE] with diagnoses which included dysphagia following cerebral infarction (difficulty swallowing after a stroke), hypertension (high blood pressure), and diabetes type 2 (the inability for the body's cell to absorb blood sugar resulting in high levels of blood sugar with disease complications, e.g., blindness.) A record review of Resident #45's quarterly MDS assessment dated [DATE] revealed Resident #45 was a [AGE] year-old female admitted for long term care with difficulty swallowing and supported with enteral feeding and medications via a g-tube. A record review of Resident #45's care plan dated 1/30/2025 revealed, Enhanced barrier precautions r/t an indwelling medical device Specify: Peg tube Date Initiated: 01/04/2025 . [NAME] gown and gloves during high-contact personal care activities Date Initiated: 01/04/2025. During an observation on 1/28/2025 at 5:32 PM revealed Resident #45's room entry presented with EBP signage and a PPE supply cabinet. Observations revealed LVN J prepared and administered medications to Resident #45 via her g-tube while LVN J wore gloves as PPE without a gown. LVN J stated she forgot to wear the gown and stated she should have worn a gown and gloves per the EBP protocol .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews the facility failed to ensure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public, for 1 of 1 secured yard reviewed for safety. 1.Daily intermittent observations, from 1/26/2025 to 1/30/2025, revealed the facility's secured backyard and smoking patio yard had a section of chain link fence a section of the chain link fencing was detached from the top rail and leaning down. 2. Daily intermittent observations, from 1/26/2025 to 1/30/2025, revealed the facility's secured backyard and smoking patio yard had several red fire rated trash cans, designated for cigarette butts, filled with non-cigarette butt trash. These failures could place residents at risk for elopement and/or fire risks. The findings included: A record review of Resident #24's admission record dated 1/30/2025 revealed an admitted [DATE] with diagnoses which included tobacco use, lack of coordination, and muscle weakness. A record review of Resident #24's quarterly MDS assessment dated [DATE] revealed Resident #24 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 12 which indicated intact cognition. Resident #24 was assessed with difficulty hearing and poor vision and used glasses. Resident #24 was assessed an elopement / wander risk and was supported for safety with a wander guard anklet. A record review of Resident #24's care plan dated 1/30/2025 revealed, At risk for elopement /wandering as evidenced by Disoriented to place, Impaired safety awareness, wanders aimlessly Date Initiated: 12/19/2024. Device: Alarm: Check via Electronic Machine Every Day Date Initiated: 12/20/2024. Device: Alarm: Visually Check Every Shift Wander guard on Right Ankle every shift for Wonder Guard. The resident has, impaired visual function r/t Disease Process . Monitor/document/report to MD the following s/sx of acute eye problems: Change in ability to perform ADLs, decline in mobility, Sudden visual loss, Pupils dilated, gray or milky, c/o halos around lights, double vision, tunnel vision, blurred or hazy vision. STCP: At risk for smoking related injury related to: supervised smoking . observe him/her for unsafe smoking behaviors or attempts to obtain smoking material from outside sources. Immediately inform facility management Date Initiated: 12/18/2024 A record review of Resident #24's physicians' orders dated 1/30/2025 revealed the physician prescribed, for her elopement / wander risk, a wander guard anklet and to have the anklet checked daily. A record review of Resident #55's admission record revealed an admitted [DATE] with diagnoses which included corneal ulcer of the right eye, generalized anxiety disorder, dementia with behavioral disturbance. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #55's annual MDS assessment dated [DATE] revealed Resident #55 was an [AGE] year-old male admitted for long term care and resided in the MCU. Resident #55 was assessed with a BIMS score of 00 which indicated severe cognitive impairment as evidenced by his inability to participate in the assessment. A record review of Resident #55's care plan dated 1/28/2025 revealed, (Resident #61) is an elopement risk/wanderer Continues placement on Memory Care at this time. is a smoker . Instruct (Resident #55) about the facility policy on smoking: locations, times, safety concerns . has a behavioral concern of increased agitation physical and verbal aggression with the possibility of throwing things . Staff to redirect resident to other activities . Intervene as needed to ensure resident safety A record review of Resident #83's admission record dated 1/30/2025 revealed an admitted [DATE] with diagnoses which included dementia (a group of symptoms affecting memory, thinking and social abilities. In people who have dementia, the symptoms interfere with their daily lives), psychotic disturbance (a cluster of symptoms, not an illness. It's sometimes described as losing touch with reality), mood disturbance, and anxiety. Further review revealed Resident #83 resided in the MCU. A record review of Resident #83's admission MDS assessment dated [DATE] revealed Resident #83 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 6 out of a possible 15 which indicated severely impaired cognition. Resident #83 was reviewed for the 6 days prior to the assessment and Resident #83 was assessed with a history of behavioral symptoms, physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) . behavior of this type occurred 1 to 3 days. verbal behavioral symptoms directed toward others (e. g., threatening others, screaming at others, cursing at others) . behavior of this type occurred 1 to 3 days. impact on others? Put others at significant risk for physical injury? Yes Further review revealed resident #83 was six foot tall and weighed 179 lbs. A record review of Resident #83's care plan dated 1/29/2025 revealed, (Resident #83) has mood problem r/t Admission, agitation and anxiety from resident to staff root cause: Resident attempting to get out of memory care unit . is a safe smoker Date Initiated: 11/07/2024 . Patient educated to appropriate smoking areas Date Initiated: 11/07/2024 If safety becomes a concern involve IDT team and resident for reevaluation of smoking needs (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 1/26/2025 at 11:30 AM revealed the facility's secured back yard / smoking patio. The patio presented with 2 red fire rated trash cans and 1 large plastic 30-gallon trash can with a plastic liner. The patio was supervised by the Admissions Coordinator and Residents #2, #24, #55, and #83 were among the 9 residents at the patio. Further observation revealed the residents were smoking cigarettes. Observation of the 30-gallon trash can revealed paper, plastic, and can trash among cigarette butts. Observations of the 2 red fire rated cigarette butt trash cans revealed more than 100 cigarette butts among plastic and paper trash. Further review revealed the yard was enclosed by a combination of 5 - 6-foot-tall wooden privacy fencing and metal galvanized chain link fencing. A section of the chain link fencing was detached from the top rail and leaning down. The Admissions coordinator stated Resident #25 was a wander risk and Residents #55 and #83 were also wander risk and resided in the secured MCU (memory Care Unit.) The Admissions coordinator stated the 30-gallon trash can had paper, plastic, and can trash among cigarette butts, the 2 red fire rated cigarette butt trash cans had more than 100 cigarette butts among plastic and paper trash, and a section of the chain link fencing was detached from the top rail and leaning down. The Admissions coordinator stated the cans had signage stating only cigarette butt trash was allowed in the cans, and the regular trash can should not have any cigarette butts. The Admissions coordinator stated the risk was a potential fire. Daily intermittent observations, from 1/26/2025 to 1/30/2025 , revealed the facility's secured backyard and smoking patio yard had a section of chain link fence missing and had a regular trash can filled with trash and cigarette butts, several red fire rated trash cans, designated for cigarette butts, filled with non-cigarette butt trash. During an interview on 1/27/2025 at 10:02 AM the operations manager stated she was unaware of the secured backyard and smoking patio yard had a section of chain link fence missing and had a regular trash can filled with trash and cigarette butts, and several red fire rated trash cans, designated for cigarette butts, filled with non-cigarette butt trash. A record review of the facility's policy titled Smoking Policy - Residents dated October 2023, revealed, Policy Statement This facility has established and maintains safe resident smoking practices. Policy Interpretation and Implementation . 5. Metal containers, with self-closing cover devices, are available in smoking areas. 6. Ashtrays are emptied only into designated receptacles. A policy for a safe environment was requested of the Administrator on 1/30/2025 and as of 2/7/2025 had not been provided. A policy on smoking was provided.