STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675013	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crowell Nursing Center	200 South B Ave Crowell, TX 79227

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 46534 Based on observation, interview, and record review the facility failed to ensure the assessment accurately reflected the resident's status for 2 (Resident #3 and Resident #38) of 13 residents reviewed for accuracy of assessment. 1. Resident #3 was a smoker and his annual MDS assessment did not indicate his use of tobacco. 2. Resident #38 had a lesion on her right cheek which was not noted in her quarterly MDS assessment. These failures could place residents at risk of not receiving necessary care and treatment. Findings Included: 1. Record review of Resident #3's admission record dated 02/10/25 revealed a [AGE] year-old male resident admitted to the facility originally on 3/02/18 and readmitted on [DATE] with diagnoses to include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath and chronic fatigue (a long-term condition that causes extreme fatigue that doesn't improve with rest). Record review of Resident #3's clinical record revealed his last quarterly MDS was completed on 12-16-2024 listing him with a BIMS of 14 indicating he was cognitively intact, and he had a functionality of being independent with all his activities of daily living. Record review of Resident #3's last annual MDS had an ARD of 07/09/24 and a completion date of 07/10/24. Section I of this MDS included a diagnosis of Tobacco Use under question I8000 Additional active diagnoses. Section J question J1300 Current Tobacco Use was answered with a 0 which indicated Resident #3 did not use tobacco. Record review of Resident #3's clinical record revealed a care plan with an admitted [DATE] with last revision on 12-13-2024 with the following: Focus: o Smoking: Resident is a smoker and is at risk for injury . (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goal: o Resident will abide by facility's smoking policy and remain safe during smoking times . Interventions: o Perform smoking assessment according to facility policy . Record review of Resident #3's smoking assessment dated [DATE] revealed he was determined to be an independent smoker. During an interview on 02/12/25 at 10:06 AM MDS LVN stated she missed that Resident #3 was a smoker on his last annual MDS. 2. Record review of Resident #38's admission record dated 02/11/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, protein-calorie malnutrition (inadequate intake of food which results in inflammation), unspecified dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain), cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), muscle wasting and atrophy in lower legs, muscle weakness, and anorexia (eating disorder characterized by inordinately low body weight and fear of gaining weight). Record review of Resident #38's quarterly MDS with an ARD of 12/13/24 and completed on 12/16/24 revealed the following: Section C-Cognitive Patterns: Resident #38 had a BIMS score of 3 which indicated severely impaired cognition. Section GG-Functional Abilities: Resident #38 used a w/c and required Substantial/maximal assistance across all ADLs. Section M-Skin Conditions: Question M1040 Other Ulcers, Wounds, and Skin Problems including D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion) was answered as None of the above were present. Record review of Resident #38's care plan completed on 12/18/24 revealed the following: Ms. [last name of Resident #38] has a hard dry callous type raised area on right outer cheek bone that resident frequent dries [sic] and [family member] prefers no treatment at this time. 12/3/24 1st Quart (quarter): no changes Date initiated: 11/21/2024 . Affected area will show no signs of infections or other complications over the next review period . Notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, or discoloration . Report changes in skin status (i.e. infection, non-healing, new areas) to physician. Provide treatment per order and monitor for changes or complications. Record review of Resident #38's Order Summary Report dated 02/10/25 revealed the following orders: An order with start date 11/18/24 apply barrier cream to dry flaky patch to left outer cheek bone every shift for skin (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An order with start date 10/25/23 Perform head to toe skin assessment. Document any changes in skin integrity in the medical record. every day shift every Wed for wound prevention/ early identification Notify the physician of any changes in skin integrity. Record review of Resident #38's progress notes revealed the following: A note by ADON dated 11/18/24 resident noted to have a 2cm in diameter dry flaky patch area to left outer cheek bone orders to apply barrier cream every shift. family informed and agreed A note by RN E dated 11/22/24 Reported slight tenderness to lesion to right lower cheek with wound care. denied pain after task completed A note by RN E dated 12/05/24 Data: resident has a lesion to right side of her face the area is dry, crusted Action: applied moisture barrier cream to the affected area no bandage applied Response: stated that had minimal tenderness to the site with the application of the barrier cream. Record review of Resident #38's MAR from November 18, 2024, to February 10, 2025, revealed the following: apply barrier cream to dry flaky patch area to left outer cheek bone every shift for skin -Start Date-11/18/2024 1500 (03:00 PM) The MAR indicated this had been done 3 times every day except for 11/18/24 when it was done two times due to order start time in the afternoon. During an observation on 02/10/25 at 02:22 PM Resident #38 was seated in her w/c in the lobby. She had a large open wound on the right side of her face. It was not covered. During an interview on 02/10/25 at 03:07 PM ADON stated the open area on Resident #38's right cheek began as a dry flaky area. During an observation on 02/10/25 at 03:45 PM Resident #38 was seated in her w/c in the lobby. She had her right elbow on the arm rest of the w/c and her right cheek resting in her right hand. She was moving the fingers of her right hand around in the wound on her right cheek. During an interview on 02/10/25 at 03:45 PM Resident #38's family member stated he had noticed the wound on her right cheek. During an observation and interview on 02/11/25 at 10:49 AM Resident #38 was seated in her w/c in her room. She stated her cheek was hurting. The wound on Resident #38's right lower cheek was shaped like a pear with the top of the pear pointing to the top her head. The outer edges of the sore were raised, pink, and [NAME]-like. Whole wound was approximately the size of a fifty-cent piece and raised from face. The outer edges of the sore were raised further than the center of the sore approximately .75 cm from the surface of the face and approximately .5 cm in width except for the bottom of the sore on side closest to her mouth where the edge was wider, approximately .75 cm. The interior of the sore was dark brown/red with whitish, wet looking splotches throughout. During an interview on 02/12/25 at 08:28 AM ADON stated MDS LVN was responsible for completing MDS assessments. She stated an inaccurate MDS could negatively affect a resident because it would not show an accurate picture of the patient. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/12/25 at 08:40 AM MDS LVN stated she followed the RAI when completing MDS assessments. MDS LVN stated Resident #38's MDS did not mention her wound because It just popped up. I've never noticed it. She stated she referred to treatment logs, medication sheets, and incident reports when completing MDS assessments. She stated that due to the small size of the facility she would often just hear what is going on. She stated an inaccurate MDS assessment would not negatively affect a resident but might negatively affect the facility's funding. When asked if a lack of funding might negatively affect a resident she stated, No, not here. During an interview on 02/12/25 at 08:45 AM ADM was asked if there was possible negative outcome for a resident to have an inaccurate MDS assessment. She stated, Anything is possible. Record review of facility policy titled MDS Completion and dated 11/5/2024 revealed the following: . 'ARD' . refers to the . (last day of MDS observation period) . According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's function capacity, using the RAI specified by the State. Record review of the Long-Term Care Facility RAI 3.0 User's Manual Version 1.18.11 dated October 2023 revealed the following: Section J: Health Conditions . The intent of the items in this section is to document a number of health conditions that impact the resident's functional status and quality of life. Other items in the section assess . tobacco use . J1300: Current Tobacco Use Steps for Assessment 1. Ask the resident if they used tobacco in any form during the 7-day look-back period. 2. If they resident states they used tobacco in some form during the 7-day look-back period, code 1, yes. 3. If the resident is unable to answer or indicates that they did not use tobacco of any kind during the look-back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period. Section M: Skin Conditions . Skin wounds and lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes. Many of these ulcers, wounds, and skin problems can worsen or increase risk for local and system infections. Steps for Assessment 1. Review the medical record, including skin care flow sheets or other skin tracking forms. 2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medial record review. 3. Examine the resident and determine whether any ulcers, wounds, or skin problems are present. Coding Instructions Check all that apply in the last 7 days. If there is no evidence of such problems in the last 7 days, check none of the above. Open Lesion(s) Other than Ulcers, Rashes, Cuts Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles, should be coded in this item.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on observation, interview, and record review the facility failed to ensure quality of care is a fundamental principle that applies to all treatment and care provided to facility residents based on the comprehensive assessment of a resident, to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, for 1 (Resident #38) of 13 residents reviewed for quality of care. The facility failed to document physician ordered weekly skin assessments to include a lesion on Resident #38's right cheek. The facility failed to revisit the option of treatment of the lesion on Resident #38's right cheek with her responsible party as the lesion progressed. These failures could place residents at risk of harm due to health issues not being recognized and treated timely. Findings Included: Record review of Resident #38's admission record dated 02/11/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, protein-calorie malnutrition (inadequate intake of food which results in inflammation), unspecified dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain), cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), and anorexia (eating disorder characterized by inordinately low body weight and fear of gaining weight). Resident #38's family member was listed as her financial POA and emergency contact. Record review of Resident #38's quarterly MDS with an ARD of 12/13/24 and completed on 12/16/24 revealed the following: Section C-Cognitive Patterns: Resident #38 had a BIMS score of 3 which indicated severely impaired cognition. Section GG-Functional Abilities: Resident #38 used a w/c and required Substantial/maximal assistance across all ADLs. Section M-Skin Conditions: No mention was made of the lesion on Resident #38's right cheek. Question M1040 Other Ulcers, Wounds, and Skin Problems including D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion) was answered as None of the above were present. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #38's care plan completed on 12/18/24 revealed the following: Ms. [last name of Resident #38] has a hard dry callous type raised area on right outer cheek bone that resident frequent dries [sic] and [family member] prefers no treatment at this time. 12/3/24 1st Quart (quarter): no changes Date initiated: 11/21/2024 . Affected area will show no signs of infections or other complications over the next review period . Notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, or discoloration . Report changes in skin status (i.e. infection, non-healing, new areas) to physician. Provide treatment per order and monitor for changes or complications. Record review of Resident #38's Order Summary Report dated 02/10/25 revealed the following orders: An order with start date 11/18/24 apply barrier cream to dry flaky patch to left outer cheek bone every shift for skin An order with start date 10/25/23 Perform head to toe skin assessment. Document any changes in skin integrity in the medical record. every day shift every Wed for wound prevention/ early identification Notify the physician of any changes in skin integrity. Record review of Resident #38's progress notes revealed the following: A note by ADON dated 11/18/24 resident noted to have a 2cm in diameter dry flaky patch area to left outer cheek bone orders to apply barrier cream every shift. family informed and agreed A note by RN E dated 11/22/24 Reported slight tenderness to lesion to right lower cheek with wound care. denied pain after task completed A note by RN E dated 12/05/24 Data: resident has a lesion to right side of her face the area is dry, crusted Action: applied moisture barrier cream to the affected area no bandage applied Response: stated that had minimal tenderness to the site with the application of the barrier cream. A note by DON dated 01/06/25 Skin lesion on right outer face is 2.5cm long and 2cm wide area has developed into a pear shape with white rough band surround .5cm deep wound bed that is pink with no bleeding or drainage noted, there also is a deep dark protruding area at the inner baseof [sic] wound, Doctor [last name of medical director] suggest a biopsy to be performed, However [family member] refuses stating that is not bothering her and he will just monitor it closely. A note by RN E dated 01/22/25 S/O tenderness to lesion to right side of face with application of cream A note by RN E dated 01/23/25 C/O tenderness to lesion to right side of face with application of medication The progress notes did not reveal any notes on Wednesdays regarding skin assessment results for any of the Wednesdays from 11/18/24 to 02/10/25. Record review of Resident #38's MAR from November 18, 2024, to February 10, 2025, revealed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	apply barrier cream to dry flaky patch area to left outer cheek bone every shift for skin -Start Date- 11/18/2024 1500 (03:00 PM) The MAR indicated this had been done 3 times every day except for 11/18/24 when it was done two times due to order start time in the afternoon. Perform head to toe skin assessment. Document any changes in skin integrity in the medical record. every day shift every Wed for wound prevention/ early identification Notify the physician of any changes in skin integrity. -Start Date- 10/25/2023 0700 (07:00 AM) The MAR indicated this had been done every Wednesday 11 times by LVN A and once by LVN B. Record review of the Assessments tab in Resident #38's EHR revealed the following: Monthly Nurse Summary reports dated 11/17/24, 12/08/24, and 01/19/25. The Monthly Nurse Summaries had a section titled G. SKIN/WOUND. All three summaries stated, No new changes in skin observed and the box for Notable changes in skin integrity was left blank. Physician Note reports dated 11/12/24, 12/12/24, and 01/15/25. All three of the reports revealed No changes or concerns noted. Under the Objective sections of all three reports was noted, Skin: Normal, no rashes, no lesions, noted. During an observation on 02/10/25 at 02:22 PM Resident #38 was seated in her w/c in the lobby. She had a large open sore on the right side of her face. It was not covered. During an interview on 02/10/25 at 03:07 PM ADON stated the open area on Resident #38's right cheek began as a dry flakey area. She stated Resident #38's family member did not want to send her out to have the area evaluated. ADON stated, Dr. [last name of facility medical director] does not know what it is but if they won't go see another doctor there is nothing else that can be done. She stated the wound had been progressing over the last two months. During an observation on 02/10/25 at 03:45 PM Resident #38 was seated in her w/c in the lobby. She had her right elbow on the arm rest of the w/c and her right cheek resting in her right hand. She was moving the fingers of her right hand around in the wound on her right cheek. During an observation and interview on 02/10/25 at 03:45 PM Resident #38's family member stated he had noticed the wound on her right cheek. When asked if he was against her seeing a doctor about the wound he stated, I don't know about that! I said we don't need to be cutting on her at this point in the game, but I'd like to have it looked at and maybe they could burn it off or do something to help it. ADM was standing beside Resident #38's family member and she stated, We can do that. During an interview on 02/11/25 at 10:49 AM Resident #38 was seated in her w/c in her room. She stated her cheek was hurting. When asked if this surveyor could look at her cheek she stated, Just don't touch it. The wound on Resident #38's right lower cheek was shaped like a pear with the top of the pear pointing to the top her head. The outer edges of the sore were raised, pink, and [NAME]-like. Whole sore was approximately the size of a fifty-cent piece and raised from face. The outer edges of the sore were raised further than the center of the sore approximately .75 cm from the surface of the face and approximately .5 cm in width except for the bottom of the sore on side closest to her mouth where the edge was wider, approximately .75 cm. The interior of the sore was dark brown/red with whitish, wet looking splotches throughout. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/11/25 at 11:05 AM LVN D stated skin assessments were documented on the MAR with a check mark. She stated she thought any actual concerns or wound measurements were kept in a folder in DON's office. During an interview on 02/11/25 at 11:06 AM ADON stated skin assessments were documented on the MAR with a check mark. When asked where actual wound measurements were documented she provided a 3-ring binder. Record review on 02/11/25 at 11:13 AM of the 3-ring binder provided by ADON on 02/11/25 at 11:06 AM revealed no mention of Resident #38 or mention of any wound that was not a pressure injury. During an interview on 02/11/25 at 11:24 AM LVN D stated she had performed skin assessments. When asked where she documented her findings she stated, It is usually the ADON or DON who documents. She stated she would take measurements and document them on a piece of paper but would have ADON or DON on duty recheck because I learned it (wound measurement) in nursing school but it is not something I do every day, so I am not confident in my measurements and I always want someone else to check them (her measurements). During an interview on 02/11/25 at 07:38 PM LVN B stated nurses were responsible for performing skin assessments as ordered by the physician. She stated she had performed skin assessments. She stated, I write down what I find and let my charge nurse know because I just graduated (nursing school) recently in December, and I am not sure if I am doing it right. LVN B stated she meant ADON or DON when she said, charge nurse. She stated she had performed skin assessments on Resident #38. When asked if she noted anything about the wound on Resident #38's cheek, LVN B stated, I think I just write it down on a paper because I am not real familiar with how to do a skin assessment. I wrote down that I noticed it has gotten worse to me over the past few months. There is an ointment and I tell them (ADON and DON) that I put it on there. She stated she felt this method of documenting skin assessments did not have a possible negative outcome to the resident. LVN B stated, I think it is pretty effective since [first name of DON] and [first name of ADON] are higher up and more familiar with what needs to be done. During an interview on 02/12/25 at 08:16 AM LVN A stated nurses were responsible for completing skin assessments as ordered by the physician. She stated if there were concerns with the skin of a resident the nurse would let ADON or DON know and possibly inform the doctor. She stated she had performed several skin assessments on Resident #38. She stated the skin assessment was documented as complete with a check mark on the MAR. LVN A stated, We document in the nurses' notes if we find something (during the skin assessment). She stated, If it (skin) is an issue [first name of DON] and [first name of ADON] keep track, I'm pretty sure they have a skin book in their office. LVN A stated a possible negative outcome of not documenting a skin assessment was, If you find something and you don't document it, then nobody else will know and you can't follow up the treatments and all of that. LVN A stated she did not document anything in Resident #38's EHR following the skin assessments she performed for Resident #38 because the skin assessment asks if there is a change, and week to week it (the wound on Resident #38's cheek) looks okay gradually it has just gotten worse. Week to week it looks the same. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/12/25 at 08:28 AM ADON stated, Me and [first name of DON] do a lot of the skin checks and nurses keep an eye on the skin. Me and [first name of DON] do a lot of the in-depth stuff and of course if they (nurses) see something they notify us. ADON stated skin assessments were documented if we find something we do treatment orders and we put it in the care plan. She stated she did not think there was a possible negative outcome of not documenting skin assessments other than with a check mark of completion on the MAR. When asked about Resident #38's wound on her cheek, ADON stated, [First name of DON] has been in contact with the doctor about that. She stated this contact may not have been documented since we did not change anything. During an interview on 02/12/25 at 09:32 AM ADM stated facility did not have a quality-of-care policy. During an interview on 02/12/25 at 10:47 AM Resident #38's physician stated Resident #38's family member was often present when he (Resident #38's physician) was doing his rounds in the facility. He stated Resident #38's family member did not want to do anything about treating her cheek when asked by nursing staff. He stated he had not spoken to Resident #38's family member about treatment again but had spoken on 02/10/25 and 02/11/25 with facility staff. He stated, They sent me a picture of her cheek. It was about 25% that size when it started. It is likely basil cell or squamous cell (types of cancer). It is rapidly growing. I couldn't believe it when I saw it yesterday (in the picture sent by the facility). He stated since Resident #38's family member was now willing to seek treatment we are in the dilemma of finding a surgeon or dermatologist who is willing to operate on an aged person. Record review of facility policy titled Following Physician Orders and dated 9/28/2021 revealed the following: . the nurse will . Carry out and implement physician orders . Document resident response to physician order in the medical record as indicated . Record review of facility policy titled Skin Assessment/Evaluation and dated 4/13/2023 revealed the following: . This policy includes the following procedural guidelines in performing the full body skin assessment. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse/wound nurse upon admission/re-admission, weekly for resident with no pressure injury . 2. Procedure . Note any skin conditions such as redness, bruising, rashes, blisters, skin tears, open areas, ulcers, and lesions. 7. Documentation of skin assessment: a. Include date and time of the assessment, your name, and position title. c. Document type of wound and wound assessment weekly. e. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). h. Document other information as indicated or appropriate.

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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** 39813 Based on interview and record review, the facility failed to ensure that the residents environment remained as free from accident hazards as was possible for one (Resident #3) of 2 residents reviewed for accident hazards. -Resident #2's last smoking evaluation was completed 9-27-2024. This failure could affect residents that smoke at the facility by placing them at risk for accidents that lead to injuries such as burns, tissue damage, and feeling of isolation. Findings include: Record review of the clinical record for Resident #3 revealed a [AGE] year-old male resident admitted to the facility originally on 3-2-2018 and readmitted on [DATE] with diagnoses to include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), paranoid schizophrenia (a disease that affects a person's ability to think, feel, and behave clearly), generalized anxiety disorder (a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), difficulty walking, abnormalities of gait and mobility, lack of coordination, muscle wasting and atrophy (the loss of muscle mass and strength due to disease, injury, or lack of use), weakness, and chronic fatigue (a long-term condition that causes extreme fatigue that doesn't improve with rest). Record review of Resident #3's clinical record revealed his last annual MDS was a quarterly completed 12-16-2024 listing him with a BIMS of 14 indicating he was cognitively intact, and he had a functionality of being independent with all his activities of daily living. Record review of Resident #3's clinical record revealed a care plan with an admitted [DATE] with last revision on 12-13-2024 with the following: Focus: o Smoking: Resident is a smoker and is at risk for injury . Goal: o Resident will abide by facility's smoking policy and remain safe during smoking times . Interventions: o Perform smoking assessment according to facility policy . Record review of Resident #3's clinical record revealed his last smoking evaluation was completed 9-27-2024. During an interview on 02-12-2025 at 09:28 AM LVN A (LVN Charge Nurse responsible for Resident #3 this shift) reported that smoking assessments were to be done on admission and quarterly by the charge nurse and the MDS coordinator. LVN A stated that if a smoking assessment was not completed as per policy then staff would not know if a resident was safe to smoke or if that resident had a decline in their ability to smoke safely. (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 02-12-2025 at 09:30 AM with the MDS Coordinator stated she would need to complete a smoking assessment when a residents MDS was due so that smoking could be addressed on the MDS. The MDS Coordinator reported that basically that would mean that the smoking assessment was due quarterly. The MDS Coordinator reviewed Resident #3's chart and reported that Resident #3 was due for a smoking assessment in December but it looked like the staff missed it and it was not completed. The MDS Coordinator reported that Resident #3's last smoking assessment was completed 9-27-2024. The MDS Coordinator reported that Resident #3 missing his quarterly smoking assessment was not a big issue because Resident #3 was basically independent and that unless a resident had a change in their ability to function then missing the assessment was not an issue. The MDS Coordinator reported that if a resident had a decline in their cognitive or mobility function then the assessment would really need to be done so that smoking safety would be addressed. During an interview on 02-12-2025 at 09:54 AM the ADON reported that smoking assessments were to be completed annually and quarterly. The ADON reported that if a smoking assessment was not completed as per policy, then a resident could have a major decline in function, and they may not be safe to smoke independently and may require increased supervision. Record review of the facility provided policy titled Smoking Policy revision 7-14-2023, revealed the following: Policy: It is the policy of this facility to provide a safe and healthy environment for resident, visitors and employees as related to smoking. Procedure: Evaluate patients that smoke/use smokeless tobacco, utilizing the Smoking Evaluation/Smokeless Tobacco tool (a) upon admission; (b) quarterly .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on observation, interview, and record review the facility failed to, in accordance with accepted professional standards and practices, maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized for 1 (Resident #38) of 13 residents reviewed for accuracy of medical records. The facility failed to correctly enter an order for barrier cream into Resident #38's EHR. The order was entered for her left cheek and the lesion was located on her right cheek. This failure could place residents at risk of receiving unnecessary treatment or not receiving necessary treatment. Findings Included: Record review of Resident #38's admission record dated 02/11/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, protein-calorie malnutrition (inadequate intake of food which results in inflammation), unspecified dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain), cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), muscle wasting and atrophy in lower legs, muscle weakness, and anorexia (eating disorder characterized by inordinately low body weight and fear of gaining weight). Record review of Resident #38's quarterly MDS completed on 12/16/24 revealed the following: Section C-Cognitive Patterns: Resident #38 had a BIMS score of 3 which indicated severely impaired cognition. Section M-Skin Conditions: No mention was made of the lesion on Resident #38's right cheek. Question M1040 Other Ulcers, Wounds, and Skin Problems including D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion) was answered as None of the above were present. Record review of Resident #38's care plan completed on 12/18/24 revealed the following: Ms. [last name of Resident #38] has a hard dry callous type raised area on right outer cheek bone that resident frequent dries [sic] and [family member] prefers no treatment at this time. 12/3/24 1st Quart (quarter): no changes Date initiated: 11/21/2024 . Affected area will show no signs of infections or other complications over the next review period . Notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, or discoloration . Report changes in skin status (i.e. infection, non-healing, new areas) to physician. Provide treatment per order and monitor for changes or complications. Record review of Resident #38's Order Summary Report dated 02/10/25 revealed the following orders: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An order with start date 11/18/24 apply barrier cream to dry flaky patch to left outer cheek bone every shift for skin Record review of Resident #38's progress notes revealed the following: A note by ADON dated 11/18/24 resident noted to have a 2cm in diameter dry flaky patch area to left outer cheek bone orders to apply barrier cream every shift. family informed and agreed A note by RN E dated 11/22/24 Reported slight tenderness to lesion to right lower cheek with wound care. denied pain after task completed A note by RN E dated 12/05/24 Data: resident has a lesion to right side of her face the area is dry, crusted Action: applied moisture barrier cream to the affected area no bandage applied Response: stated that had minimal tenderness to the site with the application of the barrier cream. A note by DON dated 01/06/25 Skin lesion on right outer face is 2.5cm long and 2cm wide area has developed into a pear shape with white rough band surround .5cm deep wound bed that is pink with no bleeding or drainage noted, there also is a deep dark protruding area at the inner baseof [sic] wound, Doctor [last name of medical director] suggest a biopsy to be performed, However [family member] refuses stating that is not bothering her and he will just monitor it closely. A note by RN E dated 01/22/25 S/O tenderness to lesion to right side of face with application of cream A note by RN E dated 01/23/25 C/O tenderness to lesion to right side of face with application of medication Record review of Resident #38's MAR from November 18, 2024, to February 10, 2025, revealed the following: apply barrier cream to dry flaky patch area to left outer cheek bone every shift for skin -Start Date-11/18/2024 1500 (03:00 PM) The MAR indicated this had been done 3 times every day except for 11/18/24 when it was done two times due to order start time in the afternoon. During an interview on 02/12/25 at 08:24 AM LVN D and LVN B stated nurses were responsible for entering orders into the EHR. They stated a possible negative outcome of an inaccurate order was, The resident would not get what they need. During an interview on 02/12/25 at 08:28 AM ADON stated nurses were responsible for entering ordering into the EHR. She stated if an order was entered incorrectly the resident can get the wrong treatment. ADON stated she probably got confused regarding which cheek the area was located on when she entered the order for Resident #38. During an interview on 02/12/25 at 08:45 AM ADM stated inaccurate orders in the EHR could lead to illness or death. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled Following Physician Orders and dated 9/28/2021 revealed the following: . 2. For consulting physician/practitioner orders . the nurse, in a timely manner will: a. Document the order by entering the order and the time, date, and signature on the physician order sheet.

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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** 46534 Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for 3 (Resident #26, Resident #31, and Resident #38) of 13 residents reviewed for environment. The facility failed to clean expired and unlabeled food out of Resident #26's personal refrigerator. The facility failed to ensure Resident #31 and Resident #38 kept their personal snacks in sealed containers. The facility failed to ensure Resident #38's personal refrigerator had a thermometer inside with which to monitor temperature of the refrigerator as per facility policy. These failures could place residents at risk of pests and/or food borne illness. Findings Included: 1. Record review of Resident #26's admission record dated [DATE] revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), muscle wasting an atrophy, muscle weakness, lack of coordination, and cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning). Record review of Resident #26's annual MDS completed on [DATE] revealed the following: Section C-Cognitive Patterns: Resident #26 had a BIMS score of 8 which indicated moderately impaired cognition. Section GG-Functional Abilities: Resident #26 used a w/c and was independent across all ADLs. Record review of Resident #26's care plan completed on [DATE] revealed the following: Resident #26 had impaired cognition and needed supervision/assistance will all decision making. Resident #26 had impaired visual function Resident #26's family requested a dorm-size refrigerator in her room for snacks and fluids. Staff were to Monitor refrigerator for proper temperature at or below 41 degrees, and maintain sanitary conditions with no out dated or spoiled items. During an observation on [DATE] at 12:06 PM Resident #26's personal refrigerator contained the following: (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A bottle of ketchup with an expiration date of [DATE]. An opaque plastic cup ,d+[DATE] full of a tan liquid with what appeared to be a partially eaten donut resting half in and half out of the top of the cup. The portion of the donut inside the cup appeared to have absorbed some of the liquid as it was discolored part way up. The donut appeared to be dry and crusty and was not touching the liquid in the cup. A small Styrofoam bowl covered with a napkin. The napkin was stuck to the contents of the bowl in two places. The contents of the bowl appeared to be banana pudding with brownish slices of banana visible and an orange-colored mash, and An opaque plastic cup almost full of clear liquid. During an observation and interview on [DATE] at 10:27 AM Resident #26 was seated in her w/c in her room. She stated staff do not clean out her refrigerator. She stated they only check the temperature of her refrigerator. She opened the refrigerator and pointed to the thermometer inside. The items observed in her refrigerator on [DATE] at 12:06 PM were still in the refrigerator. Resident #26 stated she cleaned out her refrigerator. She stated, It is not very clean today. I will probably go through here and clean this stuff out because I won't eat it. 2. Record review of Resident #31's admission record dated [DATE] revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, absolute glaucoma bilateral (severe form of disease where eye has lost all vision and has uncontrolled pressure) and unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning). Record review of Resident #31's quarterly MDS completed [DATE] revealed the following: Section C-Cognitive Patterns: Resident #31 had a BIMS score of 9 which indicated moderately impaired cognition. Section GG-Functional Abilities: Resident #31 used a w/c and was independent or required only set-up or clean-up assistance across all ADLs except for bathing where she required supervision or touching assistance. Record review of Resident #31's care plan completed on [DATE] revealed the following: Resident #31 had episodes of forgetfulness. Resident #31 had impaired visual function. During an observation on [DATE] at 12:11 PM Resident #31 had an opened bag of tortilla chips on her nightstand. The top of the bag was folded over one time and secured with a clip. During an observation on [DATE] at 02:09 PM Resident #31 was seated in her recliner in her room. The bag of tortilla chips was still on her nightstand with the top folded over one time and sealed with a clip. (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 [DATE] at 10:30 AM Resident #31 was seated in her recliner in her room. The bag of tortilla chips was still on her nightstand with the top folded over one time and sealed with a clip. She stated staff had not said anything to her about keeping the chips in a sealed container. 3. Record review of Resident #38's admission record dated [DATE] revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, protein-calorie malnutrition (inadequate intake of food which results in inflammation), unspecified dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain), cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), muscle wasting and atrophy in lower legs, muscle weakness, and anorexia (eating disorder characterized by inordinately low body weight and fear of gaining weight). Record review of Resident #38's quarterly MDS completed on [DATE] revealed the following: Section C-Cognitive Patterns: Resident #38 had a BIMS score of 3 which indicated severely impaired cognition. Section GG-Functional Abilities: Resident #38 used a w/c and required Substantial/maximal assistance across all ADLs. Record review of Resident #38's care plan completed on [DATE] revealed the following: Resident #38 had impaired cognition and therefore needed supervision/assistance with all decision making. Resident #38 had impaired visual function. During an observation on [DATE] at 12:10 PM Resident #38 had an open container with what appeared to be chocolate-covered cookies on top of her dresser, next to her bed. She also had a small refrigerator which contained a jar of jelly and a can of bean dip. The refrigerator did not contain a thermometer. During an observation on [DATE] at 10:49 PM Resident #38 was seated in her w/c in her room. The open tray of what appeared to be chocolate-covered cookies was still on top of her dresser as was her small refrigerator which still contained a jar of jelly and a can of bean dip. The refrigerator did not contain a thermometer. During an interview on [DATE] at 07:38 PM LVN B stated, We kinda all are responsible for cleaning out resident refrigerators. She stated, CNAs, us nurses, pretty much anyone can clean them out. If we look and see any food that is labelled, or drinks especially opened ones. LVN B stated, We try to put a date on the food when family brings it, so we know when to throw it out. She stated nurses were responsible for doing temperature checks on resident refrigerators every Monday. LVN B stated if the resident refrigerators were not cleaned out the residents could get very sick. She stated food that did not require refrigeration but was left out and open in a resident's room could get moldy or grow bacteria. LVN B stated residents were allowed to have open food in their rooms if they kept it in their drawers and it was just snacks like chips and candy. (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 interview on [DATE] at 07:56 AM CNA C stated CNAs were responsible for cleaning out resident refrigerators. She stated, We check them every day or every week to see if they need defrosting and make sure the temperature gauge is working. We let the nurses know (the temperature) and they document it. CNA C stated a possible negative outcome of not cleaning out resident refrigerators was, They could eat something that was old or drink something that was molded. She stated residents were allowed to have open food in their rooms. She stated a possible negative outcome of not keeping the open food in seal containers was, It could get old. During an interview on [DATE] at 08:16 AM LVN A stated everyone was responsible for cleaning out resident refrigerators. She stated nurses check the temperature on the refrigerators on Mondays. She stated residents could get sick to their stomach if the refrigerators were not cleaned out. During an interview on [DATE] at 08:28 AM ADON stated day shift nurses were responsible for cleaning out resident refrigerators and checking refrigerator temperatures on Mondays. She stated a possible negative outcome of refrigerators not being cleaned out was, They (residents) could eat something that is expired. She stated all staff were responsible for ensuring resident's personal snacks were kept in sealed containers. ADON stated, We try to all do rounds. Things get missed that they (residents) have tucked up away. She stated food left out of sealed containers could go stale. During an interview on [DATE] at 08:45 AM ADM stated housekeeping was responsible for cleaning out resident refrigerators. She stated it was really hard to keep up with because some residents tended to hoard food. She stated, We do not let any expired foods stay in the refrigerators. ADM stated a possible negative outcome of resident refrigerators not being cleaned out was, Oh yeah, there is always a danger of bacterial infection or something. ADM stated We all try to do that regarding ensuring resident food is kept in seal containers. She stated a negative outcome of residents' personal food not being stored in sealed containers was, Pest control and resident safety. Record review of facility policy titled Resident Refrigerators and dated [DATE] revealed the following: .This facility does not provide a refrigerator in a resident's room. However, it is the policy of this facility to ensure safe and sanitary use of any resident-owned refrigerators. Dormitory-sized refrigerators are allowed in a resident's room under the following conditions: . b. The refrigerator maintains proper temperatures. A thermometer shall remain in the refrigerator. Temperatures will be at or below 41 degrees F . Staff shall inspect the refrigerator weekly, clan as needed, and discard any foods that are out of compliance. Residents and staff shall comply with safe food handling and storage principles: . Foods with use by dates shall be discarded accordingly. Any food with potential concerns (i.e., smell, packaging, appearance .) shall be discarded. Food shall be in covered containers or securely wrapped. Record review of facility policy titled Food From Outside Sources or Personal Food and dated [DATE] revealed the following: . The purpose of this policy is to ensure the safe and sanitary handling of foods brought to residents by visitors, including the use and storage of these items. The task of keeping their personal foods stored in a safe and sanitary manner will be the responsibility of facility staff. Sealed containers must be used to store non-perishable items that are not consumed immediately such as a bag of potato chips, cookies . Residents are responsible for purchasing their own sealed containers for food storage in their rooms. This will also help to eliminate pests. Record review of facility policy titled Resident Rights and dated [DATE] revealed the following: . The resident has a right to a safe, clean, comfortable, and homelike environment, .

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 48491 Based on interview and record review the facility failed to provide training to their staff that at a minimum educates staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property and procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property for 1 (ST) of 15 employees reviewed for staff training. The facility failed to train ST on Abuse, Neglect, and Exploitation. These failures could place residents at risk of injury or harm due to being cared for by untrained staff. Findings included: Record review of ST's employee file revealed a hire date of 09/13/2023. The file did not contain a record of training on abuse, neglect, exploitation, and misappropriation of resident property. During an interview on 02/12/24 at 11:34 AM, ADM stated that ST worked at another facility full time and only worked at this facility occasionally. The ADM stated is the ST was trained at the other facility but could not produce any records of training for abuse, neglect, and exploitation. She stated a possible negative outcome for not having staff fully trained could be that residents could get hurt or there could be a possible death. Record review of facility provided titled, Training Requirements, dated 11/29/22 revealed in part, the following: Policy Statement: It is the policy of this facility to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. 2. The amount and types of training necessary are based on a facility assessment, state, and federal requirements. 4. All facility staff are trained to interact in a manner that enhances the resident's quality of life, quality of care and demonstrates competency in the topic areas of the training program. 6. Training content includes, at a minimum: j. Abuse, neglect, and exploitation prevention.