STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675020	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Health & Rehabilitation Center	4910 Wellington St Greenville, TX 75402

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45810 Based on observations, interviews, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 24 residents (Resident #55) reviewed for resident rights. The facility failed to ensure CNA O knocked on Resident #55's door prior to entering his room. This failure could place residents at risk for diminished quality of life, loss of dignity and loss of self-worth. Findings included: Record review of Resident # 55's face sheet dated 03/27/24 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses of lumbar spina bifida (a congenital disease that affects the spinal cord and causes problems with walking and bladder control), neuromuscular dysfunction of the bladder, high blood pressure, and major depression. Record review of Resident #55's annual MDS dated [DATE] indicated he had a BIMS score of 15 which indicated he was cognitively intact. The MDS also indicated Resident #55 required moderate assistance from staff for transfers and toileting, supervision with bathing, and he was independent with eating and bed mobility. Record review of Resident #55's undated care plan dated indicated he had cognitive impairment and at risk for decline with a goal for Resident #55 to have needs met in a timely manner, maintain a sense of dignity and interventions for staff to identify themselves with each interaction, face resident when speaking to him, and explain all procedures with terms and gestures the resident can understand. During an observation and interview on 03/25/24 at 09:42 AM Resident #55 was sitting on the side of his bed talking with surveyor when CNA O hurriedly opened resident's door without knocking on the door came inside a grabbed old tray on bedside table. Resident #55 said staff entered his room without knocking and identifying themselves on a regular basis. He said he would rather them knock on the door before they entered because this room was his house, and he would like to feel safe in his own house. Resident #55 said staff entering his room without knocking made him feel uncomfortable. (continued on next page)

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 - Few	During an interview on 03/25/24 at 09:51 AM CNA O said she should have knocked on Resident #55's door prior to her entering his room and introduced herself. She said that the facility was the residents' home, and all residents deserved dignity and privacy. During an interview on 03/27/24 at 05:07 PM the ADON said all CNAs should knock on the residents' doors and introduce themselves to the residents to ensure no patient care was taking place prior to entering. The ADON said the facility was the residents' home and they had rights. She said not knocking was a violation of the resident's rights. During an interview on 03/27/24 at 05:39 PM the DON said her expectations were for the staff to knock on residents' doors prior to entering their room to ensure no patient care was being provided at that time and introduce themselves and what they were there for to ensure residents were ok with the care that was going to be provided. This failure placed residents at risk of loss of dignity, exposure, and embarrassment. In-services related to dignity were provided annually and as needed with the staff. During an interview on 03/27/24 at 06:06 PM the Administrator said CNA O should have followed the training they received and knocked on the door and identified herself to the resident prior to providing care. She said the failure placed residents at risk for invading the resident's dignity. The Administrator said all staff were responsible for knocking prior to entering a resident's room, and in-services were provided upon hire, annually, and when there was a problem. Record review of the facility's policy Promoting/Maintaining Resident Dignity reviewed on 02/16/20 indicated: Policy It is the practice of the facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect 1. All staff members are involved in providing care to residents to promote and maintain resident dignity .7. Explain care or procedures to the resident before initiating care or activity .12. Maintain resident privacy .

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview and record review the facility failed to ensure residents had the right to be informed of and participate in his or her treatment which included, the right to be informed in advance, by the physician or other practitioner or other professional, of the risks and benefits of proposed care, treatment and treatment alternatives or treatment options to choose the alternative or option he or she preferred for 1 of 4 residents (Resident #38) reviewed for right to be informed The facility failed to obtain an informed consent based on the information of the benefits and risks for Resident #38 before administering Bupropion, an antidepressant medication, used to treat depression. This failure could place residents at risk of receiving medications they had not consented to, experiencing potential adverse reactions, and a potential decline in physical and mental health status. Findings included: Record review of Resident #38's face sheet, dated 03/28/24, indicated a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses which included anxiety (a feeling of fear, dread, and uneasiness), Deep vein thrombosis {DVT} (a medical condition that occurs when a blood clot forms in a deep vein), diabetes and stroke. Record review of Resident #38's admission MDS assessment, dated 02/04/24, indicated Resident #38 was usually understood and usually understood others. Resident #38's BIMS score was 08, which indicated he was cognitively moderately impaired. The MDS did not indicate Resident #38 was on an antianxiety medication. The MDS indicated Resident #38 required extensive assistance with bathing, limited assistance with toileting bed mobility, dressing, personal hygiene, transfers, and supervision assistance for eating. Record review of Resident #38's physician order dated 01/29/24, indicated Bupropion HCl ER XL 300 MG Oral Tablet Extended Release 24 Hour, give 1 tablet by mouth in the morning for depression and smoking cessation. Record review of Resident #38's care plan did not indicate the use of antidepression medication, Bupropion. Record review for Resident #38's consent for the use of antidepression medication, Bupropion was not documented in her chart. During an interview on 03/27/24 at 5:57 p.m., the DON said the charge nurses were responsible for getting consent. She said the ADONs were responsible for monitoring to ensure consent forms were completed. The DON looked throughout Resident #38's medical records via point-click care (facility electronic system) and did not see where his consent was in the chart. The DON said she was unsure why Resident #38 had no consent form for Bupropion. The DON stated it was important to ensure consent forms were filled out so Resident #38 or his representative could make an informed decision. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/24 at 6:20 p.m., LVN P said consent should be obtained for all psychoactive medication before being given . She said once they received an order for any psychoactive medication, they would call the family if the resident was not aware and then get 2 nurses to verify their consent over the phone and then ask the family member to sign the consent when they came to the facility. LVN P said if the charge nurses were unable to get consent, then the ADONs would obtain the consent the following morning. During an interview on 03/27/24 at 6:32 p.m., the ADON W said the charge nurses were responsible for getting the consents signed and she was supposed to follow up to ensure consents were received . She said she attended morning meeting where she learned of any new medication changes and reviewed consents and updated if needed from there. She said she was not sure why Resident #38 did not have his consent for Bupropion. She said it was important to ensure residents or representatives signed consent forms so they could make an informed decision about their care. During an interview on 03/27/24 at 6:34 p.m., Resident #38 was unable to tell the State Surveyor if he had been educated on Bupropion. He said, I do not know what that is. During an interview on 03/27/24 at 6:53 p.m., the Administrator said nurse management was responsible for ensuring psychotropic consent forms were signed and filled out. The Administrator said it was important to ensure consent forms were signed so the residents or representative understood and were able to give informed consent. Record review of facility policy, titled, Clinical Practice Guideline Use of Psychotropic medication, dated 04/05/22 indicated, Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). Policy Explanation and Compliance Guidelines: #1. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. #5. Residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interviews and record review, the facility failed to ensure each resident had the right to make choices about aspects of his or her life in the facility that were significant to the resident for 1 of 24 residents (Resident #23) reviewed for self-determination. The facility failed to ensure Resident #23 was provided showers instead of bed baths per her request. This failure could place residents at risk for being denied the opportunity to exercise his or her autonomy regarding things that are import in their life and decrease their quality of life. Findings included: Record review of a face sheet dated 03/27/2024 indicated Resident #23 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system) and chronic diastolic congestive heart failure (condition in which the heart cannot fill up with blood properly). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #23 was able to make herself understood and was understood by others. The MDS assessment indicated Resident #23 had a BIMS score of 13, which indicated her cognition was intact. The MDS assessment indicated Resident #23 was dependent on staff for showering/bathing self. Record review of Resident #23's care plan indicated she had a self-care deficit, and she was totally dependent on staff for bathing to provide showers per schedule and when needed. The care plan indicated Resident #23 was totally dependent on staff for transfers and required 2-person assistance for transfers with the use of a mechanical lift. Record review of Resident #23's Shower Sheets Assignments indicated she was scheduled for showers on the 6 am- 2 pm shift on Tuesday, Thursday, and Saturday. The Shower Sheets Assignments indicated on 03/14/2024 Resident #23 received a bed bath. During an interview on 03/24/2024 at 10:36 a.m., Resident #23 said the CNAs were giving her bed baths instead of showers because she required the Hoyer lift for transfers. Resident #23 said she had missed several showers, and last week on Thursday CNA K and CNA X wanted to give her a bed bath but she had insisted on receiving a shower and they finally gave her one. During an interview on 03/26/2024 at 1:20 p.m., CNA K said she usually worked the hall alongside CNA X. CNA K said in the past Resident #23 had requested to CNA X and herself she be given a shower. CNA K said because they were too busy and behind, they had given Resident #23 bed baths instead of showers. CNA K said if a resident requested a shower, they should get it because it was their right. CNA K said it was important to respect the residents' choices because the facility was their home and the residents had rights like she did. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/2024 at 3:48 PM, ADON M said if a resident requests a shower if should be given. ADON M said it was the residents right to choose their shower schedules and times that the residents should have the choice for a bed bath or a shower. ADON M said she was not aware Resident #23 was receiving bed baths and not showers. ADON M said that should not have happened if Resident #23 requested showers the CNAs should have given her a shower. ADON M said it was important for Resident #23's request for a shower to be respected because it was her right to take a shower. ADON M said all the staff were responsible for respecting the residents' rights. During an interview on 03/27/2024 at 4:05 PM, the DON said if Resident #23 requested a shower instead of a bed bath she should have received a shower. The DON said the CNAs had not reported to her that they were unable to give Resident #23 a shower upon her request. The DON said all the staff were responsible for ensuring the residents' rights were being followed, and their choices were respected. The DON said it was important for the residents' choices to be respected because it was their right. During an interview on 03/27/2024 at 5:14 PM, the Administrator said if Resident #23 requested a shower the CNAs should have given her a shower. The Administrator said it was important for the staff to respect the residents' choices because it was important for the staff to respect the residents' rights. Record review of the facility's policy titled, Resident Rights, reviewed 02/21/2021, indicated, .The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: a. The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident .

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on interview and record review, the facility failed to immediately notify the resident's representative(s) when there was a significant change in the resident's physical status for one (Resident #62) of 18 residents reviewed for changes in condition, in that: The facility failed to notify Resident #62's RP after she had abnormal hemoglobin lab values and required a blood transfusion. This failure placed residents at risk of a delay in treatment and their responsible party not being informed and involved in care decisions. Findings included: Record review of Resident #62's face sheet dated 03/27/24 indicate she was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of Dementia (decline in cognitive abilities that impacts everyday activities), Type 2 Diabetes (blood sugar regulation disorder), and Hypertension (high blood pressure), and anxiety. Resident #62's face sheet also indicated she had 3 family members listed for emergency contact. Record review of Resident #62's quarterly MDS assessment dated [DATE] indicated she had a BIMS score of 15 which means she was cognitively intact. Record review of Resident #62's progress note dated 2/23/24-03/25/24 indicated no entries related to the notification of Resident #62's emergency contact that resident had appointment setup on 03/20/24 to go to another facility to get a blood transfusion related to her abnormal hemoglobin lab values. Record review of Resident #62's encounter information from the infusion center dated 03/20/24 indicated she had a blood transfusion. Record review of Resident #62's labs dated 03/15/24 indicated resident had a very abnormal lab value for her hemoglobin of 6.4. Record review of Resident #62's labs dated 03/18/24 indicated resident had a very abnormal lab value for her hemoglobin of 6.3. During an interview on 03/25/24 at 03:53 PM Resident #62's emergency contact said the facility never notified them that Resident #62 had gone to another facility for a blood transfusion related to abnormal hemoglobin lab values. They said they knew of the lab values because they called the facility to check on Resident #62 when she was not feeling well enough to speak to them on her personal phone. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/24 at 10:37 AM RN A said she called the medical director about the abnormal lab values received and had begun the paperwork for getting the resident sent out to the infusion center on 3/19/24. She said she called the infusion center to check, and they had Resident #62 setup for the blood transfusion on 03/20/24 to go get the infusion. RN A said she did not notify Resident #62's emergency contacts about the labs nor the infusion because she told the resident, and she was cognitively intact to tell her emergency contacts. Responsible party should have been notified when abnormal values were received. RN A said the nurse who sent Resident #62 out to the appointment should have notified the emergency contact about the hospital visit. She said the failure of her not notifying the emergency contact placed the resident's family at risk of not being aware a change of condition that could have occurred, and the family would not be available for any decision making the resident may have needed. During an interview on 03/27/24 at 05:12 PM the ADON said her expectation was for the resident's emergency contacts to be notified of the abnormal hemoglobin labs and transfer for the blood transfusion when the nurse received the information. She said it was important for them to be aware of what was going on with the resident. During an interview on 03/27/24 at 05:41 PM the DON said the charge nurse should have contacted Resident #62's family with condition changes and any new orders received. She said the failure to notify the family placed Resident #62 at risk of the family not being aware and accident possibly happening while she was away from the facility. During an interview on 03/27/24at 06:09 PM the Administrator said the family should have been notified of the labs and the transfer for the infusion as well. She said the charge nurse who took the orders was responsible for calling the family. The Administrator said with the family not being aware it placed Resident #62 at risk for something medical that could have happened while she was at the hospital and the family not being aware. Record review of the facility policy for Notification of Changes dated 01/10/2020 indicated: Policy To provide guidance on when to communicate acute changes in status to MD, NP, and / responsible party. The facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or appropriate family member(s) of the following: 1. An accident resulting in injury to the resident that potentially requires physician intervention. 2. An emergency response situation that require EMS involvement 3. A significant change in the physical, mental or psychosocial status of the resident. 4. The need to significantly alter the resident's treatment. 5. A decision to transfer or discharge the resident to another facility. Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. In the case of a competent resident, the facility will contact the resident's physician and appropriate family member(s)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview and record review the facility failed to ensure each resident was informed before, or at the time of admission, and periodically during the residents stay, of services available in the facility and of changes for those services, which included changes for services not covered under Medicare/Medicaid or by the facility's per diem rate for 3 of 4 residents (Resident's #30, 183 and 185) reviewed for Medicare/Medicaid coverage. The facility failed to ensure Resident #30, Resident #183, and Resident #185 were given a Skilled Nursing Facility Advanced Beneficiary notice of non-coverage ({SNF ABN}, which is a document that informs a Medicare beneficiary that Medicare will no longer pay for skilled services) when discharged from skilled services at the facility before covered days were exhausted. This failure could place residents at risk for not being aware of changes to provided services. Findings include: 1.Record review of Resident #30's face sheet, indicated he was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included gastroenteritis (an inflammation of the lining of the stomach and intestines), anxiety (a feeling of fear, dread, and uneasiness), and depression (a low mood and a loss of interest in activities). Record review of Resident #30's other MDS assessment dated [DATE], indicated Resident #30 had a BIMS score of 04, which indicated his cognition was severely impaired. Record review of the SNF Beneficiary Protection Notification Review indicated Resident #30 was receiving Medicare Part A services starting on 12/28/23 and the last covered day of Part A services was 03/21/24, however, it was revealed that a SNF ABN was not completed which would have informed Resident #30 of the option to continue services at the risk of out-of-pocket cost. 2.Record review of Resident #183's face sheet indicated an [AGE] year-old female who admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included Dementia (forgetfulness), kidney failure (Loss of kidney function), and atrial fibrillation (AF), (a type of arrhythmia, or abnormal heartbeat). Record review of Resident #183's annual MDS assessment dated [DATE], indicated Resident #183 was understood and understood others. The MDS assessment indicated Resident #183 had a BIMS score of 06, which indicated her cognition was moderately impaired. Record review of the SNF Beneficiary Protection Notification Review indicated Resident #183 was receiving Medicare Part A services starting on 11/20/23 and the last covered day of Part A services was 01/25/24, however it was revealed that a SNF ABN was not completed which would have informed Resident #183 of the option to continue services at the risk of out-of-pocket cost. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.Record review of Resident #185's face sheet indicated an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included Respiratory failure (a serious condition that makes it difficult to breathe on your own), Congestive heart failure, or heart failure, (a long-term condition in which your heart can't pump blood well enough to meet your body's needs), and stroke. Record review of Resident #185's quarterly MDS assessment dated [DATE], indicated Resident #185 was understood and understood others. The MDS assessment indicated Resident #185 had a BIMS score of 08, which indicated her cognition was moderately impaired. Record review of the SNF Beneficiary Protection Notification Review indicated Resident #185 was receiving Medicare Part A services starting on 11/07/2023 and the last covered day of Part A services was 11/28/24, however it was revealed that a SNF ABN was not completed which would have informed Resident #185 of the option to continue services at the risk of out-of-pocket cost. During an interview on 03/27/24 at 7:30 p.m., MDS Coordinator R said she was not aware she was supposed to complete an SNF ABN for Resident #30 and Resident #183. She said she was not employed when Resident #185 should have been given an SNF ABN form. MDS Coordinator R said she had been only trained on giving NOMNC (Notice of Medicare Non-Coverage) when a resident was coming off skilled services by prior MDS Coordinator. She said the NOMNC forms were in a drawer in her office but no SNF ABN forms were available. She said she was not sure why the residents needed an SNF ABN form. During an interview on 03/27/24 at 7:35 p.m., MDS Coordinator Q said she was not aware she was supposed to complete an SNF ABN for Resident #30 Resident #185, and Resident #183. She said she called her regional MDS nurse today (03/27/24) and was told the BOM completed the SNF ABN because it was a financial issue. During an interview on 03/27/24 at 7:40 p.m., the BOM said she was not aware of an SNF ABN form. She called her regional BOM today (03/27/24) and was told she was not responsible for completing the SNF ABN form, it was the MDS Coordinator's responsibility. During an interview on 03/27/24 at 7:50 p.m., the DON said she was not aware of the SNF ABN forms. She said she did not know whose responsibility it was to complete the SNF ABN forms or why they needed to be completed. She said the Administrator was the overseer of the MDS Coordinator therefore she was not aware of the process. During an interview on 03/27/24 at 8:00 p.m., the Administrator said she was not aware of the SNF ABN forms. She said she had been the Administrator since August but was not sure whose responsibility it was to complete the SNF ABN form . She said she would have to have more knowledge of this process to answer the surveyor's questions. Record review of an undated document titled, Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 (2018), indicated, Medicare requires SNFs to issue the SNFABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: not medically reasonable and necessary; or considered custodial . The SNFABN provides information to the beneficiary so that she/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Health & Rehabilitation Center	4910 Wellington St Greenville, TX 75402

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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** 46892 Based on observation, interview and record review, the facility failed to ensure the residents' right to privacy during personal care for 1 of 24 residents (Resident #36) reviewed for privacy. The facility failed to ensure LVN F provided privacy for Resident #36 while she administered his g-tube medications (gastrostomy tube is a tube that gives direct access to the stomach for administration of medications and feedings). This failure could place residents at risk of having their bodies exposed to the public, low self-esteem, and a diminished quality of life. Findings included: Record review of a face sheet dated 03/27/2024, indicated Resident #36 was a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included cerebral palsy (a group of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination) and autistic disorder (developmental disabilities that can cause significant social, communication and behavioral challenges). Record review of Resident #36's Quarterly MDS assessment dated [DATE] indicated he was rarely/never understood by others, and he usually understood others. The MDS assessment indicated Resident #36 had a short-term and long-term memory problem. The MDS assessment indicated Resident #36 was dependent on staff for all ADLs. Record review of Resident #36's care plan with a target date of 04/29/2024 indicated he had cognitive impairment with a goal to meet his needs in a timely manner and that his dignity would be maintained. During an attempted interview on 03/24/2024 at 11:16 a.m., Resident #36 was non-interviewable. During an observation and interview on 03/26/2024 starting at 2:11 p.m., LVN F uncovered Resident #36 to administer his medications by g-tube (gastrostomy tube is a tube that gives direct access to the stomach for administration of medications and feedings). Resident #36 was lying on his side with is buttocks facing the entry to the room. Resident #36 bottom was exposed (he was wearing a brief). A staff member knocked on the door and asked LVN F if it was ok for EMS to bring in his roommate. LVN F said it was ok for them to enter the room. 2 EMS providers entered the room with Resident #36's roommate. Resident #36 was exposed while the EMS providers entered the room and left Resident #36's roommate. LVN F failed to pull the curtain to provide privacy for Resident #36. LVN F said she should have told the staff member and EMS providers to wait a minute, since Resident #36 was exposed. LVN F said privacy should be provided when residents were exposed to ensure their dignity was maintained. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/2024 at 3:23 p.m., ADON M said LVN F should not have allowed EMS providers to enter the room while Resident #36 was exposed. ADON M said it should not be allowed because the residents had the right for privacy and dignity. ADON M said anybody providing care should ensure the residents were treated with privacy, dignity, and respect. ADON M said she randomly walked the halls to ensure staff were providing privacy to the residents. During an interview on 03/27/2024 at 4:11 p.m., the DON said LVN F should have provided privacy to Resident #36. The DON said the residents should have privacy, so they were not exposed. The DON said she provided constant education to the staff to ensure they were providing the residents privacy and dignity during care. The DON said she made rounds daily to ensure privacy was being provided to the residents. During an interview on 03/27/2024 at 5:19 p.m., the Administrator said she expected for the nurses to provide privacy when providing resident care. The Administrator said LVN F should have pulled the privacy curtain to provide privacy for Resident #36 and prevent him from being exposed to others. The Administrator said the nurses were responsible for providing privacy, and the ADONs and DON were responsible for monitoring the nurses to ensure they were providing privacy. The Administrator said providing privacy was important to ensure the residents dignity was maintained. Record review of the facility's policy reviewed, 02/20/2021, titled, Resident Rights, indicated, . 7. Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. a. Personal privacy includes accommodations, medical treatment .

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 45810 Based on interviews and record review, the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and exploitation for 1 of 20 staff (Dietician) reviewed for develop and implement abuse policies. The facility failed to ensure the Human Resource Manager implemented the facility's abuse/neglect policy and procedure when she failed to complete an Employee Misconduct Registry (EMR) check and Criminal History check for the dietician upon hire. This failure could place residents at risk for abuse, neglect, exploitation, and misappropriation of property. Findings included: Record review of the Dietician's personnel file on 03/27/24, indicated she was hired on 07/17/23. The Dietician's employee misconduct registry nor Criminal History check was not completed upon hire. During an interview on 03/27/24 7:16 PM the Human Resources Manager said the Criminal history check and the EMR were completed on the day of hire and then annually. She said the corporate office was responsible for completing Criminal History check and the EMR upon hire. The Human Resources Manager said she requested the information from the corporate office, and they told her the state did not need the information if the dietician was not in the facility. The Human Resources Manager said the facility not having the Criminal History or EMR for the dietician placed the residents and staff at risk of having a staff member in the facility and not knowing its safe. During an interview on 03/27/24 7:26 PM the Administrator said the Criminal history check and the EMR were completed on the day of hire and then annually. She said the corporate office was responsible for completing Criminal History check and the EMR upon hire. She said the failure placed residents and staff at risk because the facility is unaware if the dietician had a criminal history. Record review of The Policy and Procedures: Abuse, Neglect, and Exploitation implemented 10/24/2022 indicated: Policy: It is the policy of this facility to provide protections for health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property .I. Screening A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. 2. Screenings may be conducted by the facility itself, third-party agency or academic institution. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The facility will maintain documentation of proof that the screening occurred. 46892

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47708 Based on interview and record review the facility failed to ensure assessments accurately reflected the resident status for 4 of 24 residents (Resident # 17, Resident #38, Resident #49, and Resident #53) reviewed for MDS assessment accuracy. The facility failed to ensure Resident # 17's, Resident #38's, Resident #49's, and Resident #53's anticoagulant (blood thinner) use was accurately coded. These failures could place residents at risk for not receiving care and services to meet their needs. 1. Record review of a face sheet dated 3/27/24 indicated Resident #17 was a [AGE] year-old female originally admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs), Parkinson's (brain disorder that causes unintended or uncontrollable movements), generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), gastro-esophageal reflux disease (stomach acid or bile irritates the food pipe lining) and essential hypertension (high blood pressure). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #17 able to make herself understood and understood others. The MDS assessment indicated Resident #17 had a BIMS score of 14, which indicated her cognition was intact. The MDS assessment indicated Resident #17 required independent assistance with eating; Partial/moderate assistance with oral hygiene; Substantial/maximal assistance with toilet use, bathing, upper body dressing, lower bathing dressing, putting on/taking off footwear and moderate assistance with personal hygiene. The MDS assessment indicated that Resident #17 was taking anticoagulant medication. Record review of the care plan last revised 1/24/24 indicated Resident #17 used oxygen therapy routinely or as needed and is at risk for ineffective gas exchange. The Care plan interventions included, administer oxygen therapy per physician's orders and monitor for signs and symptoms of respiratory distress and report to the physician as needed. Respiratory distress could include an increased respiratory rate, tachycardia(abnormally fast heart rate), diaphoresis (excessive Sweating), lethargy, confusion, persistent cough, pleuritic pain, accessory muscle use, decreased oxygen saturation, or changes in skin color such as a bluish or grey tint. Record Review of the Medication Review Report dated 3/26/24 at 9:31 a.m., did not indicate Resident #17 was taking anticoagulant medication. Medication Review Report indicated Resident #17 was prescribed Aspirin dated 1/23/24. 45879 2. Record review of Resident #38's face sheet, dated 03/28/24, indicated a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses which included anxiety (a feeling of fear, dread, and uneasiness), Deep vein thrombosis {DVT} (a medical condition that occurs when a blood clot forms in a deep vein), diabetes and stroke. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #38's admission MDS assessment, dated 02/04/24, indicated Resident #38 was usually understood and usually understood others. Resident #38's BIMS score was 08, which indicated he was cognitively moderately impaired. The MDS did indicate Resident #38 was on an anticoagulant medication. The MDS indicated Resident #38 required extensive assistance with bathing, limited assistance with toileting bed mobility, dressing, personal hygiene, transfers, and supervision assistance for eating. Record review of Resident #38's physician's orders dated 01/29/24, indicated: Aspirin EC (enteric coated) Tablet delayed release 81 MG, Give 1 tablet by mouth in the morning for high blood pressure. Record review of Resident #38's physician's orders dated 01/29/24, indicated: Clopidogrel Bisulfate (Plavix) 75 MG tablet, give 1 tablet by mouth in the morning for blood clot prevention. Record review of Resident #38's comprehensive care plan, dated 01/29/23 indicates he took an anticoagulant medication. The interventions were for staff to educate resident/family/caregiver to include the following: Take/give medication at the same time each day, use a soft toothbrush, use electric razor, avoid activities that could result in injury, take precautions to avoid falls, Signs/symptoms of bleeding, Avoid foods high in Vitamin K. These include greens such as spinach and turnips, asparagus, broccoli, cabbage, Brussels sprouts, milk, and cheese. During an interview and observation on 03/27/24 at 11:20 a.m., the MDS Coordinator R said she was responsible for the completion of the MDS for Resident #17 and Resident #38. She looked at Resident #38's quarterly MDS assessment dated [DATE] and Resident #17's on 01/30/24 on section N and said she coded them both as taking an anticoagulant medication. The MDS coordinator said she coded it that way because Aspirin and Plavix fell under the category of anticoagulant medication . She said she would go fix the MDS assessments. She said it was a mistake. She said it was important to code the MDS assessment correctly because it reflected their care. During an interview on 03/27/24 at 5:57 p.m., the DON said the MDS Coordinator was responsible for completing the MDS. The DON said she expected the assessments to be reflected in the MDS because it could be misleading if coded incorrectly. During an interview on 03/27/24 at 6:32 p.m., the ADON W said the MDS Coordinator was responsible for completing the MDS. She said she expected the MDS nurses to do an accurate assessment because it affects the resident's care and it needs to be accurate. She said she was not aware of who was responsible to ensure MDS's were accurate. During an interview on 03/27/24 at 6:53 p.m., the Administrator said the MDS Coordinator was responsible for the completion of the MDS. She said she expected the MDS assessment for any resident to be completed thoroughly and correctly based on the resident assessment. 46892 3. Record review of a face sheet dated 03/27/2024 indicated Resident #49 was a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic respiratory failure with hypoxia (condition where the lungs cannot supply enough oxygen or remove enough carbon dioxide from the blood) and chronic diastolic congestive heart failure (condition in which the heart cannot fill up with blood properly). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #49 understood others and was able to make herself understood. The MDS assessment indicated Resident #49 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #49 received an anticoagulant medication during the last 7 days or since admission/entry or reentry if less than 7 days. Record review of Resident #49's Order Summary Report dated 03/24/2024 did not indicate an order for an anticoagulant medication. Resident #49's Order Summary Report indicated she had an order for aspirin 81 mg give 1 tablet by mouth in the morning for antiplatelet (medications that stop blood cells (called platelets) from sticking together and forming a blood clot) with a start date of 01/13/2024. Record review of Resident #49's comprehensive care plan with a target date of 05/10/2024 did not indicate the use of an anticoagulant medication. Record review of the January 2024 MAR did not indicate Resident #49 was administered an anticoagulant medication. 4. Record review of a face sheet dated 03/27/2024 indicated Resident #53 was a [AGE] year-old female initially admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia (condition where the lungs cannot supply enough oxygen or remove enough carbon dioxide from the blood) and type 2 diabetes mellitus with hyperglycemia (chronic condition that affects the way the body processes blood sugar which results in high blood sugars). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #53 understood others and was able to make herself understood. The MDS assessment indicated Resident #53 had a BIMS score of 14, which indicated her cognition was intact. The MDS assessment indicated Resident #53 received an anticoagulant medication during the last 7 days or since admission/entry or reentry if less than 7 days. Record review of Resident #53's Order Summary Report dated 03/24/2024 did not indicate an order for an anticoagulant medication. Resident #53's Order Summary Report indicated she had an order for aspirin enteric coated tablet delayed release 81 mg give 1 tablet by mouth in the morning with a start date of 12/07/2022. Record review of Resident #53's comprehensive care plan with a target date of 05/10/2024 did not indicate the use of an anticoagulant medication. Record review of the January 2024 MAR did not indicate Resident #53 was administered an anticoagulant medication. During an interview on 03/27/2024 at 8:56 a.m., the RN MDS Coordinator and LVN MDS Coordinator both said they had started as MDS Coordinators in the facility in December of 2024. Both MDS Coordinators said they thought aspirin could be coded as an anticoagulant medication. The RN MDS Coordinator said she would review Resident # 17's, Resident #38's, Resident #49's, and Resident #53's medical records to ensure they were coded correctly on the MDS assessment, and provide evidence of their anticoagulant use, if available. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/27/2024 at 11:52 a.m., the RN MDS Coordinator said she had not found evidence that indicated Resident # 17, Resident #26, Resident #38, Resident #47, Resident #49, and Resident #53 had received an anticoagulant medication. The RN MDS Coordinator said it was important for the MDS assessments to be coded accurately to get an accurate representation of what they were doing for the residents. The RN MDS Coordinator said in the past she had always coded aspirin as an anticoagulant medication, and she was not aware aspirin was no longer considered an anticoagulant medication. The RN MDS Coordinator said corporate did random audits on the MDS assessments to ensure accuracy. During an interview on 03/27/2024 at 5:27 p.m., the Administrator said regional overlooked the MDS Coordinators and assessments, and she expected for them to be accurate. The Administrator said it was important for the MDS assessments to be coded accurately because that was how the facility was paid. Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (used to complete resident assessments, MDS assessments) dated October 2023 indicated in Chapter 3 pg. N-8, . Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as N0415E, Anticoagulant .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs, for 4 of 15 residents (Resident's #44, #51, #5, and #47) reviewed for care plans. 1. The facility failed to care plan Resident #44's Lorazepam (antianxiety medication) and interventions. 2. The facility failed to care plan Resident #51's Eliquis (blood thinner medicine that reduces blood clotting) and interventions. 3. The facility failed to care plan Resident #5's fall and interventions. 4. The facility failed to ensure palliative care was care planned for Resident #47. These failures could place the residents at increased risk of not having their individual needs met and a decreased quality of life. The findings include: 1.Record review of Resident #44's face sheet, dated 03/28/24, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses which included anxiety (a feeling of fear, dread, and uneasiness), diabetes, chronic obstructive pulmonary disease {COPD} (no airflow for breathing), and stroke. Record review of Resident #44's change in condition MDS assessment, dated 03/11/24, indicated Resident #44 was understood and understood by others. Resident #44's BIMS score was 12, which indicated she was cognitively intact. The MDS indicated Resident #44 required extensive assistance with bathing, toileting bed mobility, dressing, personal hygiene, transfers, and supervision assistance for eating. The MDS did not indicate Resident #44 was receiving an antianxiety medication during the look back period. Record review of Resident #44's physician order dated 2/29/24 indicated, Lorazepam Concentrate 2 MG/ML, give 0.5 ml by mouth every 4 hours as needed for anxiety. Record review of Resident #44's comprehensive care plan target date of 03/24/24 did not indicate a care plan for Lorazepam or anxiety medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.Record review of Resident #51's face sheet, dated 03/28/24, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses which included Peripheral vascular disease, or PVD, (a systemic disorder that involves the narrowing of peripheral blood vessels), chronic obstructive pulmonary disease (no airflow for breathing), high blood pressure and Bipolar(a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). Record review of Resident #51's quarterly MDS assessment, dated 01/30/24, indicated Resident #51 was understood and understood by others. Resident #51's BIMS score was 14, which indicated she was cognitively intact. The MDS indicated Resident #51 required extensive assistance with dressing, and personal hygiene, limited assistance with toileting, bathing, bed mobility, transfers, and set-up for eating. The MDS indicated Resident #51 was receiving anticoagulant medication. Record review of Resident #51's physician order dated 01/27/24 indicated: Eliquis Oral Tablet 5 MG (Apixaban), give 1 tablet by mouth every 12 hours for Prophylaxis. Record review of Resident #51's comprehensive care plan revised date 03/12/24 did not indicate a care plan for Eliquis related to anticoagulant medication. During an observation and interview on 03/27/24 at 9:58 a.m., the MDS Coordinator R said the ADON/DON does the initial care plan and the MDS does quarterly, and any changes. She said they were aware of any resident changes in the morning meeting. She said she was not sure why Resident #51's Eliquis or Resident #44's Lorazepam had not been care planned. She said care plans were created to let staff know of any changes a resident might have and the interventions needed to provide proper care. During an interview on 03/27/24 at 10:12 a.m., the MDS Coordinator Q- said she had been at facility a few months and was still learning the care plan process. She said the charge nurse does the initial baseline care plan and she does the comprehensive after she completes the 14-day MDS assessment. She said after the initial comprehensive care plan she updates the care plans quarterly. She said if a resident had any changes between the quarterly assessments, then nurse management would update the care plan. She said she was aware of Resident #51's Eliquis missing from her care plan and had already updated it after MDS Coordinator R told her. She said she was not aware of Resident #44's Lorazepam missing from her care plan. She said she was new and had not had the opportunity to review all care plans. She said care plans were done so staff would know how to care for residents. During an interview on 03/27/24 at 12:35 p.m., the DON said charge nurses, MDS, and ADONs usually worked together to ensure care plans were put in place on admission, readmission, falls, and any new orders. She said during morning meetings she would review progress notes, 24-hour reports, and incidents to ensure things had been added or discontinued from the care plan. She said the Administrator was the overseer of the MDS Coordinators. She said she was not aware Resident #44 Lorazepam and Resident #51's Eliquis had not been care planned. She said she had been reviewing care plans but had not reviewed them all. She said care plans were done so that staff would know what they should do and what intervention they should have in place. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/27/24 at 6:32 p.m., the ADON W said Resident #51's Eliquis should be care planned because it was a blood thinner, and staff needed to know what to monitor for. She said she had not had a lot of new orders and was trying to learn more but knew when Resident #51 had her new order of Lorazepam it should have been added to her care plan then. She said the care plan was a picture of the resident's care. 3.Record review of Resident #5's face sheet, dated 03/28/24, indicated a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses which included anxiety (a feeling of fear, dread, and uneasiness), Dementia (the loss of cognitive functioning), Dysphagia (difficulty swallowing) and stroke. Record review of Resident #5's quarterly MDS assessment, dated 01/26/24, indicated Resident #5 was usually understood and usually understood others. Resident #5's BIMS score was 04, which indicated he was cognitively severely impaired. The MDS indicated Resident #5 required extensive assistance with bathing, toileting bed mobility, dressing, personal hygiene, transfers, and eating. The MDS did not indicate Resident #5 had a fall. Record review of Resident #5's care plan dated 11/07/23 indicated, Resident #5 had the potential for falls related to dementia, stroke, meds, G-Tube, poor balance/unsteady, impaired cognition, medication, and communication. The interventions were for staff to educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Record review of Resident #5's progress noted dated 12/06/23 at 1:07 p.m., indicated, the Incident Note: RN A was notified by the resident's roommate that resident had fallen on the floor. Resident was noted to be lying on the floor next to his wheelchair. Resident is hard to understand verbally but he agreed he slid off his wheelchair and hit the back of his head on the bed. The resident had a pillow on the wheelchair and he agreed to sliding off it. On assessment, the resident has a nodule on his occipital, and no bleeding was noted. when asked, the resident denied pain from the rest of the body. Full range of motion to upper and lower extremities with no shortness of limbs. Res was assisted back in bed. Vital signs were taken. The resident was educated on the importance of safety and to use the call light if he needed help and to notify the nurse if he experiences any pain of new onset. During an interview on 03/27/24 at 9:58 a.m., the MDS Coordinator R said she was not aware why Resident #5's fall and or intervention had not been added to his care plan. She said all residents usually had a fall care plan. She said she and other nurse managers were responsible to make sure care plans reflexed the residents care needed. She said she would have to add it to his care plan. During an interview on 03/27/24 at 5:57 p.m., the DON said the charge nurses were responsible for starting the incident report after a fall and put interventions in place. She said the next day the ADON or herself would review the incident report, talk about the fall, and see if any other interventions needed to be added. She said then one of the nurse managers would update the care plan. She said she was not aware Resident #5's care plan had not been updated for his fall that occurred on 12/16/23. She said failure to update a care plan could cause care to be missed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/27/24 at 6:32 p.m., the ADON W said the charge nurses were responsible for putting interventions in place after a fall. She said then the ADONs/MDS nurses would care plan the intervention they needed after each fall. She said interventions were placed on the care plan so that others could see the intervention that was put in place. She said care plans were easily accessible to staff and others could see what intervention had been put in place in case they had another fall they would know what was already in place. During an interview on 03/27/24 at 6:53 p.m., the Administrator said If a resident had new orders, order changes, or falls it should be care planned. She said nurse management was the overseer of care plans. She said staff should put interventions in place to alert other staff of the interventions in place to prevent further falls. 47708 4.Record review of Resident #47 face sheet, dated 12/20/23, indicated Resident #47 was an [AGE] year-old male, initially admitted to the facility on [DATE] with diagnoses which included pneumonia (an infection that affects one or both lungs), heart failure heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), hypotension (low blood pressure), chronic kidney disease unspecified (a progressive decline in kidney function over time), type 2 diabetes mellitus with other diabetic kidney complication (chronic condition that affects the way the body processes blood sugar) and essential hypertension (high blood pressure). Record review of the admission MDS assessment, dated 2/22/24, indicated Resident #47 made himself-understood, and understood others. The assessment indicated a BIMS score of 7 which indicated a severe cognition impairment. The assessment indicated Resident #47 functional status indicated Resident #47 required supervision or touching assistance with eating; Substantial/maximal assistance with oral hygiene, bed mobility, dressing, personal hygiene, putting on/taking off footwear and toilet use; dependent assistance with toilet transfer and bed transfer. Record Review of the comprehensive care plan dated 1/23/24 indicated Resident #47 had a diagnosis of diabetes and was at risk for unstable blood sugars. The care plan interventions included, monitor for signs and symptoms of hypoglycemia (occurs when your blood sugar (glucose) level drops below the standard range) such as: diaphoresis (Excessive Sweating), dizziness, headache, confusion, hunger, irritability, pallor (pale appearance of the skin) , tachycardia (abnormally fast heart rate), slurred speech, tremor, lack of coordination, and staggering gait; Monitor blood Sugar as ordered by physician. Administer sliding scale insulin if ordered. The Care plan did not indicate palliative care. Record Review of Medication Review report dated 3/14/24 indicated Resident #47 had an active order for palliative care dated 3/14/24 . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/24 at 11:54 a.m., MDS Coordinator Q stated she was responsible for the residents MDS's upon Admission and quarterly. MDS Coordinator Q stated the nurses were responsible for completing the MDS for other issues. MDS Coordinator Q stated anything acute and new orders that the MDS coordinators would be responsible for updating the MDS assessments. MDS Coordinator Q stated Palliative care had not been planned because the significant change had just been signed this morning on 3/27/24, and she would have been working on the resident care plan if it had not been pointed out to her that palliative care was not planned. MDS Coordinator Q stated she just added palliative care today in Resident #47's care plan. MDS Coordinator Q stated the nursing staff should have care planned palliative care plan for Resident #47. MDS Coordinator Q stated the palliative care did not trigger for her to input the palliative care in the resident care plan. MDS Coordinator Q stated it was important to ensure the resident care plan was accurate because it gives an accurate assessment of the resident's needs. MDS Coordinator Q stated care plan changes were discussed quarterly during morning meeting. MDS Coordinator Q stated she did not attend the care plan meeting. MDS Coordinator Q stated she had not had a chance to complete Resident #47's care plan prior to State asking about Resident # 47, but she would have corrected the resident care plan either way. MDS Coordinator Q stated the resident should have been care planned for palliative care. MDS Coordinator Q stated she completed the care plan when she was triggered to do so by the MDS. MDS Coordinator Q stated the Administrator oversaw her at the facility. MDS Coordinator Q stated she was responsible for updating the care plans along with the nursing. During an interview on 3/27/24 at 12:03 p.m., MDS Coordinator R stated she had been in training since December of 2023. MDS Coordinator R stated the Administrator oversaw her at the facility. MDS Coordinator R stated the care plan meetings were held quarterly but she did not attend the care plan meetings. MDS Coordinator R stated she had not had a chance to complete Resident #47's care plan, but she would have corrected the resident's care plan either way. MDS Coordinator R stated the other MDS coordinator Q had been at the facility long and would answer a lot of questions for her since she was fairly new. MDS Coordinator R stated Resident #47 should have been care planned for palliative care. MDS Coordinator R stated it was important to ensure that Resident #47's care plan was accurate, So that all nursing staff know the resident wanted palliative care as a comfort measure and for Resident #47 wishes because that's what the resident wanted. During an interview on 3/27/24 at 3:37 p.m., the DON stated nursing staff and the MDS Coordinator's was responsible for doing the care plans. The DON stated she had been employed at the facility since the end of august 2023. The DON stated nursing and the MDS Coordinator usually worked together to complete the update. The DON stated in the mornings she would review the 24-hour report and discuss it in morning meetings. The DON stated a new order should be updated in the care plan as soon as the order was put into the resident's record. The DON stated to monitor that care plans were being updated that she would go in and check to ensure the care plan was updated on the care plan. The DON stated she oversaw the MDS Coordinators and nursing. The DON stated she cannot sit down a go through all care plans but the two MDS Coordinator hired are fairly new. The DON stated the two MDS coordinators reported to the Administrator but should also report to her. The DON stated she knew that the MDS Coordinator also had a regional director that the MDS coordinator also reported to from her understanding. The DON stated she was not aware that palliative care was not care planned. The DON it was important to ensure that they were updating the care plans timely to ensure the nursing staff knew what was going on with the residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/24 at 4:03 p.m., the Administrator stated she had been the Administrator since March of 2023. The Administrator stated she oversaw the MDS Administrator. The Administrator stated the MDS Coordinator was also overseen by the Regional Director. The Administrator stated care plans were discussed in the morning IDT (interdisciplinary team) meetings. The Administrator stated she did not know the time limit for the care plans should be updated but if the resident's new orders, behavior falls, refusing and whatever the topic that her expectation was the care plans to be updated timely. The Administrator did not want to elaborate on what she considered timely. The Administrator stated her monitoring process for ensuring care plans were updated was by following up with the DON to be sure all care plan updates were completed. The Administrator stated, It was important for the care plans to be updated to make sure everyone knows the correct way to care for that resident. Record Review of the facility's Comprehensive care plan policy dated 2/10/21 indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment; definitions: Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives; (1) The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma-informed; (2) The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. Record review of the facilities policy implemented, 09/24/2022, titled, Medication Reconciliation, indicated, . compare orders to hospital records, home or orders from healthcare entity, etc. obtain clarification orders as needed c. transcribe orders in accordance with procedures for admission orders .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review the facility failed to review and revise the person-centered care plan to reflect the current condition for 1 of 3 (Resident #44) residents reviewed for care plan revisions. The facility failed to update Resident #44's care plan for her Bipap (a machine that helps you breathe) being discontinued. This failure could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. 1.Record review of Resident #44's face sheet, dated 03/28/24, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses which included anxiety (a feeling of fear, dread, and uneasiness), diabetes, chronic obstructive pulmonary disease (no airflow for breathing), and stroke. Record review of Resident #44's change in condition MDS assessment, dated 03/11/24, indicated Resident #44 was understood and understood by others. Resident #44's BIMS score was 12, which indicated she was cognitively intact. The MDS indicated Resident #44 required extensive assistance with bathing, toileting bed mobility, dressing, personal hygiene, transfers, and supervision assistance for eating. The MDS did not indicate Resident #44 was on a Bipap. Record review of Resident #44's comprehensive care plan dated 10/25/23 revealed o Resident #44 had an altered sleep pattern related to sleep apnea and required a sleep machine. She also had impaired Respiratory Status related to COPD, Asthma, respiratory failure, and obesity with alveolar hypoventilation (a rare disorder in which a person does not take enough breaths per minute). Resident #44 had a history of refusing to wear her Bipap as ordered. The resident is at risk for shortness of breath, respiratory distress, increased anxiety, and hypoxia (low levels of oxygen in your body) The interventions were for staff to Introduce relaxing nonpharmacologic interventions: calm music, reading a book, and relaxation exercises before bedtime. Help the resident identify and understand the main cause of sleep difficulties. Encourage and assist residents to keep the head of the bed elevated to decrease the effects needed for effective air exchange. Record review of Resident #44's Physician order did not reveal an order for a Bipap . Record review of Resident #44's MAR dated 03/01/24-03/27/24 did not include a Bipap order. During an interview and observation on 03/27/24 at 8:51 a.m., Resident #44 was lying in her bed with RN A at her bedside. Resident #44 said she had not been on her Bipap for a long time. RN A said she was not using her Bipap and it had been a while since she wore it. RN A said she was not aware it was still on her care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/24 at 5:57 p.m., the DON said Resident #44 had refused her Bipap and it should have been taken off her care plan. She said it was an oversite. She said if someone looked at Resident #44's care plan and wondered where the Bipap was they might would have tried to find it and apply it. During an interview on 03/27/24 at 6:32 p.m., the ADON W said anytime a new order or discontinued order was received it should be added or removed to update the care plan. She said usually the ADONs or the MDS Coordinators would update a care plan. She said it was important to remove the BiPAP because it was no longer part of Resident #44 care. During an interview on 03/27/24 at 6:42 p.m., The DON said she was not able to find a policy on the revision of care plans, but she gave a policy on care planning. During an interview on 03/27/24 at 6:53 p.m., the Administrator said the care plan should be updated when the order was received to discontinue the Bipap. She said the charge nurses, ADONs, MDS Coordinators, and DON should update care plans. The administrator said she was not sure why the care plan for Resident #44 was missed. The Administrator said the MDS Coordinators were the overseers of all care plans. The administrator said care plans should be updated to inform staff of residents' needs and what interventions have been put in place or need to be followed. Record Review of the facility's Comprehensive care plan policy dated 2/10/21 indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment; definitions: Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives; (1) The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma-informed; #2 Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living, received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 24 residents (Residents #23) reviewed for ADL care. The facility failed to ensure Resident #23 was routinely showered/bathed. This failure could place residents at risk of not receiving services or care, decreased quality of life, and decreased self-esteem. Findings included: Record review of a face sheet dated 03/27/2024 indicated Resident #23 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system) and chronic diastolic congestive heart failure (condition in which the heart cannot fill up with blood properly). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #23 was able to make herself understood and was understood by others. The MDS assessment indicated Resident #23 had a BIMS score of 13, which indicated her cognition was intact. The MDS assessment indicated Resident #23 was dependent on staff for showering/bathing self. Record review of Resident #23's care plan indicated she had a self-care deficit, and she was totally dependent on staff for bathing to provide showers per schedule and when needed. The care plan did not indicate Resident #23 refused showers. Record review of Resident #23's Shower Sheets Assignments indicated she was scheduled for showers on the 6 am- 2 pm shift on Tuesday, Thursday, and Saturday. The Shower Sheets Assignments indicated the following for Resident #23: 03/05/2024 there were no initials to indicate Resident #23 was provided a shower or bed bath. 03/07/2024 there were no initials to indicate Resident #23 was provided a shower or bed bath. 03/09/2024 no shower sheet. 03/12/2024 there were no initials to indicate Resident #23 was provided a shower or bed bath. 03/14/2024 a bed bath was given. 03/16/2024 there were no initials to indicate Resident #23 was provided a shower or bed bath. 03/19/2024 there were no initials to indicate Resident #23 was provided a shower or bed bath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/21/2024 initials indicated bathing was done bed bath was marked through. 03/23/2024 no shower sheet. Record review of Resident #23's bathing task in her electronic medical record for the past 30 days did not indicate if the resident received a bed bath or shower. The bathing task only addressed the support the staff provided, and the level of assistance Resident #23 could provide during bathing. During an observation and interview on 03/24/2024 at 10:36 a.m., Resident #23 said she had missed a lot of showers. Resident #23 said the last time she received a shower was Thursday (03/21/2024). Resident #23 said she asked the CNAs for her showers when she did not receive one, but the staff would tell her they could not do it due to being short. Resident #23 said she was supposed to receive a shower yesterday (03/23/2024), but she did not press the staff about it because it seemed like they were short staffed. Resident #23's hair appeared disheveled and ungroomed. During an interview on 03/26/2024 at 10:02 a.m., LVN F said the charge nurses were responsible for ensuring the residents received their bath/showers and the ADONs double checked. LVN F said she did not have issues with the showers, and residents had not complained to her about missed baths/showers. LVN F said she reviewed the shower sheets daily to ensure the showers/baths were completed. LVN F said it was important for the residents to get baths/showers to help prevent skin breakdown, and to prevent the residents from getting yeast in places they did not want them to get it. During an interview on 03/26/2024 at 1:20 p.m., CNA K said she had missed giving people showers in the past because they were short. CNA K said she tried to give people a bed bath if she missed their showers, but there were days when they were very busy and got behind. CNA K said she had notified management that there were times when she was unable to provide bathing because they were short. CNA K said they told her they would adjust the shower schedules to spread them out throughout the day. CNA K said the DON was responsible for ensuring the residents received their baths/showers. CNA K said it was important for the residents to receive their baths/showers for hygiene, so they would not smell, and they would feel good. During an interview on 03/27/2024 at 3:16 p.m., ADON M said the CNAs documented the bed baths/showers on the shower sheets. ADON M said the DON printed them daily for the CNAs, and the CNAs were supposed to initial and indicate the type of bathing they provided. ADON M said the nurses were supposed to revie the shower sheets at the end of the shift and give them to her for review. ADON M said she reviewed the shower sheets daily and had not noticed any issues. ADON M said it was important for residents to receive showers for their dignity. ADON M said if residents refused it should be documented, and if they frequently refused it should be care planned. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/2024 at 4:05 p.m., the DON said the charge nurses should be making sure the shower sheets were completed and monitor bathing. The DON said she printed the shower sheets every morning for the CNAs to complete, and when the CNAs completed the showers or had refusals, they should let the nurses know and at the end of the shift the charge nurse signed the shower sheets and turned them in to the ADONs for review. The DON said when the charge nurses signed the shower sheets they should verify all bathing was performed. The ADONs reviewed the shower sheets daily to ensure they were completed. The DON said she had received complaints about missed showers/baths, and they were trying to fix it. The DON said they fixed it by giving a bed bath or shower when she was notified somebody had not had one. The DON said she was made aware Resident #23 had missed showers last week, so she made the CNAs give her one last week on Thursday. The DON said it was important for the residents to receive their showers/baths to prevent infections and illnesses and for their hygiene. During an interview on 03/27/2024 at 5:14 p.m., the Administrator said she expected for the CNAs to abide by the shower schedules. The Administrator said the ADONs received the shower sheets, so they should be monitoring, and then reporting to the DON, and then the DON reported to her if there were any issues. The Administrator said it was important for the residents to receive their baths/showers for their hygiene. Record review of the facility's policy titled, Resident Showers, implemented 02/11/2022, indicated, It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice . residents will be provided showers as per request or as per shower schedule .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on observations, interviews, and record review the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this was not possible or resident preferences indicate otherwise for 3 of 8 residents (Resident #1, Resident #34, and Resident #49) reviewed for nutrition. The facility failed to ensure Resident #1 received his magic cup with his meals. The facility failed to ensure Resident #34 received his health shake. The facility failed to ensure Resident #49 received her Nutritious Shake. These failures could place residents at risk for malnourishment, weight loss, skin breakdown, and decreased quality of life. Findings included: 1. Record review of Resident #1's face sheet dated 03/27/24 indicated he was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses senile degeneration of the brain (., anxiety, dementia (decline in cognitive abilities that impacts everyday activities), and protein-calorie malnutrition (inadequate food intake). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated that he had a BIMS score of 10 which indicated moderate cognitive impairment. The MDS also indicated he required supervision with toileting and transfers, setup with eating and dressing, and he was independent with bed mobility. The MDS also indicated Resident #1 was on hospice care. Record review of Resident #1's undated care plan indicated he was at risk for nutritional and hydration problems with a goal to maintain adequate nutritional and hydration status, and interventions that included: Provide, serve diet as ordered. Record review of Resident #1's order audit report dated 03/26/24 indicated resident had an order for: 1. Mechanical soft texture, thin liquids consistency, frozen nutritional treat with all meals and magic cup dated 01/03/24. 2. Mechanical soft texture, thin liquids consistency, frozen nutritional treat with all meals and gelatin dated 03/26/24 after surveyor intervention. During an observation on 03/24/24 at 12:09 PM Resident #1 was sitting in the dining room with his tray. The tray did not have a magic cup on it. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 03/25/24 at 12:12 PM Resident #1 was sitting in the dining room with his tray. The tray included an Ensure but there was no magic cup on his tray. During an interview on 03/27/24 at 05:17 PM ADON W said the residents should receive the supplements as ordered by the physician. She said the kitchen should have the items in stock, but the charge nurses were responsible for ensuring the residents received the supplements. ADON W said the risk to Resident #1 was weight loss. 45879 2.Record review of Resident #34's face sheet, dated 03/28/24, indicated a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included malnutrition (lack of proper nutrition), depression (mood disorder that causes a persistent feeling of sadness), and stroke. Record review of Resident #34's quarterly MDS assessment, dated 02/07/24, indicated Resident #34 was usually understood and understood by others. Resident #34's BIMS score was 05, which indicated he was severely cognitively impaired. The MDS indicated Resident #34 required total assistance with bathing, toileting bed mobility, dressing, personal hygiene, transfers, supervision, and eating. The MDS did not indicate Resident #34 had weight loss. Resident #34's physician order dated 02/27/23 revealed a pureed textured diet, mildly thick-nectar consistency, and a house shake with all meals. Record review of Resident #34's comprehensive care plan target date of 04/14/23 indicated, Resident #34 received a puree textured, mildly thick nectar consistency diet and was at risk for a decline in nutrition and hydration status related to his dementia, impaired vision, communication, medication respiratory complication, dysphasia (difficulty swallowing), history of alcohol abuse, poor dentation, acid reflux, contractures of the right, left wrist, and elbow, and recent amputation. The interventions were for staff to provide and serve supplements as ordered. During an observation on 03/24/24 at 12:50 p.m., Resident #34 was in the dining room being assisted with lunch by CNA X. Resident #34 did not have a health shake on his meal tray as indicated on his meal ticket. CNA X went to the kitchen door and asked about the health shake but was told they were out. During an observation on 03/25/24 at 12:40 p.m., Resident #34 was in the dining room being assisted with lunch and no health shake on his tray. During an observation and interview on 03/26/24 at 1:43 p.m., The DM said she had ordered the house shake and they were supposed to be delivered on 3/25/24. On 3/25/24 Resident #34 had Ensure on his tray but not a health shake as ordered. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/26/24 at 1:49 p.m., LVN B said he was responsible for checking the meal tickets before the trays were delivered to the tables. He said if the residents were missing an item from their tray card, he was supposed to ask the kitchen to supply it. He said he asked the kitchen about the health shake and was told they were out. He said he did not notify anyone because at the time he did not think about it. He said most residents were on health shakes because of weight loss or to maintain their current weight. He said he should have notified the doctor when they were out of health shakes, but he did not. He said today (03/26/24) they served Ensure in place of health shakes. During an interview on 03/26/24 at 1:57 p.m., the DM said she usually ordered 2-3 cases at a time of magic cups. She said when she attempted to order last week (03/11/24) they were out of stock. She said she was not sure of the exact date that she was completely out of magic cups. She said she ordered health shakes weekly and when she went to order Friday (03/22/24) they were out of stock. She said she did not notify the Administrator of them being out of magic cups or on backorder. She said she did not notify anyone about being out of health shakes because it had only been 2 days. She said she did notify the cooperate dietitian yesterday (03/25/24) about the back order of magic cups and health shakes. She said she recommended that she offer the Gelatin unless they were on thickened liquids because it was too thin. She said most residents do not like the Gelatin. The DM said to her knowledge the purpose of magic cups was to help them maintain their weight or prevent them from losing more weight. She said they did not have an alternate place to order supplies. She said it was very important for the residents to receive the magic cup or health shake as ordered because they could lose weight. During a phone interview on 03/26/24 at 2:36 p.m., the cooperate dietitian said the DM called her yesterday about being out of house shakes and magic cups. She said she expected the DM to let her know on the day she was out of any supplies. She said if resident were not receiving their health shakes or magic cups it could be a potential for weight loss or lack of wound healing. She said they did not have another supplier or a sister facility they could get supplies from. She said she had to check on a few things to see what the facility could do and reach out to the area manager. During an interview on 03/26/24 at 3:36 p.m., the Administrator said she was not aware the facility was out of magic cups or health shakes. She said the DM did not mention they were out until after surveyors started questioning staff. She said she expected the DM to notify her if they were out of any supplies in the kitchen. She said if residents were not receiving magic cups or health shakes as ordered they could lose weight. 46892 3. Record review of a face sheet dated 03/27/2024 indicated Resident #49 was a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic respiratory failure with hypoxia (condition where the lungs cannot supply enough oxygen or remove enough carbon dioxide from the blood), type 2 diabetes mellitus with diabetic neuropathy (insulin resistance leading to high blood sugars which results in nerve damage caused by prolonged high blood sugar levels), and chronic diastolic congestive heart failure (condition in which the heart cannot fill up with blood properly). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #49 understood others and was able to make herself understood. The MDS assessment indicated Resident #49 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #49 was independent for eating, oral personal, and toileting hygiene and required supervision for showering/bathing herself. The MDS assessment indicated Resident #49 had a loss of 5% or more in the last month or loss of 10% or more in last 6 months. The MDS assessment indicated Resident #49 required a therapeutic diet. Record review of the comprehensive care plan with a target date of 05/10/2024 indicated Resident #49 received a controlled carbohydrate and no added salt diet and was at risk for decline in nutrition and hydration status related to dementia, mental illness, congestive heart failure, respiratory status, pain, arthritis, constipation, and gastroesophageal reflux disease (condition that occurs when stomach acid repeatedly flows back in to the tube connecting your mouth and stomach). The goal was for Resident #49 to maintain adequate nutritional and hydration status as evidenced by weight being stable with no signs or symptoms of malnutrition or dehydration being present through the next review date. The interventions included provide and serve diet as ordered and registered dietician to evaluate and make diet/supplement change recommendations as needed. Resident #49's care plan indicated she had an unplanned/unexpected weight loss related to recent hospitalization . Resident #49 did not prefer facility food., and she would eat cereal and lunchmeat. The goal was for Resident #49 to have no further weight loss through the next review date. The interventions include for the registered dietician to evaluate and make diet/supplement change recommendations as needed. Record review of Resident #49's Order Summary Report dated 03/24/2024 did not indicate an order for Nutritious Shake. Record review of a meal ticket dated 03/23/2024, Sunday, lunch indicated Nutritious Shake-4 ounces. During an observation of the lunch meal and interview on 03/23/2024 beginning at 12:10 p.m., Resident #49 received her lunch tray, and requested her Nutritious Shake from the staff in the dining room. The staff told her there were no Nutritious Shakes to give her. RN A said the Dietary Manager (who was in the kitchen that day) told her there were no Nutritious Shakes to give to the residents. RN A brought the Dietary Manager out of the kitchen. The Dietary Manager said when she left on Friday (03/22/2024) there were Nutritious Shakes in the kitchen for the residents, therefore, the Nutritious Shakes must have run out after she left. The Dietary Manager said the Nutritious Shakes had been ordered and would arrive on Monday 03/25/2024. The Dietary Manager said they did not have any Magic Cups for the residents either. The Dietary Manager said the Magic Cups were on back order, and she had been trying to order them for the past 2 weeks. The Dietary Manager said none of the residents that required a Nutritious Shake or Magic Cup had received one. During an interview on 03/24/2024 at 3:03 p.m., Resident #49 said she had not received a Nutritious Shake for the past 3 days. She said the staff had told her they did not have any Nutritious Shakes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/25/2024 at 9:02 a.m., NP G said the Nutritious Shakes and Magic Cups were recommended by the Dietician and nursing put the orders in. NP G said he had not been notified the Magic Cups were back ordered, and he had not been notified the facility had not had any Magic Cups for the past 2 weeks. NP G said he had not been notified that the facility did not have any Nutritious Shakes. NP G said it was unacceptable for the facility to be out of Magic Cups for that long. NP G said the staff should have let him know and he could have discussed with the Dietician an alternate nutritional supplement for the residents. NP G said it was extremely important for the residents to get the Magic Cups and Nutritious Shakes for them to get the nutritional intake they needed. NP G said not providing the Magic Cups and Nutritional Shakes could lead to weight loss. During an interview on 03/27/2024 at 10:58 a.m., RN A said the kitchen told her they did not have any Nutritious Shakes or Magic Cups. RN A said she had not notified the physician that the facility did not have any Nutritious Shakes or Magic Cups. RN A said she should have let the physician know, but she did not because she was confused about whose responsibility it was to ensure the nutritional supplements were available for the residents. RN A said she was not aware she should have notified the ADONs or DON that there were no Nutritious Shakes or Magic Cups to give to the residents. RN A said not giving the residents Nutritious Shakes and the Magic Cups could lead to weight loss. During an interview on 03/27/2024 at 3:20 p.m., ADON M said she had not been notified that there were no Magic Cups or Nutritious Shakes for the residents. ADON M said she had not run into that before, but the nurses should have notified the Administrator or the DON and contacted the physician for orders. ADON M said the residents not receiving nutritional supplements could lead to weight loss and the residents not getting enough nutrition. Record review of the facility Diets, Nutrition, and Hydration policy revised on 08/2023 indicated: Policy Diet and hydration orders for newly admitted residents and changes to existing diets or fluids will be written as reflected in the Facility Diet Manual. Fundamental Information The facility will provide each resident with three meals daily and a nourishing snack at bedtime. Each meal will be provided according to physician orders, Facility Diet Manual, and menu spread sheet . House Supplements: The physician, practitioner, or Dietitian may choose to order House supplements to provide residents with additional Calories and Protein. The term house supplement will cover all items listed in the supplement rotation guide, this allows for rotating of various supplements and foods, so that residents do not become dissatisfied with the same shake day after day. The physician order should state frequency of the supplement. All procedures for supplements should be followed. One serving will be provided per ordered supplement .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observations, interviews, and record review the facility failed to ensure that residents requiring respiratory care were provided such care, consistent with professional standards of practice for 6 of 14 residents (Residents #44, #51, #17, #60, #47, and #53) who were reviewed for respiratory care. 1.The facility failed to ensure Resident #44 had an oxygen order. 2. The facility failed to ensure Resident #51's oxygen filter on the oxygen concentrator filter was cleaned. 3. The facility failed to ensure Resident #17's oxygen filter on the oxygen concentrator filter was cleaned weekly and Resident #17's oxygen nasal cannula tubing was bagged when not in use. 4. The facility failed to ensure Resident #60's oxygen concentrator filter was cleaned weekly. 5. The facility failed to ensure Resident #47's nebulizer mask was placed in a bag after use. 6. The facility failed to ensure Resident #53's BiPAP (machine that helps a person to regulate their breathing pattern while they are asleep or when respiratory symptoms flare) mask was functioning properly. The facility failed to ensure Resident #53's BiPAP mask was stored properly. These failures could place residents who receive respiratory care at risk for developing respiratory complications and a decreased quality of care. 1.Record review of Resident #44's face sheet, dated 03/28/24, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease {COPD} (no airflow for breathing), anxiety (a feeling of fear, dread, and uneasiness), diabetes, and stroke. Record review of Resident #44's change in condition MDS assessment, dated 03/11/24, indicated Resident #44 understood and was understood by others. Resident #44's BIMS score was 12, which indicated she was moderately cognitively impaired. The MDS indicated Resident #44 required extensive assistance with bathing, toileting, bed mobility, dressing, personal hygiene, transfers, and supervision assistance for eating. The MDS indicated Resident #44 received oxygen. Record review of Resident #44's physician orders did not indicate an order for oxygen on 03/25/24. Record review of Resident #44's physician orders dated 03/26/24 indicated, may have oxygen at 5L via nasal cannula (after surveyor intervention). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #44's comprehensive care plan dated 08/02/23 indicated Resident#44 used oxygen therapy routinely because of the risk for ineffective gas exchange, heart failure, COPD, bronchitis, and/or emphysema. The interventions were for staff to apply oxygen as ordered. During an observation and interview on 03/25/24 at 3:19 p.m. Resident #44 was in her bed with oxygen at 5l via nasal cannula. She said she had to have her oxygen because she could not breath without it. During an observation and interview on 03/26/24 at 2:10 p.m., LVN B said Resident #44's oxygen was set at 2l via nasal cannula. He went to look in the EMR system and saw an order had been placed today (03/26/24) by the DON for oxygen at 5L via nasal cannula. He said residents who had COPD usually do not have oxygen set at 5L. He called the doctor to verify the order and the physician said he wanted Resident #44's oxygen setting to be at 5L via nasal cannula. LVN E went to Resident #44's room and set the oxygen at 5L as ordered. He said he was not aware Resident #44 did not have oxygen orders before the surveyor questioned him about her orders. He said charge nurses were responsible to put orders in the EMR system for oxygen once they received the order. He said it was important to have orders, so the resident would receive the correct amount of oxygen. He said Residents oxygen were not set at the ordered level it could cause respiratory issues. 2. Record review of Resident #51's face sheet, dated 03/28/24, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Peripheral vascular disease, or PVD , (a systemic disorder that involves the narrowing of peripheral blood vessels), chronic obstructive pulmonary disease (no airflow for breathing), high blood pressure, and Bipolar (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). Record review of Resident #51's quarterly MDS assessment, dated 01/30/24, indicated Resident #51 understood and was understood by others. Resident #51's BIMS score was 14, which indicated she was cognitively intact. The MDS indicated Resident #51 required extensive assistance with dressing, and personal hygiene, limited assistance with toileting, bathing, bed mobility, transfers, and set-up for eating. The MDS indicated Resident #51 was receiving oxygen. Record review of Resident#51 orders dated 01/30/24 indicated, oxygen at 3 LPM via nasal cannula. Record review of Resident#51's care plan dated 03/29/23 indicated, Resident#51 used oxygen therapy routine as needed and was at risk for ineffective gas exchange. This was related to her diagnosis of COPD. The intervention was for staff to apply oxygen as ordered. During an observation on 03/25/24 at 10:14 a.m., Resident # 51 was lying in her bed with her eyes closed. Resident #51's oxygen was set at 3L per nasal cannula. Resident #51's oxygen filter was covered with a brown-like substance. During an observation and interview on 03/26/23 at 2:30 p.m., LVN B observed Resident #51's oxygen filter was dirty. He said the night shift usually cleaned the filters, but he would get hers cleaned. He said if filters were dirty, it could affect their breathing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/27/24 at 5:57 p.m., the DON said the charge nurses were responsible for placing orders in the computer when they received a new order. She said the ADONs should follow up the next morning to ensure orders were placed in the computer system. The DON said oxygen filters should be cleaned weekly by the night nurses She said she oversaw the entire process. She said it was important to have orders and the correct orders in the system for oxygen and for oxygen filters to be cleaned to prevent respiratory issues. During an interview on 03/27/24 at 6:32 p.m., ADON W said she expected nurses to put orders in the computer system when they received new orders. She said Resident #51 should have an oxygen order with the correct flow of oxygen because she wears oxygen. She said oxygen filters were supposed to be cleaned on Wednesday nights along with changing and dating the oxygen tubing. She said the filters were clean for clean air and if they were not cleaned it could cause the resident to have some respiratory issues. She said the responsibility started with the charge nurse and then the ADONs. She said the department heads made rounds Monday through Friday and if they saw any issues, they would let us know in the morning meeting. During an interview on 03/27/24 at 6:53 p.m., the Administrator said nurse managers were the overseers of orders and oxygen filters. She said oxygen should have an order to ensure Resident #44 was receiving oxygen at the correct rate. She said she did not know when oxygen filters were supposed to be cleaned but knew they should be clean to prevent respiratory issues for Resident #44. 47708 3. Record review of a face sheet dated 3/27/24 indicated Resident #17 was a [AGE] year-old female originally admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs), Parkinson's (brain disorder that causes unintended or uncontrollable movements), generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), gastro-esophageal reflux disease (stomach acid or bile irritates the food pipe lining), and essential hypertension (high blood pressure). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #17 was able to make herself understood and understood others. The MDS assessment indicated Resident #17 had a BIMS score of 14, which indicated her cognition was intact. The MDS assessment indicated Resident #17 required independent assistance with eating, partial/moderate assistance with oral hygiene, substantial/maximal assistance with toilet use, bathing, upper body dressing, lower bathing dressing, putting on/taking off footwear, and moderate assistance with personal hygiene. The MDS assessment indicated Resident #60 used oxygen while a resident at the facility. Record review of the care plan last revised on 1/24/24 indicated Resident #17 used oxygen therapy routinely or as needed and was at risk for ineffective gas exchange. The Care plan interventions included, administering oxygen therapy per physician's orders, monitoring for signs and symptoms of respiratory distress, and report to the physician as needed. Respiratory distress could include an increased respiratory rate, tachycardia, diaphoresis, lethargy, confusion, persistent cough, pleuritic pain, accessory muscle use, decreased oxygen saturation, or changes in skin color such as a bluish or grey tint. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Medication Administration Review report dated 3/26/24 indicated Resident #17 had a physician order for oxygen at 2-3 liters per minute via nasal canula. The Medication Review report did not indicate an order for oxygen filter cleanings. During an observation on 3/26/24 at 09:32 a.m., Resident # 17's oxygen filter was dirty with a white fuzzy matter coming out of the oxygen concentrator filter. During an observation on 3/26/24 at 09:32 a.m., Resident #17's oxygen tubing for her wheelchair was hanging over the back of the chair underneath the resident's jacket. During an interview on 3/26/24 09:32 a.m., Resident #17 stated, O, my tubing is always hung on the back of my chair and is never put in a bag., I didn't know it needed to be put in a bag when I'm not using it . 4. Record review of a face sheet dated 3/25/24 indicated Resident #60 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus without complications (chronic condition that affects the way the body processes blood sugar), heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), chronic obstructive pulmonary disease with acute exacerbation (chronic inflammatory lung disease that causes obstructed airflow from the lungs), and essential hypertension (high blood pressure). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #60 was able to make himself understood and understood others. The MDS assessment indicated Resident #60 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #60 required clean up assistance with eating, moderate assistance with oral hygiene, toileting hygiene, bathing, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS assessment indicated Resident #60 used oxygen therapy while a resident at the facility. Record review of the care plan last revised 1/26/24 indicated Resident #60 used oxygen therapy routinely or as needed and was at risk for ineffective gas exchange. The care plan interventions included, administer oxygen therapy per physician's orders, monitor for signs and symptoms of respiratory distress, and report to the physician as needed. Respiratory distress could include an increased respiratory rate, tachycardia, diaphoresis, lethargy, confusion, persistent cough, pleuritic pain, accessory muscle use, decreased oxygen saturation, or changes in skin color such as a bluish or grey tint. Position the resident with her head of the bed elevated whenever possible to allow for optimal lung expansion and gas exchange. Record review of the Medication Administration Review dated 3/25/24 indicated Resident #60 had an order for oxygen filter inspection weekly, clean/change if needed. During observation on 3/25/24 at 02:55 p.m., Resident #60's oxygen concentrator filter was dirty with a white fuzzy matter on it . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Record review of Resident #47 face sheet, dated 12/20/23, indicated Resident #47 was an [AGE] year-old male, initially admitted to the facility on [DATE] with diagnoses which included pneumonia (an infection that affects one or both lungs), heart failure heart (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), hypotension (low blood pressure), chronic kidney disease unspecified (a progressive decline in kidney function over time), type 2 diabetes mellitus with other diabetic kidney complication (chronic condition that affects the way the body processes blood sugar), and essential hypertension (high blood pressure). Record review of the admission MDS assessment, dated 2/22/24, indicated Resident #47 made himself-understood, and understood others. The assessment indicated a BIMS score of 7 which indicated a severe cognitive impairment. The assessment indicated Resident #47 functional status indicated Resident #47 required supervision or touching assistance with eating, substantial/maximal assistance with oral hygiene, bed mobility, dressing, personal hygiene, putting on/taking off footwear, and toilet use dependent assistance with toilet transfer and bed transfer. The MDS did not indicate oxygen therapy. Record Review of the comprehensive care plan dated 1/23/24 indicated Resident #47 had a diagnosis of diabetes and was at risk for unstable blood sugars. The care plan interventions included, monitor for signs and symptoms of hypoglycemia such as: diaphoresis, dizziness, headache, confusion, hunger, irritability, pallor, tachycardia, slurred speech, tremor, lack of coordination, and staggering gait. Monitor blood sugar as ordered by the physician. Administer sliding scale insulin if ordered. Record review of the Medication Administration Review report dated 3/26/24 indicated Resident #47 did not indicate a physician order for oxygen. The Medication Review report did not indicate an order for oxygen filter cleanings. During an observation on 3/27/24 at 9:00 a.m., Resident #47's nebulizer mask was hanging off the bag. The nebulizer mask was not placed directly inside the bag. During an interview on 3/27/24 at 9:03 a.m., after being called to the resident's room by the State Surveyor, the charge nurse RN L stated Resident #47's nebulizer mask should have been placed inside the bag and not hanging on the side of the bag. RN L stated it was important to ensure the mask was placed inside the bag to prevent cross contamination. RN L stated staff had been trained on making sure the nebulizer masks were placed inside the bag and not hanging on the side of the bags. RN L stated recent in-services on changing the tubes every Wednesday night shift. RN L stated he worked the 6am to 6pm shift. RN L stated ADON M oversaw him. RN L stated his process from monitoring staff was, First he got to work, he got the nurse report from previous shift, then he goes down each hall to do his treatments, and then he addressed all residents concern. RN L stated most of the residents on his hall were independent and did mostly for themselves. RN L stated the residents had an order for the oxygen filters. RN L stated when staff changed the tubing staff were to also change the filters. After reviewing the filter to Resident #47's concentrator, the charge nurse, RN L, stated the filter did not appear to be clean. RN L stated the risk to the resident for his oxygen filter not being clean was infection control. RN L stated he was not aware the residents filter was dirty. RN L stated he oversaw the residents and staff on the 200 hall and the 100 hall. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/24 at 9:25a.m., ADON M stated she had been the ADON since October of 2023. ADON M stated she oversaw staff on the 200 hall and the 100 hall. ADON M stated she was not aware of staff not cleaning the oxygen filters. ADON M stated the staff had been signing off that they had been cleaning the filters. ADON M stated she conducted a random check to verify that staff were cleaning the oxygen filter. ADON M stated her last random check was completed last week and she had not checked the oxygen filters this week. ADON M stated it was important for the oxygen filters to be cleaned so the resident was not breathing in dirty air. ADON M stated staff have been in-serviced on cleaning the filter, but she still reminds staff to ensure they are cleaning the filters, since they sign off on the filters being cleaned. ADON M stated Resident #47 should have had a bag to put her oxygen nasal cannula tubing inside it. ADON M stated the risk for the oxygen nasal tube not being placed in bag because of risk for infection control. ADON M stated the DON oversaw her. During an interview on 3/27/24 at 3:48 p.m., the DON stated she knew the filters were there. The DON stated she did not know when the filters were changed last. The DON stated she had the old concentrators replaced. The DON stated the facility had ordered new filter concentrators. The DON stated she oversaw all nursing staff at the facility. The DON stated staff had not been in-serviced on enclosed filters. The DON stated filters should be cleaned weekly on Wednesday. The DON stated on Thursday, the quality-of-life team conducts room rounds checking all filters and oxygen tubing. The DON stated the ADON also conducted rounds on Thursday and would make rounds throughout the week. The DON stated it was important to ensure the filters were changed to prevent decreased amount of respiratory issues. During an interview on 3/27/24 at 4:15 p.m., the Administrator stated at the time she did not know the oxygen concentrator filter needed to be replaced every two years according to the manufacturer. The Administrator stated the filter did appear to be dirty and not cleaned. The Administrator stated the resident's oxygen filter orders will have to be updated to reflect what the manufacture instructions indicated. The Administrator stated she did not know how old the oxygen concentrators were nor how long the resident has had the Everflo oxygen concentrator. The Administrator stated she was not aware that the o2 filters were not being replaced. The Administrator stated she will be monitoring oxygen filter changes by using the quality-of-life form to check the filters. The Administrator stated if the filters were not changed regularly, it could cause respiratory issues. The Administrator stated the nebulizer should have been placed inside the bag. The Administrator stated she was not aware that the nebulizer was not placed inside the bag. The Administrator stated she was not aware of Resident #17 nasal tubing hanging on the chair and not placed in bag after use. The Administrator stated, The harm that could potentially to be caused the resident was infection control. 46892 6. Record review of a face sheet dated 03/27/2024 indicated Resident #53 was a [AGE] year-old female initially admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia (condition where the lungs cannot supply enough oxygen or remove enough carbon dioxide from the blood) and obstructive sleep apnea (sleep related breathing disorder). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #53 understood others and was able to make herself understood. The MDS assessment indicated Resident #53 had a BIMS score of 14, which indicated her cognition was intact. The MDS assessment indicated Resident #53 was independent for eating, required substantial/maximal assistance with toileting hygiene, shower/bathe self, and supervision/touching assistance for personal hygiene. The MDS assessment indicated Resident #53 used a non-invasive mechanical ventilator (BiPAP, CPAP machine used to deliver oxygen while asleep) Record review of Resident #53's Order Summary Report dated 03/24/2024 indicated assist resident with applying BiPAP at bedtime with a start date of 03/02/2023. Record review of Resident #53's care plan with a target date of 05/17/2024 indicated she had impaired respiratory status related to a diagnosis of obstructive sleep apnea with BiPAP use and history of respiratory failure. Resident #53's care plan indicated a goal of the resident will be compliant with the use of BiPAP through the next review date. Resident #53's care plan indicated interventions which included assist/encourage resident to use BiPAP as ordered and monitor/document resident use/refusals of BiPAP. During an observation and interview on 03/24/2024 at 10:57 a.m., Resident #53 said her breathing machine (BiPAP) was not working properly. Resident #53 said she had not worn it for 2-3 months because when she put it on it blew air out from the top of the mask. Resident #53 said the nurses were aware, and they told her they would look into it, but she did not hear back from them. Resident #53 said the BiPAP helped her sleep better. Resident #53's BiPAP mask was laying at her bedside not in a bag exposed to air. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 03/27/2024 at 10:17 a.m., RN L said he was not aware Resident #53's BiPAP was not working properly. RN L went into Resident #53's room to demonstrate to the state surveyor the BiPAP machine was functioning. Resident #53's BiPAP mask was laying at her bedside not in a bag exposed to the air. RN L attempted to put the BiPAP mask on Resident #53 and was unable to. Resident #53 said she would put it on herself and when she attempted to put it on one of the straps that held the BiPAP mask down was loose and unable to be reattached. Resident #53 said that was why the air was coming out of the mask when she attempted to wear it. Resident #53 said that was why she would put it on at night, and then take it off because the air would start blowing out of the mask and onto all of her face. RN L said a couple months ago one of the straps on the side of Resident #53's BiPAP mask had come off. RN L said he had provided a different mask for Resident #53, but she did not like the fit of the new mask. RN L said he improvised and taped that side of the strap back on so she could use the same mask. An observation was made of one of the straps that had been taped down to the mask to keep it in place on the opposite side of the strap that was loose. RN L said when he had provided Resident #53 a new mask and she did not like it, he did not contact respiratory therapy to try to get her a new mask or to see if she needed one with a better fit. RN L said he should have contacted respiratory therapy for them to evaluate Resident #53, but he did not because he thought he had improvised to make it work. RN L said the whole team was responsible for ensuring residents respiratory equipment was functioning properly. RN L said it was important for Resident #53 to be using her BiPAP because it helped her sleep apnea and it helped with her breathing. RN L said Resident #53's BiPAP not being worn or used properly placed her a t risk for changes in oxygenation levels and it could cause respiratory distress. RN L said Resident #53's BiPAP mask should be stored in a bag. RN L said he was not sure why it was not in a bag. RN L said the person that took off the mask should place it in a bag, and if any staff member noticed it was not bagged when they were walking by, they should place it in a bag. RN L said he thought the ADONs made rounds to ensure they were in a bag. RN L said it was important for the masks to be stored properly to prevent cross contamination which can lead to an infection, and because the masks could collect dust and that could lead to allergies. During an interview on 03/27/2024 at 3:26 p.m., ADON M said masks for BiPAP machines and nasal cannulas should be stored in a respiratory bag. ADON M said the nurses were responsible for ensuring they were stored in a bag. ADON M said it was a collective effort to ensure the masks and nasal cannulas were stored in a bag. ADON M said this was monitored by the department heads making daily room rounds. ADON M said she tried to go down the halls and check rooms daily as well. ADON M said it was important for the masks to be stored in a bag because they did not want to cause an infection and to decrease cross contamination. ADON M said she was not aware Resident #53's BiPAP mask was not stored in a bag. ADON M said if a mask for the BiPAP was not working properly the nurses should contact respiratory therapy as soon as they were made aware it was not working. ADON M said the nurses as well as nurse management were responsible for ensuring residents respiratory equipment was functioning properly. ADON M said the nurses were supposed to tell her if the resident's respiratory equipment was not working, but the nurses had not told her. ADON M said it was important for the BiPAP mask to be working properly because if the resident had sleep apnea, they needed the extra oxygen and to ensure the resident was receiving the amount of oxygen they needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/27/2024 at 4:14 p.m., the DON said masks and cannulas should be stored in respiratory bags and changed weekly. The DON said the department heads made rounds daily to ensure they were stored properly. The DON said it was important for the masks and cannulas to be stored properly to keep illnesses down, to make sure they stayed clean, and to ensure the residents did not experience exacerbation (worsening) of respiratory illnesses. The DON said the nurses had not informed her Resident #53's mask was not functioning properly. The DON said the night shift nurse should have notified her Resident #53's BiPAP mask was not functioning properly. The DON said respiratory therapy and the physician should have been notified. The DON said a BiPAP was necessary to ensure the resident was getting the oxygen they needed while they were asleep. During an interview on 03/27/2024 at 5:21 p.m., the Administrator said she was not aware Resident #53's BiPAP mask was not functioning properly. The Administrator said in the past they had replaced the mask. The Administrator said if a mask was not functioning properly she expected the nurses to contact respiratory therapy for them to evaluate. The Administrator said the nurses should be monitoring the BiPAP masks to ensure they were working properly and should ensure the mask is bagged. The Administrator said the BiPAP mask should be stored in a bag to ensure it was clean and for infection control. The Administrator said it was important for Resident #53's BiPAP to be working properly when worn so she could breathe better. During an interview on 03/27/2024 at 5:51 p.m., LVN N said at night she placed Resident #53's BiPAP mask next to her so she would put it on. LVN N said Resident #53 would take off her mask in the middle of the night. LVN N said she was aware Resident #53's mask was ripped, but Resident #53 had pulled it and made it work. LVN N said she believed she had notified the other nurses that Resident #53's BiPAP mask was ripped so they could notify respiratory therapy during the day. LVN N said it was important for Resident #53's BiPAP mask to be working properly because she had sleep apnea and not getting the oxygen, she required could damage her heart. Record review of the facility's policy revised 1/5/20, titled, Oxygen Administration indicated, Policy: To describe methods for delivering oxygen to improve tissue oxygenation; Completion of Procedure (2) when oxygen not in use, store oxygen tubing and nasal cannula or mask in small plastic bag; Concentrator: (1) clean filter weekly. Record Review of the facility policy dated 9/28/21, titled Following physician orders indicated, .for consulting physician/practitioner orders received via telephone, the nurse will: (a) Document the order on the physician order form, notating the time, date, name, and title of the person providing the order, and the signature and title of the person receiving the order. (b) Follow facility procedures for verbal or telephone orders including noting the order, submitting to pharmacy, and transcribing to medication or treatment administration record. (c) Carry out and implement physician orders (d) Document resident response to physician order in the medical record as indicated . Record Review of the oxygen concentrator instructions for Everflo oxygen concentrators indicated, the Everflo air inlet filter should be replaced every 12 months to a maximum of 24 months or more frequently in an environment of high dust, and between patient use. The air inlet filter should be replaced by an authorized home care provider. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled, Noninvasive Ventilation CPAP, BiPAP, Trilogy, origination date 12/16/2021, indicated, The facility will provide noninvasive ventilation as per physician's orders and current standards of practice . replace equipment immediately when it is broken or malfunctions .

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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** 46892 Based on observations, interviews, and record review the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel and all drugs and biologicals used in the facility were labeled in accordance with professional standards for 1 of 1 treatment carts, 2 of 5 medication carts (100 Hall Nurse Cart, 300 Hall Nurse Cart and the 400 Hall Nurse cart), 1 of 1 medication storage room reviewed for drugs and biologicals, and 3 of 3 Residents. (Resident #49, Resident #233, Resident #52) The facility failed to ensure the Treatment Cart and the 400 Hall Nurse cart were secured and unable to be accessed by unauthorized personnel. The facility failed to label medications with an open date for Resident #49's insulin pen and Resident #52's and Resident #233's inhalers on the 100 Hall Nurse cart. The facility failed to label with an open date a multidose vial of Lidocaine 1% 200 mg/20 ml on the 300 Hall Nurse cart. The facility failed to discard a vial of Influenza Vaccine afluria Quadrivalent (flu vaccine) opened 01/24/2024 and a vial of Tuberculin Purified Protein Derivative Diluted Aplisol (test administered to diagnose TB) opened 02/06/2024 that were in the medication fridge in the medication storage room. These failures could place residents at risk of not receiving the therapeutic benefit of medications, not receiving drugs and biologicals as needed, and a drug diversion. Findings included: 1. Record review of a face sheet dated 03/27/2024 indicated Resident #49 was a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included type 2 diabetes mellitus with diabetic neuropathy (insulin resistance leading to high blood sugars which result in nerve damage cause by prolonged high blood sugar levels). Record review of Resident #49's Order Summary Report dated 03/24/2024 indicated an order for Victoza Subcutaneous Solution Pen-injector (insulin pen) 18 mg/3ml Inject 1.2 mg subcutaneously (under the skin) in the morning with a start date of 01/13/2024. 2. Record review of a face sheet dated 03/27/2024 indicated, Resident #52 was a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #52's Order Summary Report indicated orders for Ventolin 90 Base mcg/actuation aerosol solution (inhaler used to treat shortness of breath) 2 puff inhale orally every 4 hours as needed. Resident #52's Order Summary Report did not indicate orders for the Spiriva or Albuterol inhalers. 3. Record review of a face sheet dated 03/27/2024 indicated Resident #233 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease with acute lower respiratory infection. Record review of Resident #233's Order Summary Report indicated orders for Advair Diskus Aerosol Powder Breath Activated 100-50 mcg/dose (Fluticasone-Salmeterol) 1 inhalation every 12 hours with a start date of 03/11/2024. During an observation on 03/24/2024 at 3:17 p.m., the Treatment Cart was on the 200-hallway unlocked. During an observation and interview on 03/24/2024 at 3:19 p.m., Treatment Nurse E returned to the Treatment Cart. Treatment Nurse E said the treatment cart should be locked when she walked away from it. Treatment Nurse E said somebody called her away from the Treatment Cart and she guessed she did not lock it. Treatment Nurse E said it was important for the Treatment Cart to be locked for safety purposes, and so no one could get into it and take what they were not supposed to take. During an observation and interview on 03/25/2024 starting at 4:38 p.m., the 100 Hall Nurse Medication cart was checked. Resident #49's Victoza insulin pen did not have an open date. Resident #52's Spiriva, Albuterol, and Ventolin inhalers did not have an open date. Resident #233's Advair diskus did not have an open date. LVN F said she was not sure if the inhalers had to be dated when opened. The DON walked by and LVN F asked the DON. The DON said the Advair was supposed to be dated when opened, and the other inhalers did not require an open date. The DON said she would get the policy. LVN F said insulin pens should be dated when opened because they would expire and lose their effectiveness. In the medication fridge in the medication storage room there was a vial of Influenza Vaccine afluria Quadrivalent opened 01/24/2024 (which indicated the vial had been opened more than 30 days ago and should have been discarded) and a vial of Tuberculin Purified Protein Derivative Diluted Aplisol opened 02/06/2024 (which indicated the vial had been opened more than 30 days ago and should have been discarded). LVN F said she did not know how long the Influenza Vaccine and the Tuberculin Purified Protein Derivative Diluted Aplisol were good for after being opened. LVN F said she did not know because she did not administer those medications. LVN F said the ADONs checked the medication fridge and discarded items that were out of date. During an observation and interview on 03/26/2024 at 11:22 a.m., the 400 Hall Nurse cart was unlocked on the 400 Hall. Several staff and residents walked by. LVN B said he forgot to lock his medication cart, and he knew it should be locked for the safety of the residents. During an observation of the 300 Hall Nurse cart and interview on 03/26/2024 beginning at 2:44 p.m., a multi-dose 20 ml vial of Lidocaine 1% 200 mg/20 ml was opened with no open date. LVN B said the person that opened the vial was responsible for placing an open date on it. LVN B said it was important for opened vials to be dated with opened because they were only good for a certain amount of time. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/27/2024 at 3:42 p.m., ADON M said someone from corporate went to the facility to check the medication carts, and the pharmacy checked them once a month. ADON M said the inhalers should be dated when opened. ADON M said the nurses and herself were responsible for checking the medication fridge in the medication storage room and discarding medications that were out of date. ADON M said she had not been checking the medication fridge once a month like she should have been because she was having to work the floor a lot lately. ADON M said the nurses and herself should be checking the vaccines to ensure they did not need to be discarded after opened. ADON M said it was important for insulins and inhalers to be dated when opened so the staff would know when it was past the recommended days and the medication could be discarded. ADON M said if insulins and inhalers were not dated after being opened and the vaccines and tuberculin were not discarded within the required timeframe the medications would not be as effective. ADON M said anytime the nurses stepped away from a medication or treatment cart they should lock it. ADON M said she monitored to ensure the medication and treatment carts were locked by checking them when she randomly walked the halls. ADON M said it was important to ensure the medication and treatment carts stayed locked because anybody could go by and have access to the medications and things they do not need to have access to and residents could open it and take something they should not be taking. During an interview on 03/27/2024 at 4:28 p.m., the DON said the medication and treatment carts should be locked when they walked away from it. The DON said when she made round daily, she looked at the medication and treatment carts to ensure they remained locked. The DON said every once in a while, she had noticed them not being locked. The DON said it was important for the medication and treatment carts to stay locked so nobody could get into them, and so the residents did not get into sharps or other items that could be harmful to the residents if they got a hold of them. The DON said once a month the ADONs checked the medication carts and the medication fridge to check for expired medications. The DON said the influenza vaccine and tuberculin should be discarded after 30 days per manufacturers recommendations. The DON said the insulins and inhalers should be dated when opened. The DON said it was important for them to be dated when opened because they could lose their potency and not be as effective for the resident receiving it. The DON said it was important for the vaccines and tuberculin to be discarded because they would not be as effective if used past the required timeframe. Record review of the facility's policy titled, Medication Storage, implemented 01/20/2021, indicated, It is the policy of this facility to ensure all medications housed on premises will be stored, dated and labeled according to the manufacturer's recommendations . a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) . c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart . Medication Carts are routinely inspected for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels . Record review of the undated package insert for Tuberculin Purified Protein Derivative Diluted Aplisol indicated, .vials in use for more than 30 days should be discarded . Record review of the undated package insert for Seqirus, Influenza Vaccine afluria Quadrivalent, indicated, . once the stopper of the multi-dose vial has been pierced the vial must be discarded withing 28 days .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47708 Based on observations, interviews, and record review, the facility failed to ensure that menus were followed for the noon time (lunch) meal to meet the nutritional needs for the residents on a pureed food consistency diet (5 of 5) residents were reviewed for puree food consistency diet. 1. The facility served the residents on a pureed food consistency diet the wrong scoop size servings on the macaroni and cheese for the noon time (lunch) meal on 3/25/24. 2) The facility failed to follow puree recipe for lunch meal served on 3/26/24. 3) The Dietary Staff failed to serve the puree residents puree bread on the 3/25/24. This failure affected all residents in the facility who required pureed food consistency by placing them at risk of not receiving adequate nutritive food value needed to promote/maintain health. Findings included: 1. Record review of the facility diet and nourishment roster on 03/25/2024 indicated there were 5 residents in the facility on pureed food consistency diet. Record Review of the week 1 menu dated 3/24/24, indicated the lunch meal items included glazed ham, mixed vegetables, macaroni and cheese, breadstick, citrus gelatin, choice of beverage. (Substitute) Chicken soup, grilled cheese. Record Review of the facility extended menu on 3/24/24 indicated the pureed macaroni and cheese were to be served with the number #6 scoop size. During observation on 3/24/24 at 12:01 p.m., Cook S was observed serving the puree macaroni and cheese using the #12 scoop. Cook S did not give the resident a second scoop of the puree macaroni and cheese prior to serving the residents on a puree diet. Cook S did not serve the residents on puree diet the puree bread. Cook S did have the Puree bread on the stream table prior to serving the residents on pureed diet. During an interview on 3/24/24 at 12:01p.m., Cook S stated she thought she had given the puree residents two scoops of the puree macaroni and cheese. Cook S stated she forgot to make the puree bread and the Dietary Manager made the puree bread after she had already served the puree residents for the lunch meal. Cook S stated she had forgotten to serve the puree bread after all the residents had been served for the lunch meal on 3/24/24. Cook S stated she used the #12 scoop size to serve the puree macaroni and cheese. During an interview on 3/24/24 at 12:01 p.m., the Dietary Manager stated the #6 scoop should have been used instead of the #12 scoop size used to serve the puree macaroni and cheese or the residents should have been given two scoops of the puree macaroni and cheese. The Dietary Manager stated the cook should have served the residents on a puree diet, puree bread. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record Review of the week 1 menu dated 3/24/24, indicated the lunch meal items included Glazed ham, mixed vegetables, macaroni and cheese, breadstick, citrus gelatin, choice of beverage: (Substitute) Chicken soup, grilled cheese. Record Review of the puree fruit recipe sheet indicated, the fruit recipe for 10 puree residents indicated to add 1 1/2 quarts of drained fruit, with 1/4 cup plus 1 tablespoon of food thickener. The preparation methods included: (1) Measure drained fruit and place in food processor, process until fine in consistency, (2) Measure and add food thickener, process until smooth, (3) Using a rubber spatula, scrape down the sides of the food processor, process for 30 seconds. (4) Place in serving pan, or shape into individual serving bowls Cover and refrigerate, chill to 40F or below and serve #10 scoop or equivalent. Record Review of the puree rice recipe sheet indicated, for 10 puree resident the following ingredients for rice included: 1 1/2 cup of Pureed Rice Mix, 4 cups of hot 190-degree water/ milk and 1/4 cup of melted margarine. The preparation methods included: (1) Measure all ingredients, mix melted margarine into water then stir into pureed, (2) Cover with plastic wrap and foil re-heat in 350 F oven to 190 F and (3) serve using a #10 scoop. Record Review of the puree Cinnamon Apple slices indicated the following: (1) For Pureed: Measure desired# of servings into food processor. Blend until smooth. Add apple juice if product needs thinning. Add commercial thickener if product needs thickening. Serve with a #10 scoop. During observation and interview of puree meal prepared by Cook T for the lunch meal served on 3/26/24 at 10:48 a.m., the following was noted: Cook T added 8 teaspoons of thickeners, and 1 Liter of chili into the blender and mixed for 45 seconds; Cook T added (6) 4 ounce scoops of cooked greens, (6) 4 ounce scoop of juice from the greens and 6 teaspoons of thickener then mixed in the blender for 35 seconds; Cook T added (7) 4 ounces scoops of rice, 1 1/2 cup of milk, 3 teaspoons of thickener, 1 ounce of butter using #20 scoop size then mixed in blender for 30 seconds. Cook T placed all separately mixed food items in a pan to be served to the residents on 3/26/24 for the lunch meal. Cook T was observed not using the recipe book. Cook T stated she did not use the recipe book because It was just can chili and she cooked her collard greens how she made her collard greens at home. Cook T stated she was aware of how to use the recipe book and where the recipe book was in the kitchen. Cook T stated, It was important to follow the recipe book because some residents can't eat salt. During observation and interview of puree meal prepared by Cook S for the lunch meal served on 3/26/24 at 11:15 a.m., the following was noted: Cook S added (6) 5.33 fluid ounces of hot cinnamon apple slices to the blender, (3) scoops of cinnamon apple slices juice and then she mixed in the blender for about 22 seconds. Cook S then placed the pureed cinnamon apple slices in a pan to serve for the lunch meal. Cook S was observed not using the recipe book. Cook S stated she looked at the recipe book prior to the State Surveyor coming into the kitchen. Cook S stated, I was used to making the cinnamon apple slices and that is why I did not use the recipe book. Cook S stated, It was important to ensure staff was following the recipe book to ensure the residents did not receive the wrong food and because some residents were diabetics and could not have sugar in their foods. During an attempted interview on 3/27/24 at 3:30 p.m., Cook S was unavailable to be reached by phone for further questioning. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 3/27/24 at 10:50 a.m., the Dietary Manager stated she had been an employee at the facility for 3 years. The Dietary Manager stated the regional manager oversaw her. The Dietary Manager stated she oversaw the kitchen. The Dietary Manager stated she was responsible for ensuring staff were using the correct scoop sizes. The Dietary Manager stated she was responsible for ensuring staff were following the recipe book. The Dietary Manager stated she could not say off the top of her head when her last test tray was. The Dietary Manager stated when she informed the Administrator that she needed to have a test tray done, she would pick a staff member to test the foods. The Dietary Manager stated sometimes in the morning meetings when a test tray needed to be done that the Administrator will test the foods. The Dietary Manager stated her previous manager told her that the test trays needed to be done once a week. The Dietary Manager stated she only conducted test trays when she was told to do so. The Dietary Manager stated in the past, staff have been trained on the scoop sizes but had not been trained this year on the scoop sizes and the recipe book. The Dietary Manager stated it was important to ensure staff were given the residents the proper amount of food to maintain the weight and for nutrition value. During an interview on 3/27/24 at 10:02 a.m., the Regional Director stated she had just received the facility's account within the last few weeks with the facility. The Regional Director stated she was not aware the dietary staff were not using the right scoop sizes. The Regional Director stated she did expect staff to use the correct scoop sizes per meal item. The Regional Director stated she did expect staff to follow the recipe book. The Regional Director stated she oversaw the dietary manager. The Regional Director stated she had her regional dietician complete an audit on Tuesday (March 19, 2024). The Regional Director stated she inspected the kitchen once or twice a month. The Regional Director stated she did a recipe in-service yesterday (3/26/24), but she was not aware of the scoop issues and will complete an in-service on that today on (3/27/24). The Regional Director stated, It was important for the residents to receive the proper amount of food for nutritional value to ensure the residents are getting the correct calorie per meal and thee scoop sizes were important to ensure residents are getting the proper portion sizes per meal. During an interview on 3/27/24 at 4:38 p.m., the Administrator stated she had been the Administrator since March of 2023. The Administrator stated she oversaw the kitchen. The Administrator stated the Dietary Manager was responsible for ensuring staff used the correct scoop sizes and followed the recipe book. The Administrator stated she expected staff to use the correct scoop sizes per meal item and to follow the recipe. The Administrator stated, if necessary, she would inspect the kitchen. The Administrator stated her last kitchen inspection was A long time ago, too long honestly. The Administrator stated she was not aware if staff had completed any in-services on scoop sizes or how to use the recipe book. The Administrator stated, It was important for the residents to receive the proper amount of food for resident nutritional value. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of menus and nutritional adequacy revised dated on 10/1/18, indicated, menus are planned to meet the average resident's nutritional needs; A pre-planned menu is provided to the facility, which has been planned or reviewed by a Registered Dietitian and includes meals that are adequate to meet the average resident's nutritional needs. The meal planning guide in the Facility Diet Manual is used as the basis for menu planning. Food Group Minimum Daily Servings Meat or Equivalent 5 Ounces Vegetables 2-3 Servings, Fruits 2 Servings, Starches/Grains 5-6 Servings, Milk 2 Servings; When a facility has a functional resident menu committee, this committee may choose to make changes to the planned menus. Menu changes will be made at least one week in advance and will be made on the week at a glance and extended for all diets on the menu spread sheets. All menu changes will be reviewed and approved by the facility's Dietitian or Consultant Dietitian. When making menu changes it is important to make sure all food groups are represented in adequate numbers, and that menu changes are extended for all therapeutic diets per the facility diet manual. A policy for following the recipe guidelines was requested on 3/27/24 from the Administrator but not received prior to exit on 3/27/24 at 10 p.m.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47708 Based on observations, interviews, and record review, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 4 of 4 residents (Resident #23, Resident #49, Resident #47 and Resident #17), 1 of 3 meals were reviewed for palatability, attractiveness, and appetizing. 1) The dietary staff failed to provide food that was palatable and appetizing temperature for Resident #23, Resident #49, Resident #47 and Resident #17. These failures could place residents at risk of decreased food intake, hunger, and unwanted weight loss. The findings included: Record Review of the week 1 menu dated 3/24/24, indicated the lunch meal items included glazed ham, mixed vegetables, macaroni and cheese, breadstick, citrus gelatin, choice of beverage: (Substitute) Chicken soup, grilled cheese. During an interview on 03/24/2024 at 10:46 AM, Resident #23 said the food was terrible and that it was really bland. During an interview on 03/24/2024 at 3:05 p.m., Resident # 49 said the food was over seasoned, and it tasted awful. During an interview on 03/24/24 at 03:10 p.m., Resident #47 stated the food was terrible. During an interview on 03/26/24 at 09:32 a.m., Resident #17 stated the food was too spicy. During an observation on 3/25/24 at 11:43 a.m., observations of food temperatures were made on the steam table by Cook S. The results were as followed, regular glazed ham 148 F, regular mixed vegetables 175 F, regular macaroni and cheese 176 F, breadstick temperature was not taken, and the regular citrus gelatin dessert was 39 F. During a test tray interview with the Dietary Manager and State Surveyors on 3/25/24 at 1:00 p.m., The Dietary Manager stated the following regarding the regular food diet for lunch served on 3/25/2024: Regular Glazed Ham was warm and tasted like ham, mixed vegetables was good, macaroni and cheese was bland and cold, breadsticks were good, and citrus gelatin desserts were good. The State Surveyors stated the ham was warm and tasted like ham, mixed vegetables were good, macaroni and cheese was bland and cold, breadsticks were good and the citrus gelatin dessert was good. During an attempted interview on 3/27/24 at 3:30 p.m., Cook S was unavailable to be reached by phone for further questioning. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 3/27/24 at 10:39 a.m., The Dietary Manager stated she had been the dietary manager for 3 years and the regional manager oversaw her. The Dietary Manager stated she did not taste the foods every day because there was a lot of food that she did not eat. The Dietary Manager stated sometimes the cook would ask her if she could taste the foods, but she attempted to taste the foods each shift. The Dietary Manager stated she had not done in-services this year, but staff have been trained in the past on how to follow the recipes. She stated they were on a new program and staff had been having a hard time finding the recipe in the new program book. The Dietary Manager stated if she got food complaints in a grievance, she would have a conversation with the resident, and then she would try to address the complaint with the resident in a meeting with the residents. The Dietary Manager stated she would try to come up with a plan that will satisfy the resident and then the Administrator would sign off on the grievance concerning food complaints. The Dietary Manager stated it was important to ensure the food was palatable, attractive, and appetizing to the residents because if the food tasted good and looked good then it would help the residents to eat more. During an interview on 3/27/24 at 10:08 a.m., the Regional Director stated she had been the regional director a few weeks. The Regional Director stated he did oversee the dietary manager. The Regional Director stated she did a test tray at each audit at the facility. The Regional Director stated the audits were done by her monthly and the dietary manager did weekly audits. The Regional Director stated she did hear the food was spicy from the residents yesterday (3/26/24). The Regional Director stated the food complaints were handled in grievances and the dietary staff would make the necessary adjustments as needed, including ensuring staff followed the recipe book. The Regional Director stated in-services on the recipe book were completed for all staff dietary staff on (3/26/24). The Regional Director stated it was important to ensure the residents were getting their nutrition by eating and to ensure the residents enjoyed what they were eating. During an interview on 3/27/24 at 4:42 p.m., the Administrator stated she had been the Administrator since March of 2023. She stated she oversaw the Dietary Manager. The Administrator stated she ordered test trays from the kitchen. The Administrator stated her last test tray was completed on 2/7/24 and her food was delicious. The Administrator stated she had been ordering a test tray monthly, but she had not done a monthly test tray for March of 2024 yet. The Administrator stated residents had complained about food variety. The Administrator stated the new company changed the menus and she had been getting compliments on the new menu. She stated she handled food complaints in the IDT (interdisciplinary team) meetings with staff. The Administrator stated the Dietary Manager visited with every resident and would go over a preference check with each resident. The Administrator stated it was important that food was palatable, attractive, and appetizing to the residents so the residents will eat the food. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of menus and nutritional adequacy revised dated on 10/1/18, indicated, menus are planned to meet the average resident's nutritional needs; A pre-planned menu is provided to the facility, which has been planned or reviewed by a Registered Dietitian and includes meals that are adequate to meet the average resident's nutritional needs. The meal planning guide in the facility diet manual is used as the basis for menu planning. Food Group Minimum Daily Servings Meat or Equivalent 5 Ounces Vegetables 2-3 Servings, Fruits 2 Servings, Starches/Grains 5-6 Servings, Milk 2 Servings; When a facility has a functional resident menu committee, this committee may choose to make changes to the planned menus. Menu changes will be made at least one week in advance and will be made on the week at a glance and extended for all diets on the menu spread sheets. All menu changes will be reviewed and approved by the facility's Dietitian or Consultant Dietitian. When making menu changes it is important to make sure all food groups are represented in adequate numbers, and that menu changes are extended for all therapeutic diets per the facility diet manual. The policy did not include information on palatability.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47708 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in (1 of 1) kitchen reviewed for dietary services. 1) The Dietary staff failed to date all food items. 2) The Dietary staff failed to dispose of expired food items in the refrigerator. 3) The Dietary staff failed to effectively seal, label, and date refrigerated food items. 4) The Dietary staff failed to to repair a leak in the kitchen ceiling. These failures could place residents at risk for food contamination and foodborne illness. The findings included: During an observation on [DATE] at 10:37 a.m., of Refrigerator #1, the following was indicated: -(1) 5-pound block of sliced cheese had no open date and no received date. -(1) 5 slices of cheese in saran wrap and not bagged, had no open date, no expiration date, and no received date. -(1) 8 quarts of lettuce in a container had a preparation date of [DATE] and had no expiration. (expired) -(1) 5 slices of bologna opened and not bagged, had no open date, received dates, and expiration date. During observation on [DATE] at 10:48 a.m., of Freezer #2, the following was indicated: -(3) 6.5 pounds of sliced strawberries did not have and received date and no expiration date. During an observation on [DATE] at 11:43 a.m.,there was a leak in the kitchen ceiling above the food preparation area in the kitchen. During an interview on [DATE] at 10:37 AM, Dishwasher U stated the cheese found in the refrigerator should have included an open date, a received date, and an expiration date on it. (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 [DATE] at 10:47, the CDM (Certified Dietary Manager) V stated the bologna should have been bagged and included an open date, received date, and an expiration date on it. CDM V stated she would just throw away the bologna. CDM V stated when food was prepared that it was good for 7 days in the refrigerator. The CDM V stated she would have an aide put the dates on the frozen sliced strawberries found in freezer #2. CDM V stated the frozen strawberries should have had a received date and an expiration date. During an attempted phone interview on [DATE] at 3:30 p.m., Cook S was unavailable to be reached by phone for further questioning. During a phone interview on [DATE] at 10:30 a.m., the Dietary Manager stated she had been the dietary manager at the facility for 3 years. She stated the regional manager oversaw her at the facility. The Dietary Manager stated all food items in the refrigerator needed to be labeled, dated with received date, open date, and expiration date. The Dietary Manager stated staff did not have any recent in-services on labeling, dating, and resealing food items in the refrigerator and freezer. The Dietary Manager stated she will wait until the last crew had left for the day and she will ensure staff had completed everything in the kitchen weekly on Sunday nights. The Dietary Manager stated she took a video of the leak and sent it to the Administrator. The Dietary Manager stated she could not say the leak had been repaired because the leak was still occurring in the kitchen from the ceiling. The Dietary Manager stated she would consider the leak in the kitchen a fall hazard because the leak was right where her staff served meals. She stated it would be important to prevent bacteria and expired food could be a hazard to the resident's health. During an interview on [DATE] at 10:13 a.m., the Regional Director stated she had been employed at the facility for a few weeks. The Regional Director stated she oversaw the Dietary Manager. The Regional Director stated all food items in the refrigerator were to be labeled, dated with received date, open date, and expiration date. The Regional Director stated she did not have a reason as to why all the food items were not labeled, dated, and expired foods thrown out. The Regional Director stated labeling and dating were on her to do list for the dietary staff. The Regional Director stated she was not sure if the dietary manager had completed any in-services on labeling and dating with the dietary staff in the past. The Regional Director stated she conducted walk throughs once or twice a month and the dietary manager conducted walk throughs daily. The Regional Director stated the leak in the kitchen had been repaired before according to the Administrator, but the state surveyor would have to follow up with the Administrator for more information on the leak in the kitchen. The Regional Director stated it was important for the dietary staff to follow the facility's policy for disposing of expired foods, labeling, and dating food items for the resident's safety and to avoid food borne illnesses. (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 [DATE] at 4:49 p.m., the Administrator stated she had been employed at the facility since March of 2023. The Administrator stated she oversaw the Dietary Manager. The Administrator stated all food items in the refrigerator needed to be labeled, dated with received date, open date, and expiration date. The Administrator stated that it was not to her knowledge that staff had not completed any in-services on labelling and dating all food items, resealing refrigerated, and frozen food items. The Administrator stated she conducted walk throughs in the kitchen quarterly. The Administrator stated the leak in the kitchen was reported to her on Monday [DATE]. The Administrator stated the leak in the kitchen had been repaired previously on [DATE]. The Administrator stated the Dietary Manager had informed her this week of the leak from the kitchen ceiling. The Administrator stated she did not know when someone could come back out to repair the leak in the kitchen, but she would follow up with the repair company. The Administrator stated she did consider the leak in the kitchen ceiling to be a fall hazard for the dietary staff. The Administrator stated she was not aware of the dietary staff not labeling, dating, and resealing refrigerated food items in the refrigerator according to the facility policy. The Administrator stated it was important to ensure staff were labeling, dating, and resealing refrigerator and frozen food items for the safety of the residents. Record Review of the Facility's policy revised dated [DATE] titled Frozen and Refrigerated Foods Storage, indicated, (7) Refrigerate cooked foods in shallow containers to speed the cooling process. Proper labeling of cooked foods includes the date placed in the refrigerator, and an expiration or use by date. Refrigerated products that are opened must be labeled with an opened on date. The use by date is 7 days from when the product was opened, unless there is a manufacturer's use by, expiration or sell by date. For all foods that have a manufacturer use by, sell by or expirations dates this date will be used. Examples of foods that typically have manufacturer, use by, sell by or expirations dates are cottage cheese, milk, sour cream, pre-pared refrigerated salads etc.; foods prepared in the building and properly cooled will be dated as to the date prepared and "use by" date which will be 7 days from the date prepared. (9) items stored in the refrigerator must be dated upon receipt, unless they contain a manufacturer use by, sell by, best by date, or a date delivered. Most pick stickers do have the delivery date on the sticker. They must also be dated with an expiration date unless they have one from the manufacturer (i.e., milk cartons, eggs); (11) All refrigerated and frozen items in storage will contain a minimum label of common name of product and dated as noted above. Record Review of the FDA Food Code for 2022, ,d+[DATE] Maintenance and Operations ,d+[DATE]. 11-Repairing indicated, PHYSICAL FACILITIES must be maintained in good repair.

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Greenville Health & Rehabilitation Center	4910 Wellington St Greenville, TX 75402

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview and record review the facility failed to arrange an appointment with an outside resource for 1 of 24 residents (Resident #66) reviewed for the use of outside resources. The facility failed to ensure Resident #66's appointments with nephrology (specialty for kidneys/kidney disease, function) and with hematology (specialty for blood and blood diseases) were scheduled after she discharged from the hospital on 02/26/2024. This failure could place residents at risk of not receiving needed medical care. Findings included: Record review of a face sheet dated 03/27/2024 indicated Resident #66 was a [AGE] year old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system), type 2 diabetes mellitus with hyperglycemia (chronic condition that affects the way the body processes blood sugar which leads to high blood sugars), thrombocytopenia (low blood platelet (blood cells help blood clot) count), and acquired absence of kidney. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #66 had reentered from a short-term general hospital on 02/26/2024. The MDS assessment indicated Resident #66 was able to make herself understood and understood others. The MDS assessment indicated Resident #66 had a BIMS score of 11, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #66 was independent for eating, required set up or clean up assistance with toileting hygiene and personal hygiene, and supervision or touching assistance with bathing. Record review of Resident #66's discharge orders from her hospitalization , admitted [DATE] and discharge date [DATE], indicated discharge patient instructions, no heparin products to be given and needed to add heparin as an allergy. Follow-up appts within 1 to 2 weeks with nephrology and within 1 week Resident #66 needed the next available hematology evaluation. Record review of the Order Summary Report dated 03/24/2024, did not indicate an order to follow-up with nephrology (specialty for kidneys/kidney disease, function) or to follow up with hematology (specialty for blood and blood diseases) for an evaluation. Record review of Resident #66's care plan with a target date of 06/06/2024 did not address referrals to nephrology or appointments with nephrology, and the care plan did not address an appointment with hematology. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/2024 at 10:17 a.m., RN L said he was not aware Resident #66 required follow up appointments with nephrology and hematology. RN L checked the transport book and said there were no appointments scheduled for Resident #66. RN L said if a resident required a follow-up appointment the nurses would put an order in the electronic medical record for an appointment, schedule the appointment, and put it in the transport book. RN L said the nurses were responsible for scheduling follow-up appointments and the ADONs assisted if needed. RN L said it was important for follow-up appointments to be scheduled to ensure the treatment the residents were receiving was working, to help them improve, and so they could have necessary labs drawn for the appointments. During an interview on 03/27/2024 at 3:54 p.m., ADON M said as of right now she did not think Resident #66's had any appointments scheduled. ADON M said the nurses reviewed the discharge orders and follow-up appointments, and then the ADONs and the DON looked over them after to ensure things were not missed. ADON M said she had reviewed Resident #66's discharge orders, and she was not aware of the follow-up appointments. ADON M said she had not noticed them that it got missed. During an interview on 03/27/2024 at 4:35 p.m., the DON said the nurses received the discharge orders, reviewed them, and put the orders into the residents' electronic medical records. The DON said depending on the time of the day the resident was readmitted if the orders were reviewed by the ADONs the same day of the next morning. The DON said the ADONs reviewed the orders after the nurses to ensure they were put in correctly. The DON said she was not aware of Resident #66's discharge orders to follow up with nephrology and hematology. The DON said it was important for follow-up appts to be scheduled because if the residents had something going on the diagnoses needed to be addressed. The DON said Resident #66's follow-up appointments to nephrology and hematology not being scheduled could be life threatening for her. During an interview on 03/26/2024 at 5:29 p.m., the Administrator said she expected the nurses to follow discharge orders and schedule follow-up appointments. The Administrator said she was not clinical and could not address what it placed residents at risk for. Record review of the facilities policy implemented, 09/24/2022, titled, Medication Reconciliation, indicated, . compare orders to hospital records, home or orders from healthcare entity, etc. obtain clarification orders as needed c. transcribe orders in accordance with procedures for admission orders .

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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** 46892 Based on observation, interview, and record review, the facility failed to ensure the medical record was complete and accurately documented for 1 of 24 residents (Resident #66) reviewed for resident records. The facility failed to ensure Resident #66's allergy to Zyvox (antibiotic) and Heparin (anticoagulant medication) were added to her list of allergies after she readmitted from the hospital on 02/26/2024. This failure could place residents at risk of receiving medications they are allergic to and inaccurate medical records. Findings included: Record review of a face sheet dated 03/27/2024 indicated Resident #66 was a [AGE] year old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system), type 2 diabetes mellitus with hyperglycemia (chronic condition that affects the way the body processes blood sugar which leads to high blood sugars), thrombocytopenia (low blood platelet (blood cells help blood clot) count), and acquired absence of kidney. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #66 had reentered from a short-term general hospital on 02/26/2024. The MDS assessment indicated Resident #66 was able to make herself understood and understood others. The MDS assessment indicated Resident #66 had a BIMS score of 11, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #66 was independent for eating, required set up or clean up assistance with toileting hygiene and personal hygiene, and supervision or touching assistance with bathing. Record review of Resident #66's discharge orders from her hospitalization , admitted [DATE] and discharge date [DATE], indicated discharge patient instructions, no heparin products to be given and needed to add heparin as an allergy. Resident #66's allergies were listed as Zyvox, Macrobid (antibiotic), Azithromycin, Naproxen, Propoxyphene, Pseudoephedrine, Tramadol, Heparin, and Ketolides. Record review of the Order Summary Report dated 03/24/2024 indicated Resident #66's allergies were Azithromycin (antibiotic), Naproxen (medication used for pain/fever), Propoxyphene (pain medication), Pseudoephedrine (decongestant medication), Tramadol (pain medication), Macrolides and Ketolides (antibiotics). Resident #66's Order Summary Report did not list Zyvox (antibiotic) or Heparin (anticoagulant medication) as an allergy. Record review of Resident #66's care plan with a target date of 06/06/2024 indicated she was allergic to the following medications Macrolides, Ketolides, Azithromycin, Naproxen, Propoxyphene, Pseudoephedrine, Tramadol. Zyvox and Heparin were not included on the care plan as allergies. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/2024 at 10:17 a.m., RN L said the nurse that admitted the resident was responsible for reviewing the discharge orders and putting them in the Resident's electronic medical record. RN L said he was not the nurse when Resident #66 readmitted to the facility, and he did not know who the nurse that readmitted her was. RN L said he was not aware there were new allergies listed that needed to be added to Resident #66's allergy list. RN L said it was important for the allergy list to be current to ensure the residents did not receive something they were not supposed to because this could lead to the resident having an allergic reaction. During an interview on 03/27/2024 at 3:54 p.m., ADON M said the nurses reviewed the discharge orders/instructions, and then the ADONs and the DON looked over them after to ensure things were not missed. ADON M said she had reviewed Resident #66's discharge orders, and she was not aware of the new allergies that were added. ADON M said she had not noticed them that it got missed. ADON M said it was important for allergies to be listed correctly listed because the residents could have an allergic reaction. ADON M said it was important for Resident #66's Zyvox and Heparin allergies to be included on her allergy list because she could receive something she was allergic to and it could cause her harm. During an interview on 03/27/2024 at 4:35 p.m., the DON said the nurses received the discharge orders, reviewed them, and put the orders into the residents' electronic medical records. The DON said depending on the time of the day the resident was readmitted if the orders were reviewed by the ADONs the same day of the next morning. The DON said the ADONs reviewed the orders after the nurses to ensure they were put in correctly. The DON said she was not aware of Resident #66's discharge orders to add Zyvox and Heparin to her allergy list. The DON said it was important for allergies to be added so the residents did not have a severe reaction. During an interview on 03/26/2024 at 5:29 p.m., the Administrator said she expected the nurses to follow discharge orders and add allergies to the residents' medical records for continuum of care. The Administrator said she was not clinical and could not address what it placed residents at risk for. Record review of the facilities undated policy titled, Allergies, indicated, Responsibility: licensed nurse, resident's attending physician . Record allergies on resident care plan and in nurses admitting notes .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 3 residents (Resident #1) reviewed for hospice services. The facility failed to obtain Resident #1's physician's order for hospice services, most recent physician order, and the most recent hospice plan of care. The facility failed to obtain the most recent hospice certification. This deficient practice could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. Findings included: Record review of Resident #1's face sheet dated 03/27/24 indicated he was an [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses of senile degeneration of the brain, anxiety, dementia (decline in cognitive abilities that impacts everyday activities), and protein-calorie malnutrition (inadequate food intake). Record review of Resident #1's quarterly MDS dated [DATE] indicated he had a BIMS score of 10 which indicated moderate cognitive impairment. The MDS also indicate he required supervision with toileting and transfers, setup with eating and dressing and he was independent with med mobility. The MDS also indicated Resident #1 was on hospice care. Record review of Resident #1's undated care plan indicated he had a terminal illness and was receiving hospice services related to the diagnosis of senile degeneration of the brain with interventions in place to coordinate with hospice to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. Record review of Resident #1's order summary report dated 03/27/24 did not reveal an order for hospice care. Record review of Resident #1's hospice binder on 03/27/24 at 4:00 PM, indicated the last written certification was completed 06/20/23 that was certified from 06/20/23-08/23/23. There was not a recent plan of care update noted in the facility's hospice binder. The last plan of care order noted was dated 01/15/24. Record review of Resident #1's EMR on 03/27/24 at 04:02 PM, indicated the hospice administration record and the facility's physician orders did not match. The following orders were noted on the hospice medication record and not in Resident #10's facility's order summary report: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Fluvoxamine Maleate oral tablet 100mg 1 tab daily for schizophrenia dated 10/28/21. During an interview on 03/27/24 at 3:50 PM RN A said Resident #1 receives hospice services and he should have had an order for hospice in the EMR. She said she could not locate the order for hospice. RN A said the hospice binder should have been up to date and orders should have matched the facility orders, but she was not responsible for the notebook. RN A said the hospice binder not being updated placed Resident #1 at risk for a medication error. During an interview on 03/27/24 at 4:12 PM the hospice company RN said the nurses were at the facility weekly and the binders should have been updated every certification. The hospice company RN said the plan of care should have been updated every 2 weeks and with any changes to Resident #1's medications or care. She said the nurse that was at the facility on 03/27/24 quit on 03/27/24 and another RN that had seen Resident #1 would bring updated documents on 03/28/24. The hospice company RN said the failure placed Resident #1 at risk of medications being given to in error and the nursing home not being made aware of the frequency of the visits (nurses or aides) or plan of care for Resident #1. During an interview on 03/27/24 at 05:00 PM ADON W said the hospice was responsible for ensuring the hospice binder was up to date and the facility relied on hospice to come in and do their part. ADON W said the responsibility for ensuring the book was updated would have probably fallen on her. She said the medication list should be updated at least every 2 weeks when the hospice company completed their meeting as well as when any changes were made. She said the risk to Resident #1 was medications not up to date, possible errors, and it could have caused issues with resident care he received from nurses or aides coming in the facility from hospice. ADON W said she had never really read through a hospice binder. During an interview on 03/27/24 at 05:48 PM the DON said the hospice company was responsible for ensuring the hospice binder, medications, and care plans were up to date. She said the hospice nurses came in weekly and should have been updating care plans bi-weekly and medications monthly or with any changes. The DON said it placed Resident #1 at risk for medication errors and a break in continuity of care. During an interview on 03/27/24 at 06:12 PM the Administrator said her expectation was for the hospice binders to be up to date and the hospice company was responsible, but the nursing staff should also monitor to ensure the binder was up to date. She said the risk to the resident was an issue with continuity of care and errors being made with care. Record review of the facility Coordination of Hospice Services Policy dated 04/21/2021 indicated: Policy: When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being. Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the resident's care. 2. The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs, goals, and recognized standards of practice in consultation with the resident's attending physician/practitioner and resident's representative, to the extent possible.

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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** 45879 Based on observations, interviews, and record review, 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 for 4 of 4 reviewed (Resident #38 and Resident #47, Resident #14, and Resident #66) for infection control practices. 1. The failed to ensure CNA X performed hand hygiene or change gloves while providing incontinent care for Resident #38. 2.The facility staff failed to properly dispose of used PPE in the biohazard bin. 3.The facility failed to ensure CNA D did not leave trash and a sheet in Resident #14's room after providing care to her. 4.The facility failed to ensure Treatment Nurse H performed hand hygiene after glove removal and performed proper glove changes while providing wound care to Resident #66 . These failures could place any resident at the facility requiring incontinent care, wound care, and isolation at risk for infections. Finding included: 1. Record review of Resident #38's face sheet, dated 03/28/24, indicated a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses which included anxiety (a feeling of fear, dread, and uneasiness), deep vein thrombosis {DVT } (a medical condition that occurs when a blood clot forms in a deep vein), diabetes, and stroke. Record review of Resident #38's admission MDS assessment, dated 02/04/24, indicated Resident #38 was usually understood and usually understood others. Resident #38's BIMS score was 08, which indicated he was cognitively moderately impaired. The MDS did indicate Resident #38 was usually incontinent of bladder and bowel. The MDS indicated Resident #38 required extensive assistance with bathing, limited assistance with toileting bed mobility, dressing, personal hygiene, transfers, and supervision assistance for eating. During an observation on 03/24/24 at 2:56 p.m., CNA X was performing incontinent care on Resident #38. She cleaned his buttocks first and then moved to the front peri area without hand hygiene. Then she wiped the peri area in a circular motion, she used her dirty gloves and grabbed a clean brief and applied it without changing her gloves or conducting hand hygiene. During an interview on 03/24/24 at 3:15 p.m., CNA X said she did not realize she did not perform hand hygiene or change her gloves before touching Resident #38's clean brief. She said she did not realize she wiped in a circular motion. She said you should wipe front to back. She said she knew without hand hygiene she could spread infection. She said she had been trained at the facility on peri care and incontinent care. (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 interview on 03/24/24 at 5:57 p.m., the DON said she expected the CNA to change her gloves between clean and dirty and to use hand hygiene between glove changes. The DON said failure to do appropriate incontinence care could cause infections. During an interview on 03/24/24 at 5:53 p.m., the Administrator said she expected all staff to use proper hand hygiene techniques between dirty and clean areas with all care. The Administrator said the DON was responsible for ensuring staff were trained on incontinent care and infection control. She said improper hand hygiene could place the resident at risk for infection. Record review of CNA X competencies of hand hygiene and incontinent was completed on 09/12/23. 47708 2.Record review of Resident #47 face sheet, dated 12/20/23, indicated Resident #47 was an [AGE] year-old male, initially admitted to the facility on [DATE] with diagnoses which included pneumonia (an infection that affects one or both lungs), heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), hypotension (low blood pressure), chronic kidney disease unspecified (a progressive decline in kidney function over time), type 2 diabetes mellitus with other diabetic kidney complication (chronic condition that affects the way the body processes blood sugar), and essential hypertension (high blood pressure). Record review of the admission MDS assessment, dated 2/22/24, indicated Resident #47 made himself-understood, and understood others. The assessment indicated a BIMS score of 7 which indicated severe cognitive impairment. The assessment indicated Resident #47's functional status required supervision or touching assistance with eating, substantial/maximal assistance with oral hygiene, bed mobility, dressing, personal hygiene, putting on/taking off footwear and toilet use,; dependent assistance with toilet transfer, and bed transfer. During an observation on 3/27/24 at 9:00 a.m., Resident #47 had used PPE (soiled gown and gloves) discarded in Resident #47's personal trash can. During an interview on 3/27/24 at 9:03 a.m., after being called to the resident's room by the State Surveyor, the charge nurse (RN L) stated staff was not to put used PPE in resident #47's personal trash can. RN L stated the biohazards gowns, gloves, and PPE should have been placed inside the biohazards bin located inside the resident bathroom. RN L stated it was important to ensure biohazards were placed in the biohazard bins for infection control. RN L stated he worked the 6 am to 6 pm shift. RN L stated the ADON oversaw him. RN L stated he oversaw the residents and staff on the 100 and 200 halls. (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 interview on 3/27/24 at 9:25 a.m., ADON M stated she was the ADON at the facility. ADON M stated she had been the ADON since October of 2023. Stated she oversaw staff on the 200 hall and the 100 hall. ADON M stated she was not aware of staff putting biohazard PPE in Resident #47's personal trash can. ADON M stated all biohazard PPE she be put in the biohazard bins. ADON M stated it was important for PPE to be properly disposed of because biohazard materials should be disposed in biohazards bins to prevent contamination. ADON M stated in-services were completed on how to properly dispose of biohazard PPE. ADON M stated every shift was responsible for making sure they were taking it out before the biohazard bin was full. ADON M stated, prior to in-services being completed by staff, it was a constant reminder of staff to make sure they were properly disposing of used biohazard PPE. ADON M stated the DON oversaw her. During an interview on 3/27/24 at 3:48 p.m., the DON stated before COVID they were told the biohazard PPE could be thrown in the regular trash can, so staff needed to be reeducated on where to put the used biohazard PPE. The DON stated she oversaw the nursing staff. The DON stated she was responsible for ensuring staff properly disposed of their PPE. The DON stated if the PPE was not soiled that she did not see a harm to the residents, but she understood. During an interview on 3/27/24 at 4:15 p.m., the Administrator stated she was not aware of staff putting biohazard PPE in the resident's personal trash can. The Administrator stated the harm that could be caused to the resident was infection control. 46892 3. Record review of a face sheet dated 03/27/2024 indicated Resident #14 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life) and thrombocytopenia (low blood platelet (blood cells help blood clot) count). Record review of a Comprehensive MDS assessment dated [DATE], indicated Resident #14 was able to make herself understood and understood others. The MDS assessment indicated Resident #14 had a BIMS score of 7, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #14 required substantial maximal assistance with toileting hygiene and partial/moderate assistance with personal hygiene. The MDS assessment indicated Resident #14 was always incontinent of urine and bowel. Record review of Resident #14's care plan indicated Resident #14 was incontinent of bowel and bladder to check frequently for wetness and soiling and change as needed. During an observation and interview on 03/24/2024 at 2:40 p.m., there was a clear bag with a dirty brief, gloves, wipes, and an unbagged sheet laying next to it on the floor against the wall in Resident #14's room. Resident #14 was unable to tell me if she knew who had left it there. Resident #14's roommate overheard and said the CNAs left it on the floor after changing Resident #14, and they would be back to get it later because that is what they usually did. (continued on next page)

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	675020	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Health & Rehabilitation Center	4910 Wellington St Greenville, TX 75402

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of a face sheet dated 03/27/2024 indicated Resident #66 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system), type 2 diabetes mellitus with hyperglycemia (chronic condition that affects the way the body processes blood sugar which leads to high blood sugars), thrombocytopenia (low blood platelet (blood cells help blood clot) count), and acquired absence of kidney. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #66 had reentered from a short-term general hospital on 02/26/2024. The MDS assessment indicated Resident #66 was able to make herself understood and understood others. The MDS assessment indicated Resident #66 had a BIMS score of 11, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #66 was independent for eating, required set up or clean up assistance with toileting hygiene and personal hygiene, and supervision or touching assistance with bathing. The MDS assessment did not indicate any wounds. Record review of Resident #66's care plan with a target date of 06/06/2024 indicated she had a surgical wound, and it was at risk for infection, pain, and a decrease in functional abilities. The goal was for her wound to be free from signs and symptoms of infection. The interventions included to provide wound care per the physician's order. Record review of Resident #66's Order Summary Report dated 03/24/2024 indicated the following orders: Contact isolation for diagnosis of UTI with ESBL (Extended-spectrum beta-lactamases bacteria that commonly causes infections and are considered resistant mechanisms with few antibiotic choices to treat the infections which can be spread through contaminated hands and surfaces) Resume abdominal wound dressings as ordered by the physician, clean midpoint abdominal wound with normal saline, pat dry, pack wound with 1/2 inch packing strip, cover with 4 x 4 border gauze, until healed every day shift. During an observation and interview starting on 03/24/2024 at 2:50 p.m., CNA D was observed coming out of Resident #66's room with a clear trash bag that contained a PPE gown. CNA D went down the hall to the trash barrel and disposed of it. CNA D said she had left the trash bag on the floor because Resident #14's family member wanted her to be changed and she did not have her trash barrels with her. CNA D said she was not sure about the sheet on the floor she might have left it there, but she could not remember. CNA D said linens should not be left on the floor they should be bagged and placed in the linen barrel because of germs. CNA D said trash should be placed in the trash barrel and not left on the floor in the rooms after providing care because of cross contamination. CNA D said she thought if she was not doing patient care she did not have to wear a gown, and since she had just gone in to give Resident #66 water, she really did not need to wear a gown. CNA D said PPE was not supposed to be carried outside of the room it should be removed and disposed prior to leaving the residents room to prevent cross contamination and for germ control. (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 of wound care and interview on 03/26/2024 9:33 a.m., Treatment Nurse H cleaned Resident #66's bedside table, removed her gloves, and applied a new pair of gloves. Treatment Nurse H did not perform hand hygiene in between glove changes. Treatment Nurse H then removed Resident #66's dirty dressing, cleansed the wound with normal saline and gauze, packed it with the packing strip, and applied the clean dressing. Treatment Nurse H removed her gloves and performed hand hygiene. Treatment Nurse H failed to remove her gloves and perform hand hygiene after removing Resident #66's dirty dressing, prior to cleansing the wound, packing it, and covering it with a clean dressing. Treatment Nurse H said she did not perform hand hygiene in between gloves changes because her hands were already clean when she has applied gloves, and her hands did not get dirty. Treatment Nurse H said she could have changed gloves after removing the dirty dressing. Treatment Nurse H said not performing hand hygiene adequately and not changing gloves appropriately while providing wound care could reinfect the resident and contaminate the wound. Treatment Nurse H said hand hygiene was important to not cross contaminate. During an interview on 03/27/2024 at 3:40 p.m., ADON M said after incontinent care was provided the trash should not be left on the floor, and linen should not be left on the floor. ADON M said the linen should be bagged and placed in the linen barrel and the trash should be placed in the trash barrel. ADON M said the nurses should be checking the rooms to ensure they CNAs were not leaving trash and linens on the floor. ADON M said when she made her daily rounds, she had not noticed the CNAs leaving trash or linens on the floor. ADON M said it was important for the trash and linens to not be left on the floor because it could result in cross contamination. During an interview on 03/27/2024 at 4:21 p.m., the DON said hand hygiene should be performed after glove changes. The DON said when providing wound care gloves should be changed after removing the soiled dressing and hand hygiene performed. The DON said she monitored the treatment nurses and she had not notified any issues with the way Treatment Nurse H performed wound care. The DON said it was important to provide proper wound care to keep bacteria down and prevent wound infections. The DON said the CNAs should be taking the trash and linens out of the room after providing care and disposing of it in the proper barrels. The DON said linen should be bagged. The DON said she had noticed the CNAs were leaving trash and linens in the room and she has provided education and in-services to them. The DON said the head CNA, ADONs, and herself made rounds throughout the day to ensure trash and linens were not left on the floor in the residents' rooms. The DON said it was important for trash and linens to be disposed of properly for infection control and to prevent odors. During an interview on 03/27/2024 at 6:53 p.m., the DON said when a resident was placed on isolation, they let the staff know and put up the kits with PPE on the door with a sign that indicated what type of precaution the resident was on and to let the staff know what PPE was required when entering the room. The DON said CNA D should have removed her PPE inside the room prior to exiting Resident #66's room and disposed of it in the biohazard box inside the room. The DON said it was important for PPE to be removed prior to leaving the residents room for infection control and to prevent the spread of infection. Record review of the facility's policy titled, Hand Hygiene, reviewed 02/11/2022, indicated, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors . the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled, Infection Prevention and Control Program, indicated, .soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled linen shall not be kept in the resident's room or bathroom . Record review of the facility's policy titled, Transmission-Based (Isolation) Precautions, indicated, .Contact precautions refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment . c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination . Record review of the Facility Policy on Infection control policy revised dated on 4/12/2023 did not indicate how staff should properly dispose of used PPE. Record review of CDC (Center for Disease Control) guidelines last reviewed on 10/3/22 indicated, dispose of all PPE in appropriate waste containers (2) Ensure that healthcare personnel have immediate access to and are trained and able to select, put on, remove, and dispose of PPE in a manner that protects themselves, the patient, and others.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 45810 Based on interview and record review, the facility failed to develop, implement, and maintain annually an effective training program for existing staff, consistent with their expected roles for 1 of 20 employees (Dietician) reviewed for required annual trainings. The facility failed to ensure the Dietician received required dementia training upon hire 07/17/23. These failures placed residents at risk for unmet needs due to untrained staff. Findings included: Record review of Personnel Files on 03/27/24 indicated the dietician was hired on 07/17/23 and had no dementia training upon hire. During an interview on 03/27/24 at 06:17 PM the Human Resources Manager said the corporate office was responsible for the training required upon hire for the dietician. She said she had reached out to the corporate office by email, and they refused to send the information needed. The Human Resources Manager said the failure placed staff at risk for not knowing how to correctly care for a resident with dementia. During an interview on 03/27/24 at 06:27 PM the Administrator said the corporate office had access to the dietician hire records and it should have been sent to the facility for the Human Resources Manager to file. The Administrator said the failure of not having training placed the employee ineligible to work and usure if she had the knowledge required. Record review of the facility policy Training Requirements dated 11/29/2022 indicated: Policy: 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. Policy Explanation and Compliance Guidelines . 5. Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. 6. Training content includes, at a minimum: a. Effective communication for direct care staff. b. Resident rights and facility responsibilities for caring of residents. c. Elements and goals of the facility's QAPI program. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Written standards, policies, and procedures for the facility's infection prevention and control program. e. Written standards, policies, and procedures for the facility's compliance and ethics program. f. Behavioral health including informed trauma care g. Restraints h. HIV i. Dementia management and care of the cognitively impaired. j. Abuse, neglect, and exploitation prevention. k. Safety and emergency procedures. 7. It is the responsibility of each employee, volunteer, or contract staff to complete required training. a. The facility offers a variety of training methods and times to accommodate individuals. b. An individual's failure to complete required training in a timely manner will result in termination of employment or contractual/volunteer status .10. Documentation of required training may be forwarded to the HR Department to be placed into the individual's personnel file or in accordance with facility policy for retention of training records.