STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675051	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Rehabilitation & Healthcare Center	502 East Coke Rd Winnsboro, TX 75494

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observation, interview, and record review the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 15 residents (Resident #12) reviewed for reasonable accommodations. The facility failed to ensure Resident #12's call light was within reach while in bed. This failure could place residents at risk for a delay in assistance and decreased quality of life. Findings include: Record review of a face sheet dated 11/20/2024 indicated Resident #12 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included unspecified sequelae of unspecified cerebrovascular disease (residual neurological effects of a stroke), vascular dementia unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain and it causes problems with reasoning, planning, judgment, and memory), and acquired absence of the right and left leg above the knee, Record review of the Quarterly MDS assessment dated [DATE] indicated, Resident #12 was sometimes understood by others and sometimes understood others. The MDS assessment indicated Resident #12 had a BIMS score of 00, which indicated his cognition was severely impaired. The MDS assessment indicated Resident #12 was dependent on staff for toileting, showering/bathing self, and personal hygiene. The MDS assessment indicated Resident #12 was dependent for rolling and transfers. Record review of the care plan revised 08/05/2024 indicated Resident #12 was a high risk for falls to anticipate and meet his needs, be sure his call light was within reach, encourage the resident to use it for assistance as needed, and he needed a prompt response to all his requests for assistance. During an observation and interview on 11/18/2024 at 2:07 PM, Resident #12 was in his bed and said he needed assistance with his TV. Instructed Resident #12 to use his call light for staff assistance. Resident #12 said, I ain't got one. Upon observation of Resident #12's call light it was on the floor by the edge of his nightstand out of his reach. Surveyor stopped MA C to assist Resident #12. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/19/2024 at 8:03 AM Resident #12's call light was on the floor by the edge of his nightstand out of his reach. During an observation and interview on 11/19/2024 at 3:21 PM, CNA E said Resident #12 was able to use a call light. CNA E said they should be checking the residents to ensure they had their call lights every round and at least every 2 hours. CNA E said it was important for the residents to have their call light accessible to them in case they needed assistance. CNA E said if they did not have their call light accessible to them, they were not getting the care they needed at the moment. CNA E went into Resident #12's room and pulled the call light off the floor where it laid close to the edge of the nightstand beside Resident #12's bed out of his reach. CNA E gave Resident #12's call light to him, asked him to press it, to ensure it was functioning properly. Resident #12 activated the call light, and it was functioning. During an interview on 11/20/2024 at 3:00 PM, the DON said when the staff left the room, they should make sure the call light was within reach. The DON said she had made rounds and ensured all the residents call lights were within reach, so she knew at one point he had it. The DON said sometimes when Resident #12 turned and repositioned himself he knocked it off the bed onto the floor. The DON said all the staff were responsible for making sure call lights were within reach. The DON said if the call light was not within reach, they would not be able to push the call light to get the staff's attention. During an interview on 11/20/2024 at 3:26 PM, the Administrator said all residents should have their call light within reach, and if it was not within arm's reach, it was in the wrong spot. The Administrator said typically the CNAs were responsible for ensuring the residents' call lights were within reach, but anyone moving the resident or repositioning them could ensure their call light was within reach. The Administrator said it was important for the residents to have their call lights within reach because it was their only means of communication. The Administrator said the residents could need something small or they could be choking so they needed to have their call light so staff could respond in a timely and efficient manner. Record review of the facility's policy titled, Resident Call System, reviewed 03/28/2023, indicated, Policy Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation Policy Interpretation and Implementation 1. Each resident is provided with a means to call staff directly for assistance from his/her bed .

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F 0580 Level of Harm - Actual harm Residents Affected - Some	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** 46892 Based on observation, interview, and record review the facility failed to consult with the resident's physician when there was a significant change in the resident's physical and mental status that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications for 1 of 15 (Resident #19) residents reviewed for notification of change. The facility failed to ensure Resident #19's physician was notified of his increased pain following a wound debridement (removal of dead or unhealthy tissue from the wound to promote the healing process) by the Wound Care NP on 11/12/2024. This failure could place residents at risk for experiencing unnecessary pain, not receiving necessary treatments and medications, and a decreased quality of life. Findings included: Record review of a face sheet dated 11/20/2024 indicated Resident #19 was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included pressure ulcer of sacral region, stage 4 (sore that extends below the subcutaneous fat into the deep tissues, including muscle, tendons, ligaments, and bone in the lower back, buttocks area) and pain. Record review of Resident #19's Quarterly MDS assessment dated [DATE] indicated he was understood by others and was able to understand others. The MDS assessment indicated Resident #19 had a BIMS score of 15, which indicated his cognition was intact. The MDS assessment indicated Resident #19 was dependent for showering/bathing, toileting hygiene, and required supervision or touching assistance for personal hygiene. The MDS assessment indicated Resident #19 received pain medications as needed. The MDS assessment did not indicate Resident #19 received non-medication intervention for pain. The MDS assessment indicated Resident #19 experienced pain occasionally, it occasionally affected his sleep, and it rarely or not at all interfered with his therapy and day-to-day activities. Record review of Resident #19's care plan with a target date of 01/21/2025 indicated he had acute/chronic pain related to low backpain, gout (pain, swelling of the joints), and rhabdomyolysis (muscle injury or breakdown). Interventions included to administer allopurinol, Tylenol, oxycodone as per orders to give half an hour before treatments or care, anticipate the residents need for pain relief and respond immediately to any complaint of pain, and evaluate the effectiveness of pain interventions, review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Resident #19's care plan indicated he had a stage 4 pressure injury/ulcer to left buttock related to obesity, immobility, and refusal of care. Interventions included to administer medications as ordered, monitor/document for side effects and effectiveness, administer treatments as ordered and monitor for effectiveness, and to treat pain as per orders prior to treatment/turning to ensure the resident's comfort. Record review of Resident #19's Order Summary Report dated 11/19/2024 indicated: (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	Oxycodone 10 mg give 1 tablet by mouth every 4 hours as needed for severe pain may use oxycodone 5 mg 2 tablets to equal 10 mg with a start date of 03/19/2024. Tylenol give 1000 mg by mouth every 8 hours as needed for pain with a start date of 03/19/2024. Hydrocodone-Acetaminophen 7.5-325 mg give 1 tablet by mouth every 6 hours as needed for pain related to pressure ulcer of sacral region, stage 4 with a start date of 09/29/2024. Wound left buttock apply lidocaine 5% to wound center prior to procedure. Cleanse wound and peri-wound (around the wound) with normal saline, apply barrier cream around wound, apply collagen with silver, finish packing with normal saline moistened Kerlix AMD (gauze dressing used to reduce the growth of bacteria), cover with gauze and abdominal pad, secure with tape, change daily every day shift with a start date of 11/12/2024. Wound left buttock apply lidocaine 5% to wound center prior to procedure. Cleanse wound and peri-wound with normal saline, apply barrier cream around wound, apply collagen with silver, finish packing with normal saline moistened Kerlix AMD, cover with gauze and abdominal pad, secure with tape, change daily every day shift with a start date of 11/13/2024. Hydrocodone-Acetaminophen 5-325 mg give 2 tablets by mouth every 24 hours as needed for pain related to pressure ulcer of sacral region, stage 4 give prior to wound care treatments with a start date of 11/19/2024. Hydrocodone-Acetaminophen 7.5-325 mg give 2 tablets by mouth every day shift related to pain give daily prior to wound care with at start date of 11/19/2024. Record review of Resident #19's Wound-Weekly Observation Tool dated 11/10/2024 indicated he had a stage 4 pressure ulcer to the left buttock which he admitted with. The measurements were length 2 cm, width 1.4 cm, depth 2.5 cm. The wound had undermining (a wound complication that occurs when the edges of the wound separate this creates a pocket of dead space beneath the skin, the damage extends underneath). The Wound-Weekly Observation tool indicated Resident #19 had pain prior to wound treatment. The rating of the resident's pain was left unanswered. Pain interventions included pain medication prior to treatment and lidocaine cream applied in the wound bed. Record review of Resident #19's Wound-Weekly Observation Tool dated 11/12/2024 indicated he had a stage 4 pressure ulcer to the left buttock which he admitted with. The measurements were length 2.9 cm, width 1.4 cm, depth 2.3 cm. The wound had undermining (a wound complication that occurs when the edges of the wound separate this creates a pocket of dead space beneath the skin, the damage extends underneath). The Wound-Weekly Observation tool indicated Resident #19 had pain prior to wound treatment. The rating of the resident's pain was left unanswered. Pain interventions included pain medication prior to treatment and lidocaine cream applied in the wound bed. Record review of Resident #19's progress notes dated 11/12/2024-11/19/2024 did not indicate Resident #19's wound was debrided by the Wound Care NP, and they did not indicate Resident #19 had increased pain. Record review of Resident #19's November 2024 MAR indicated. is this resident in pain? 0 indicated no pain, 1-3 indicated mild pain, 4-6 indicated moderate pain, 7-10 indicated severe pain. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	11/12/2024: day shift, evening shift, and night shift indicated 0 (no pain). 11/13/2024: day shift and evening shift indicated 0 (no pain), night shift indicated 4 (moderate pain). 11/14/2024: day shift and evening shift indicated 0 (no pain), night shift indicated 4 (moderate pain). 11/15/2024: day shift 1 (mild pain), evening shift 4 (moderate pain), night shift 0 (no pain). 11/16/2024: day shift 4 (moderate pain), evening shift 4 (moderate pain), night shift 0 (no pain). 11/17/2024: day shift 0 (no pain), evening shift 3 (mild pain), night shift 0 (no pain). 11/18/2024: day shift 5 (moderate pain), evening shift 0 (no pain), night shift 0 (no pain). Record review of Resident #19's November 2024 MAR indicated, Norco 7.5-325 mg (Hydrocodone-Acetaminophen) give 1 tablet by mouth every 6 hours as needed for pain related to pressure ulcer of sacral region, stage 4 order date 09/29/2024: Administered 11/13/2024 for pain level of 5, 10:08 AM and was effective. Administered 11/14/2024 for pain level of 4, 8:56 AM and was effective. Administered 11/15/2024 for pain level of 4, 7:30 AM and was effective. Administered 11/15/2024 for pain level of 4, 5:47 PM and was effective. Administered 11/17/2024 for pain level of 9, 9:32 AM and was effective. Administered 11/18/2024 for pain level of 5, 9:01 AM and was effective. Record review of Resident #19's November 2024 MAR indicated; Tylenol Oral Tablet (Acetaminophen) give 1000 mg by mouth every 8 hours as needed for pain order date 03/19/2024: Administered 11/17/2024 for pain level of 8, 5:05 AM and was effective. Administered 11/18/2024 for pain level of 8, 4:59 AM and was effective. Administered 11/18/2024 for pain level of 3, 10:15 AM and was effective. Record review of Resident #19's November 2024 TAR indicated: Apply lidocaine 5% to wound center prior to procedure. Cleanse wound and peri wound with non-cytotoxic agent-normal saline, apply barrier cream around wound, apply collagen with silver, finish packing with NS moistened Kerlix AMD, cover with gauze and abdominal pad, secure with medipore tape change daily every day shift order date 10/30/2024, discontinued date 11/12/2024. The TAR indicated this was completed daily from 11/1/2024-11/11/2024. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	Lidocaine External Cream 5 % Apply to L buttocks topically every day shift for pain control & apply prior to wound care and leave for 2 minutes order date 06/15/2024 discontinued date 11/11/2024. The TAR indicated this was completed daily from 11/1/2024-11/10/2024. Wound #1 to left buttock apply lidocaine 5% to wound center prior to procedure. Cleanse wound and periwound with non-cytotoxic agent-normal saline, apply barrier cream around wound, apply collagen with silver, finish packing with NS moistened Kerlix AMD, cover with gauze and abdominal pad, secure with medipore tape change daily every day shift order date 11/12/2024. The TAR indicated this was completed daily from 11/13/2024-11/18/2024. During an interview on 11/18/2024 at 11:32 AM, Resident #19 said the wound care doctor had debrided his wound last week (11/12/2024), and he had been having increased pain during wound ever since. Resident #19 said the pain was while the wound care was being performed. Resident #19 said the pain did not affect his daily activities, eating, or sleep. Resident #19 said he had been asking the nurses to up his pain medication because every nerve ending is on fire. Resident #19 said they had been offloading the wound to help the pain. Resident #19 said he used to be an RN, so he was not big on narcotics (he tried not to use a lot of narcotic medications). Resident #19 said when he could he used Tylenol extra strength which usually took his pain away, but when they did the wound care, he wanted the narcotics because he did not want to hurt. Surveyor asked Resident #19 if observation of wound care could be done. Resident #19 said surveyor was going to get to listen to him holler and curse because the wound care was painful. Resident #19 said today's (11/18/2024) wound care had been completed, but surveyor could observe the wound care tomorrow (11/19/2024) since it was completed daily. Resident #19 said he could not refuse to have the wound care performed because his insurance required him to be compliant with the doctor's orders. During an observation of wound care with the Wound Care NP and LVN B on 11/19/2024 starting at 10:04 AM, Resident #19 was in bed. The Wound Care NP removed Resident #19's dressing and Resident #19 hollered out due to the pain. The Wound Care NP asked if Resident #19 wanted him to stop. Resident #19 said no to continue. The Wound Care NP continued, removed the old dressing, and measured the wound. The Wound Care NP did not apply any spray or creams to Resident #19. The Wound Care NP left, and LVN B started the wound treatment. LVN B started cleaning the wound and Resident #19 hollered out and said he had been in pain ever since the wound was debrided. LVN B asked Resident #19 if he wanted her to stop and he said no. LVN B continued and applied collagen, and Resident #19 continued to holler and said, it feels like somebody's taken a blow torch to my ass, careful please it's very sensitive. LVN B stopped and asked Resident #19, Can you take it?. Resident #19 said don't stop keep going. LVN B continued to pack the wound and Resident #19 again said feels like a torch to my butt. LVN B continued and finished the wound care. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	During an interview on 11/19/2024 at 10:57 AM, LVN B said Resident #19 received two hydrocodone 5-325 mg tablets prior to his wound care treatment today (11/19/2024). LVN B said Resident #19 started seeing the wound care NP last Tuesday (11/12/2024), and the wound care NP debrided Resident #19's wound on 11/12/2024. LVN B said ever since it was debrided Resident #19 had been hollering and screaming more with the wound care. LVN B said she had not contacted the doctor until yesterday afternoon (11/18/2024) and received an order for 2 hydrocodone tablets before wound care treatments. LVN B said Resident #19 was receiving oxycodone, but it was changed to hydrocodone because his insurance would not cover the oxycodone. LVN B said the order for oxycodone should have been discontinued from Resident #19's orders. LVN B said they used lidocaine prior to performing the wound care to help the pain, but when the wound care NP did his wound visits he used lidocaine spray, so she did not apply the lidocaine to Resident #19's wound prior to wound care today (11/19/2024). LVN B said she did not notice the wound care NP did not spray Resident #19 with lidocaine. LVN B said since Resident #19 had been hollering with pain she should have contacted the doctor to have his pain during wound care addressed when she noticed he had increased pain. LVN B said Resident #19 had been complaining of having a burning type of pain and said it was a burning sensation. LVN B said the lidocaine gel helped with the burning sensation, but Resident #19 was still complaining of pain. LVN B said Resident #19's pain tolerance was not very good, and he had a low pain tolerance. LVN B said pain was what the resident said it was. LVN B said she had not reported to the doctor that Resident #19 was having a burning type of pain. LVN B said Resident #19's pain was better today (11/19/2024), but he was still hurting therefore the medication was not effective. LVN B said she would contact the doctor to let him know the medication was not effective during wound care. LVN B said it was important for pain to be adequately addressed because they did not want to hurt Resident #19 and it could cause depression, a decline, and his nutrition to decline. During an attempted phone interview on 11/19/2024 at 12:29 PM, the Medical Director did not answer the phone. During an interview on 11/19/2024 at 12:31 PM, RN D said Resident #19 received pain management prior to starting his wound care. RN D said Resident #19 had a low pain tolerance, and he did complain about pain during the wound care. RN D said she put the lidocaine on the wound prior to doing his wound care and he received hydrocodone 7.5 mg prior to his wound treatment. RN D said she barely removed the tape and Resident #19 hollered with pain, and she would ask him if he wanted her to stop and Resident #19 said to proceed. RN D said the lidocaine relieved some of Resident #19's pain. RN D said Resident #19 described the pain to the wound as sore. RN D said she did not report to the doctor Resident #19 was having pain because he had pain every single time they did the wound care. RN D said the doctor was notified initially and that was why they had the order for the lidocaine and hydrocodone. RN D said Resident #19 wanted them to continue with the wound care because he knew it had to be done. RN D said she stopped and asked him if he wanted her to stop, but he had been having pain with wound care since his admission to the facility. RN D said pain was uncomfortable and it affected someone intensely. RN D said it was not good for the residents to have pain and everybody had a different type of pain. During an interview on 11/19/2024 at 1:27 PM, the Wound Care NP's wound evaluation for 11/12/2024 was requested from the DON and not received upon exit of the facility. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	During an interview on 11/19/2024 at 2:11 PM, the DON said pain medications should be administered 30 minutes prior to wound care. The DON said lidocaine should be applied to Resident #19's wound bed prior to wound care. The DON said in the past she had assessed Resident #19's pain and talked to him about what he wanted them to do. The DON said Resident #19 was having pain and they increased his pain medication hydrocodone 5 mg to 7.5 mg a few days ago. The DON said it was hard to judge Resident #19's pain because even if they got a wipe and just touched him and started turning him, he had the same type of expression of pain as he did during wound care. The DON said ever since the wound was debrided last week (11/12/2024) the wound had been more sensitive and sharper. The DON said the pain medication was increased to 2 tabs today (11/19/2024). The DON said prior to today the nurses had not notified her Resident #19 was having increased pain to his wound. The DON said the nurses should have called the doctor and let him know he was debrided, and the pain medication was no longer sufficient. The DON said if there was a change in condition the nurses should notify the doctor. The DON said they were not going to stop Resident #19 from hollering out. The DON said if Resident #19 was saying the pain medication was not working, they needed to make sure the medication was changed. The DON said the nurses should be assessing the pain and asking the residents if it was something new, where the location was, had the intensity changed, if it was acute or chronic pain, and ask the resident if the medication was effective. The DON said they would also try alternatives for pain relief such as a low air loss mattress, ice pack, repositioning, pain patches. The DON said she did not think their pain assessment included the type of pain the patient was experiencing such as if it was throbbing or burning or what type of pain. The DON said it was hard with someone that was bedbound to do more interventions. The DON said Resident #19 was not receiving therapy for his wound, but he was receiving physical therapy to maintain his mobility. The DON said if a resident's pain was not managed properly, it could affect their mood and their day-to-day activity. During an attempted phone interview on 11/20/2024 at 11:49 AM, the Medical Director did not answer the phone. During an interview on 11/20/2024 at 12:06 PM, the Wound Care NP said last Tuesday (11/12/2024) was the first time he had seen Resident #19, and he may have debrided Resident #19's wound but he was not sure because he usually did not debride on the first visit. The Wound Care NP said Resident #19 had yelled out due to the pain during the first visit, but they asked him if he wanted them to stop and Resident #19 replied no. The Wound Care NP said the way Resident #19 acted during the wound visit this week (11/19/2024) was the example of how he had acted the previous week. The Wound Care NP said, not that I remember he did not have any pain. The Wound Care NP said he only used lidocaine spray when he debrided wounds, therefore he did not use the lidocaine spray on Resident #19 on 11/19/2024. The Wound Care NP said when people are premedicated they do a lot better. The Wound Care NP said Resident #19 had been premedicated on the visit for 11/19/2024. The Wound Care NP said when people received pain medications prior to the wound care visit they did better and were less sensitive. The Wound Care NP said if a person was reporting pain and burning pain, they needed to address the pain with medications. The Wound Care NP said the facility should consider giving Resident #19 pain medications prior to his treatment because he was sensitive to pain. The Wound Care NP said the mental anticipation of pain was making Resident #19's pain more severe. The Wound Care NP said if the current medications being used for pain during wound care were not working, they needed to see what we need to do, increase the dose or have additional medication to help the pain. The Wound Care NP said the facility was responsible for contacting the facility's medical director to obtain orders for pain medication. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	During an interview on 11/20/2024 at 3:22 PM, the Administrator said if a resident was having pain, he expected the nurses to contact the doctor. The Administrator said they wanted to keep pain as low as feasibly possible. The Administrator said some residents had concerns regarding the use of medications for pain, but they should give them over the counter medications and try to abide by their wishes. The Administrator said it was important for the residents' pain to be addressed because pain affected the resident's quality of life in a dramatic fashion. The Administrator said increased pain could be a sign of something emergent and that could be the only warning sign of a condition. Record review of the facility's policy titled, Pain Management Program Policy, revised 01/2023, indicated, The facility will ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management . 4. The facility will identify any situations or interventions where an increase in the resident's pain may be anticipated, for example, wound care, ambulation, or repositioning. Obtain orders for pharmaceutical interventions, pain medications, and or non pharmaceutical interventions such as heat, cold, massage and relaxation etc. and/or refer to therapy for skilled therapeutic interventions . With a new onset of pain, complete a pain evaluation in the EMR. Determine an appropriate pharmacological intervention under the direction of the physician or a non pharmacological intervention. Re-evaluate the resident after 45 min to one hour to determine if your intervention has been effective and document outcome in the EMR/Progress Notes and ensure new orders and updated care plan are completed .The ongoing evaluation of the status (presence, increase or reduction) of a resident's pain is vital, including the status of underlying causes, the response to interventions to prevent or manage pain, and the possible presence of adverse consequences of treatment .If pain has not been adequately controlled, it may be necessary to reconsider the current approaches and revise or supplement them as indicated .

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Lakeview Rehabilitation & Healthcare Center	502 East Coke Rd Winnsboro, TX 75494

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47006 Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable homelike environment for 1 of 2 dining rooms (back dining room) reviewed for cleanliness of the physical environment. The facility failed to ensure the windowsill in the back dining room was free of cobwebs, bugs, and dust from 11/18/24 to 11/20/24. This failure could place residents at risk for a decreased quality of life and an unsanitary environment. The findings included: During an observation on 11/18/24 at 11:51 AM, the windowsill of the back dining room had numerous cobwebs, dead bugs, and a thick layer of gray dust. During an observation on 11/19/24 at 8:34 AM, the windowsill of the back dining room had numerous cobwebs, dead bugs, and a thick layer of gray dust. During an observation on 11/20/24 at 10:31 AM, the windowsill of the back dining room had numerous cobwebs, dead bugs, and a thick layer of gray dust. During an interview on 11/20/24 beginning at 1:03 PM, the Housekeeping Supervisor stated the housekeeping staff were responsible for ensuring the back dining room was cleaned. The Housekeeping Supervisor stated the housekeeping staff worked together to clean the back dining room. The Housekeeping Supervisor stated she worked the floor along with her housekeeping staff. The Housekeeping Supervisor stated cleaning the dining room included: the blinds, windowsills, and walls. The Housekeeping Supervisor stated she should have cleaned the windowsill each time the dining room was cleaned but she had not had time this week. The Housekeeping Supervisor stated it was important to ensure the windowsills were free from cobwebs, bugs, and dust to prevent cross contamination and to ensure the environment was cleaned. During an interview on 11/20/24 beginning at 2:51 PM, the Administrator stated the housekeeping staff were responsible for ensuring the back dining room was cleaned. The Administrator stated the windowsills should have been cleaned at least 3 - 4 times per week. The Administrator stated the facility had recently taken the decorations away to add the fall decorations but hadn't gotten to cleaning the windowsill yet. The Administrator stated the Housekeeping Supervisor was responsible for monitoring to ensure the windowsills were cleaned. The Administrator stated it was important to ensure the windowsills were free from cobwebs, bugs, and dust so it was more hygienic. The Administrator stated it was also important to maintain the cleanliness of the facility to promote resident happiness and comfort. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Homelike Environment policy, revised February 2021, reflected the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include .clean, sanitary and orderly environment .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview and record review the facility failed to ensure assessments accurately reflected the resident status for 1 of 15 residents (Resident # 13) reviewed for MDS assessment accuracy. The facility failed to ensure Resident # 13's dialysis treatments were accurately reflected on her Quarterly MDS assessment with an ARD of 10/28/2024. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: Record review of a face sheet dated 11/20/2024 indicated Resident #13 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included end stage renal disease (kidneys cease functioning on a permanent basis). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #13 was usually understood by others and usually understood others. The MDS assessment indicated Resident #13 had a BIMS score of 10, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #13 required partial/moderate assistance with toileting, showering/bathing self, and supervision or touching assistance with personal hygiene. Resident #13's MDS assessment in Section O, 0110J1 did not indicate she received dialysis while a resident at the facility. Record review of Resident #13's Order Summary report dated 11/19/2024 indicated resident to receive dialysis 3 days a week on Tuesday, Thursday, and Saturday at the dialysis center with a start date of 08/24/2024. Record review of Resident #13's care plan reviewed 11/19/2024 indicated she required hemodialysis related to renal failure. Resident #13's care plan indicated to encourage resident to go for the scheduled dialysis appointments on Tuesday, Thursday, and Saturday. Record review of Resident #13's Dialysis Communication Forms indicated she went to dialysis on 10/22/2024 and 10/24/2024. During an interview on 11/20/2024 at 2:41 PM, the DON said she was the RN that signed the MDS assessments. The DON said there was a care plan review tab that she used so she could review the MDS assessments before signing them. The DON said if dialysis was on the MDS they should have checked it for Resident # 13 because she received dialysis. The DON said she did not know if she had just missed it or what. The DON said it was important for the MDS to be accurate so they knew who triggered (required special monitoring) and they could monitor them. The DON said she did not know how the MDS not being accurate could negatively affect the residents. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/2024 at 3:19 PM, the MDS Coordinator said Resident #13's dialysis should have been coded on the MDS assessment. The MDS Coordinator said she just missed it. The MDS Coordinator said it was important to code the MDS assessments accurately to ensure the MDS accurately reflected the resident's status for accurate reimbursement and to make sure the MDS assessment painted the picture of the resident's care and services. During an interview on 11/20/2024 at 3:17 PM, the Administrator said he expected for the MDS to be accurate, and it should reflect what was being done at the facility. The Administrator said he expected for the MDS Coordinator and the DON to complete the MDS assessments accurately. The Administrator said it was important for the MDS to be coded accurately so it accurately reflected what they did and what the residents needs were and for them to be reimbursed properly. Record review of the facility's, MDS Coding Policy, reviewed January 4, 2023, indicated, .utilize the most up to date Resident Assessment Instrument (RAI) manual for determination of coding each section of the Resident Assessment, timely and accurately. The most current RAI manual may be found on the CMS.gov website. Record review of the Resident Assessment Instrument 3.0 User's Manual, dated October 2024, indicated . O0110J1 code peritoneal or renal dialysis which occurs at the nursing home or at another facility .

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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** 46928 Based on interview and record review, the facility failed to ensure each resident's person-centered comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 of 15 residents (Residents #29), reviewed for care plans. The facility failed to revise Resident #29's care plan to reflect the need for weekly weights and ensure plus three times a day for his weight loss. This failure could affect residents of the facility by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings included: Record review of the Resident #29's order summary report dated 11/20/24, indicated Resident #29 was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of anxiety, protein-calorie malnutrition (inadequate intake of food such as a source of protein, calories, and other essential nutrients), muscle wasting and atrophy (loss of muscle mass and strength), and dysphagia (difficulty swallowing). The order summary report indicated Resident #29 had the following orders: *Enhanced diet, mechanical soft texture, honey thickened consistency, large portions, Nutra freeze cup, with lunch and dinner, double desserts related to unspecified protein-calorie malnutrition with an order start date of 10/17/24. *Ensure Plus three times a day combine with 4 pumps of the simply thick to bring to honey thick consistency with a start date of 09/13/24. *Weekly weight one time a day every Wednesday with a start date 08/28/24. Record review of Resident #29's quarterly MDS assessment dated [DATE], indicated Resident #29 was sometimes understood and sometimes understood others. The MDS assessment indicated Resident #29 had a BIMS score of 0, indicating his cognition was severely impaired. Resident #29 was independent with eating. The MDS assessment indicated Resident #29 had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. Resident #29 was on a mechanically altered diet. Record review of Resident #29's comprehensive care plan revised on 09/27/24, indicated Resident #29 had a potential nutritional problem related to moderate nutritional risk evaluation and weight loss. The care plan interventions indicated for regular diet, mechanical soft texture honey thickened consistency, large protein portions, Nutra freeze cup with lunch and dinner and double desserts. The care plan failed to address Resident #29's orders for weekly weights and ensure plus three times a day. (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 11/20/24 at 1:47 PM, LVN A said Resident #29's care plan should reflect the weekly weights and the ensure plus. LVN A said Resident #29's care plan should be updated so it was known to all staff and charge nurses Resident #29 was being monitored for weight loss. LVN A said failure to update Resident #29's care plan could cause Resident #29 to not receive his supplement or his weekly weight not be obtained. LVN A said she was unsure of who was responsible for updating the care plans. During an interview on 11/20/24 at 1:55 PM, the DON said she expected Resident #29's weight loss interventions to be under his nutrition care plan so staff was aware of what was going on. The DON said since the orders for Resident #29's weekly weight and ensure plus were on his MAR, staff was still able to do the interventions to ensure Resident #29 did not have a weight loss. The DON said the MDS nurse was responsible for ensuring the care plans were updated. During an interview on 11/20/24 at 2:15 PM, the Administrator said he expected the residents' care plans to be based on their assessments to ensure their goals were reached. The Administrator said if the goals changed, then the care plan should be adjusted to reflect the changes. The Administrator said the care plan interventions should have been updated as the care plan was a record, they could use to gage the effectiveness of interventions for future references. The Administrator said the DON and MDS Coordinator were responsible for ensuring the care plans were being updated. During an interview on 11/20/24 at 3:19 PM, the MDS Coordinator said she reviewed physician orders daily and updated the care plan according to the physician's orders. The MDS Coordinator said she also updated the care plans according to the MDS schedule. The MDS Coordinator said she was responsible for updating the care plans. The MDS Coordinator said she missed putting Resident #29's interventions for his weight loss on the care plan. The MDS Coordinator said it was important to ensure the care plans were updated so the CNA's could have properly taken care of the residents. Record review of the facility's policy Care plans- Comprehensive Person-Centered reviewed 2023, indicated . A comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 8. The comprehensive, person-centered care plan will: a. include measurable objectives and timeframes; b. describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychological well-, being . 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents conditions change .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 1 resident (Resident #198) reviewed for incontinence. The facility failed to ensure Resident #198 was provided prompt incontinent care on 11/18/24 when his bed sheets and clothing were wet up to his shoulders and were brown around the edges of the wet spots. These failures could place residents at risk for urinary tract infections, skin breakdown, and a decreased quality of life. The findings included: Record review of the face sheet dated 11/20/24, reflected Resident #198 was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting his right dominant side (weakness or paralysis of the right side after having a stroke). The face sheet reflected Resident #198 developed a urinary tract infection on 11/13/24. Record review of the admission MDS assessment, dated 11/05/24, reflected Resident #198 had clear speech and was usually understood by others. The MDS reflected Resident #198 was usually able to understand others. The MDS reflected Resident #198 had a BIMS score of 14, which indicated no cognitive impairment. The MDS reflected Resident #198 had no behaviors or refusal of care. The MDS reflected Resident #198 required substantial/maximal assistance with toileting hygiene (helper does more than half the effort). The MDS reflected Resident #198 was frequently incontinent of urine. Record review of the comprehensive care plan, revised on 11/13/24, reflected Resident #198 had a urinary tract infection. Record review of the comprehensive care plan, revised on 11/18/24, reflected Resident #198 was incontinent of his bladder. The interventions included: staff to perform incontinent care during daily care and as needed .change clothing as needed after incontinence episodes. Record review of the SBAR assessment dated [DATE], reflected Resident #198 had a suspected UTI. The assessment reflected Resident #198 had symptoms which included increased confusion, and urinary frequency. The assessment reflected the physician ordered blood work and a urinalysis. Record review of the culture and sensitivity report dated 11/12/24, reflected Resident #198 had a high range of Enterococcus Faecalis (pathogen) detected in his urine sample. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the order summary report dated 11/20/24, reflected Resident #198 had an order, which started on 11/13/24, for Levaquin (antibiotic) 500 mg by mouth one time a day for a urinary tract infection. Record review of the MAR dated November 2024 reflected Resident #198 received Levaquin (antibiotic) 500 mg by mouth one time a day for a urinary tract infection. The MAR indicated the order was started on 11/13/24 and was scheduled to end on 11/22/24. During an observation and interview on 11/18/24 beginning at 9:27 AM, Resident #198 was lying in the bed with the head of his bed elevated slightly. Resident #198's sheets were visible wet near his shoulders and the edges of the wet spots on the sheets were brown. Resident #198 stated he wanted assistance getting out of the bed. Resident #198 stated he used his urinal when he was able to reach it. Resident #198 stated he had been wet all night. Resident #198 said he was not affected by his sheets being wet. During an observation and interview on 11/18/24 beginning at 9:35 AM, CNA M and CNA N entered Resident #198 and provided incontinent care. Resident #198 had his urinal under the blankets that was filled with urine. CNA M removed the urinal and told Resident #198 she would have to change his incontinent brief because it was tore to pieces. CNA M and CNA N agreed that Resident #198's bed and bedsheets were wet up to his shoulders. During an interview on 11/19/24 beginning at 3:23 PM, CNA N stated Resident #198 normally used his urinal, but he leaked around it most of the time. CNA N said Resident #198 did not normally require a full bed or linen change due to urine incontinence. CNA N said she was unsure when the night crew completed their last round. CNA N said she normally started her rounds after breakfast. CNA N said she had just started rounding at approximately 9:30 AM when they changed Resident #198. CNA N said it was important to ensure Resident #198 was changed promptly after urination to prevent stinging from the urine and skin breakdown. CNA N stated it could have made Resident #198 smell if it was not cleaned up. During an attempted telephone interview on 11/19/24 at 4:30 PM NA P did not answer the phone. Surveyor was unable to leave a voicemail related to a full voicemail box. A brief text message was sent, and no response was obtained upon exit of the facility. During an interview on 11/19/24 beginning at 4:37 PM, CNA O said rounds were completed typically every 2 - 3 hours. CNA O stated she worked double shifts on evening and night shifts. CNA O said she did not work with Resident #198 on the early morning of 11/18/24. CNA O said NA P was assigned to Resident #198's hall. CNA O stated the last round was started on 11/18/24 at approximately 3:45 AM. During an attempted telephone interview on 11/20/24 at 9:16 AM NA P did not answer the phone. Surveyor was unable to leave a voice message related to the mailbox being full. No return call upon exit of the facility. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 beginning at 10:36 AM, CNA M stated she worked on the day shift. CNA M said she normally started rounds after breakfast. CNA M said Resident #198 sometimes required a full linen bed change due to incontinence. CNA M said Resident #198 used his urinal. CNA M stated on 11/18/24 at approximately 9:30 AM was the first time she had laid eyes on Resident #198. CNA M said she was unsure what time night shift completed their rounds. CNA M said rounds should have been completed at least every 2 hours. CNA M said it was important to ensure Resident #198 was changed promptly after urination to prevent skin breakdown, redness, or open areas. CNA M said not changing Resident #198 promptly after urination could have made his UTI worse. During an interview on 11/20/24 beginning at 1:37 PM, LVN B said incontinent rounds should have been completed at least every 2 hours. LVN B said Resident #198 required total assistance with incontinent care. LVN B said Resident #198 should have been checked at least every 2 hours. LVN B stated she was responsible for monitoring to ensure the CNAs completed their rounds every two hours. LVN B said she looked at the residents first thing in the morning when she arrived, at approximately 7 AM to ensure everything was okay. LVN B stated the CNAs did not report Resident #198 had required a full linen bed change related to incontinence or that his bed had brown rings. LVN B said she expected the CNAs to report those things to her. LVN B said she was unsure what time night shift completed their last rounds. LVN B said it was important to ensure prompt incontinent care was performed to prevent skin breakdown and prevent infections from becoming worse. During an interview on 11/20/24 beginning at 2:18 PM, the DON stated she expected the facility staff to ensure incontinent rounds were completed. The DON stated rounds were constantly completed by the day shift staff. The DON stated she expected night shift to start the last round at approximately 4:30 AM to 5 AM. The DON stated the last round should not have been started any earlier than 4:30 AM and if it was, that was not the normal routine. The DON stated the day shift crew normally started their first rounds after breakfast at approximately 8 AM to 8:30 AM. The DON stated it was important for prompt incontinent care to have been performed to avoid adverse effects such as skin breakdown. The DON stated not performing prompt incontinent would have had no effect on Resident #198's urinary tract infection. During an interview on 11/20/24 beginning at 2:51 PM, the Administrator stated he expected incontinent rounds to have been completed at the start of their shift, during their shift, and at the end of their shift. The Administrator stated if there was down time, they should have been rounding. The Administrator stated the first round and last round were non-negotiable. The Administrator stated the nurse on the hall was responsible for monitoring to ensure incontinent round were completed. The Administrator stated residents who were found wet to their shoulders with the wet spots brown around the edges should have been reported to the charge nurse. The Administrator stated it was important to ensure residents were provided prompt incontinent care to maintain their comfort. The policy for bladder incontinence was requested and not provided upon exit of the facility. During an interview during the exit conference on 11/20/24 beginning at 4:25 PM, the Regional Nurse stated she spoke with NA P regarding Resident #198. The Regional Nurse stated NA P reported he checked Resident #198 at approximately 4:45 AM on 11/18/24 and provided care at that time. No documentation was provided by the Regional Nurse.

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F 0697 Level of Harm - Actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observation, interview, and record review the facility failed to ensure pain management was provided to residents who require such services, consistent with professional standards of practice for 1 of 3 residents (Resident #19) reviewed for pain. The facility failed to ensure Resident #19 received adequate pain management during wound care after he reported increased pain following a wound debridement (removal of dead or unhealthy tissue from the wound to promote the healing process) by the Wound Care NP on 11/12/2024. This failure could place residents at risk for experiencing unnecessary pain and a decreased quality of life. Findings included: Record review of a face sheet dated 11/20/2024 indicated Resident #19 was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included pressure ulcer of sacral region, stage 4 (sore that extends below the subcutaneous fat into the deep tissues, including muscle, tendons, ligaments, and bone in the lower back, buttocks area) and pain. Record review of Resident #19's Quarterly MDS assessment dated [DATE] indicated he was understood by others and was able to understand others. The MDS assessment indicated Resident #19 had a BIMS score of 15, which indicated his cognition was intact. The MDS assessment indicated Resident #19 was dependent for showering/bathing, toileting hygiene, and required supervision or touching assistance for personal hygiene. The MDS assessment indicated Resident #19 received pain medications as needed. The MDS assessment did not indicate Resident #19 received non-medication intervention for pain. The MDS assessment indicated Resident #19 experienced pain occasionally, it occasionally affected his sleep, and it rarely or not at all interfered with his therapy and day-to-day activities. Record review of Resident #19's care plan with a target date of 01/21/2025 indicated he had acute/chronic pain related to low backpain, gout (pain, swelling of the joints), and rhabdomyolysis (muscle injury or breakdown). Interventions included to administer allopurinol, Tylenol, oxycodone as per orders to give half an hour before treatments or care, anticipate the residents need for pain relief and respond immediately to any complaint of pain, and evaluate the effectiveness of pain interventions, review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Resident #19's care plan indicated he had a stage 4 pressure injury/ulcer to left buttock related to obesity, immobility, and refusal of care. Interventions included to administer medications as ordered, monitor/document for side effects and effectiveness, administer treatments as ordered and monitor for effectiveness, and to treat pain as per orders prior to treatment/turning to ensure the resident's comfort. Record review of Resident #19's Order Summary Report dated 11/19/2024 indicated: Oxycodone 10 mg give 1 tablet by mouth every 4 hours as needed for severe pain may use oxycodone 5 mg 2 tablets to equal 10 mg with a start date of 03/19/2024. (continued on next page)

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	675051	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Rehabilitation & Healthcare Center	502 East Coke Rd Winnsboro, TX 75494

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Some	Tylenol give 1000 mg by mouth every 8 hours as needed for pain with a start date of 03/19/2024. Hydrocodone-Acetaminophen 7.5-325 mg give 1 tablet by mouth every 6 hours as needed for pain related to pressure ulcer of sacral region, stage 4 with a start date of 09/29/2024. Wound left buttock apply lidocaine 5% to wound center prior to procedure. Cleanse wound and peri-wound (around the wound) with normal saline, apply barrier cream around wound, apply collagen with silver, finish packing with normal saline moistened Kerlix AMD (gauze dressing used to reduce the growth of bacteria), cover with gauze and abdominal pad, secure with tape, change daily every day shift with a start date of 11/12/2024. Wound left buttock apply lidocaine 5% to wound center prior to procedure. Cleanse wound and peri-wound with normal saline, apply barrier cream around wound, apply collagen with silver, finish packing with normal saline moistened Kerlix AMD, cover with gauze and abdominal pad, secure with tape, change daily every day shift with a start date of 11/13/2024. Hydrocodone-Acetaminophen 5-325 mg give 2 tablets by mouth every 24 hours as needed for pain related to pressure ulcer of sacral region, stage 4 give prior to wound care treatments with a start date of 11/19/2024. Hydrocodone-Acetaminophen 7.5-325 mg give 2 tablets by mouth every day shift related to pain give daily prior to wound care with at start date of 11/19/2024. Record review of Resident #19's Wound-Weekly Observation Tool dated 11/10/2024 indicated he had a stage 4 pressure ulcer to the left buttock which he admitted with. The measurements were length 2 cm, width 1.4 cm, depth 2.5 cm. The wound had undermining (a wound complication that occurs when the edges of the wound separate this creates a pocket of dead space beneath the skin, the damage extends underneath). The Wound-Weekly Observation tool indicated Resident #19 had pain prior to wound treatment. The rating of the resident's pain was left unanswered. Pain interventions included pain medication prior to treatment and lidocaine cream applied in the wound bed. Record review of Resident #19's Wound-Weekly Observation Tool dated 11/12/2024 indicated he had a stage 4 pressure ulcer to the left buttock which he admitted with. The measurements were length 2.9 cm, width 1.4 cm, depth 2.3 cm. The wound had undermining (a wound complication that occurs when the edges of the wound separate this creates a pocket of dead space beneath the skin, the damage extends underneath). The Wound-Weekly Observation tool indicated Resident #19 had pain prior to wound treatment. The rating of the resident's pain was left unanswered. Pain interventions included pain medication prior to treatment and lidocaine cream applied in the wound bed. Record review of Resident #19's progress notes dated 11/12/2024-11/19/2024 did not indicate Resident #19's wound was debrided by the Wound Care NP, and they did not indicate Resident #19 had increased pain. Record review of Resident #19's November 2024 MAR indicated. is this resident in pain? 0 indicated no pain, 1-3 indicated mild pain, 4-6 indicated moderate pain, 7-10 indicated severe pain. 11/12/2024: day shift, evening shift, and night shift indicated 0 (no pain). (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	11/13/2024: day shift and evening shift indicated 0 (no pain), night shift indicated 4 (moderate pain). 11/14/2024: day shift and evening shift indicated 0 (no pain), night shift indicated 4 (moderate pain). 11/15/2024: day shift 1 (mild pain), evening shift 4 (moderate pain), night shift 0 (no pain). 11/16/2024: day shift 4 (moderate pain), evening shift 4 (moderate pain), night shift 0 (no pain). 11/17/2024: day shift 0 (no pain), evening shift 3 (mild pain), night shift 0 (no pain). 11/18/2024: day shift 5 (moderate pain), evening shift 0 (no pain), night shift 0 (no pain). Record review of Resident #19's November 2024 MAR indicated, Norco 7.5-325 mg (Hydrocodone-Acetaminophen) give 1 tablet by mouth every 6 hours as needed for pain related to pressure ulcer of sacral region, stage 4 order date 09/29/2024: Administered 11/13/2024 for pain level of 5, 10:08 AM and was effective. Administered 11/14/2024 for pain level of 4, 8:56 AM and was effective. Administered 11/15/2024 for pain level of 4, 7:30 AM and was effective. Administered 11/15/2024 for pain level of 4, 5:47 PM and was effective. Administered 11/17/2024 for pain level of 9, 9:32 AM and was effective. Administered 11/18/2024 for pain level of 5, 9:01 AM and was effective. Record review of Resident #19's November 2024 MAR indicated; Tylenol Oral Tablet (Acetaminophen) give 1000 mg by mouth every 8 hours as needed for pain order date 03/19/2024: Administered 11/17/2024 for pain level of 8, 5:05 AM and was effective. Administered 11/18/2024 for pain level of 8, 4:59 AM and was effective. Administered 11/18/2024 for pain level of 3, 10:15 AM and was effective. Record review of Resident #19's November 2024 TAR indicated: Apply lidocaine 5% to wound center prior to procedure. Cleanse wound and peri wound with non-cytotoxic agent-normal saline, apply barrier cream around wound, apply collagen with silver, finish packing with NS moistened Kerlix AMD, cover with gauze and abdominal pad, secure with medipore tape change daily every day shift order date 10/30/2024, discontinued date 11/12/2024. The TAR indicated this was completed daily from 11/1/2024-11/11/2024. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Some	Lidocaine External Cream 5 % Apply to L buttocks topically every day shift for pain control & apply prior to wound care and leave for 2 minutes order date 06/15/2024 discontinued date 11/11/2024. The TAR indicated this was completed daily from 11/1/2024-11/10/2024. Wound #1 to left buttock apply lidocaine 5% to wound center prior to procedure. Cleanse wound and periwound with non-cytotoxic agent-normal saline, apply barrier cream around wound, apply collagen with silver, finish packing with NS moistened Kerlix AMD, cover with gauze and abdominal pad, secure with medipore tape change daily every day shift order date 11/12/2024. The TAR indicated this was completed daily from 11/13/2024-11/18/2024. During an interview on 11/18/2024 at 11:32 AM, Resident #19 said the wound care doctor had debrided his wound last week (11/12/2024), and he had been having increased pain during wound ever since. Resident #19 said the pain was while the wound care was being performed. Resident #19 said the pain did not affect his daily activities, eating, or sleep. Resident #19 said he had been asking the nurses to up his pain medication because every nerve ending is on fire. Resident #19 said they had been offloading the wound to help the pain. Resident #19 said he used to be an RN, so he was not big on narcotics (he tried not to use a lot of narcotic medications). Resident #19 said when he could he used Tylenol extra strength which usually took his pain away, but when they did the wound care, he wanted the narcotics because he did not want to hurt. Surveyor asked Resident #19 if observation of wound care could be done. Resident #19 said surveyor was going to get to listen to him holler and curse because the wound care was painful. Resident #19 said today's (11/18/2024) wound care had been completed, but surveyor could observe the wound care tomorrow (11/19/2024) since it was completed daily. Resident #19 said he could not refuse to have the wound care performed because his insurance required him to be compliant with the doctor's orders. During an observation of wound care with the Wound Care NP and LVN B on 11/19/2024 starting at 10:04 AM, Resident #19 was in bed. The Wound Care NP removed Resident #19's dressing and Resident #19 hollered out due to the pain. The Wound Care NP asked if Resident #19 wanted him to stop. Resident #19 said no to continue. The Wound Care NP continued, removed the old dressing, and measured the wound. The Wound Care NP did not apply any spray or creams to Resident #19. The Wound Care NP left, and LVN B started the wound treatment. LVN B started cleaning the wound and Resident #19 hollered out and said he had been in pain ever since the wound was debrided. LVN B asked Resident #19 if he wanted her to stop and he said no. LVN B continued and applied collagen, and Resident #19 continued to holler and said, it feels like somebody's taken a blow torch to my ass, careful please it's very sensitive. LVN B stopped and asked Resident #19, Can you take it?. Resident #19 said don't stop keep going. LVN B continued to pack the wound and Resident #19 again said feels like a torch to my butt. LVN B continued and finished the wound care. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	During an interview on 11/19/2024 at 10:57 AM, LVN B said Resident #19 received two hydrocodone 5-325 mg tablets prior to his wound care treatment today (11/19/2024). LVN B said Resident #19 started seeing the wound care NP last Tuesday (11/12/2024), and the wound care NP debrided Resident #19's wound on 11/12/2024. LVN B said ever since it was debrided Resident #19 had been hollering and screaming more with the wound care. LVN B said she had not contacted the doctor until yesterday afternoon (11/18/2024) and received an order for 2 hydrocodone tablets before wound care treatments. LVN B said Resident #19 was receiving oxycodone, but it was changed to hydrocodone because his insurance would not cover the oxycodone. LVN B said the order for oxycodone should have been discontinued from Resident #19's orders. LVN B said they used lidocaine prior to performing the wound care to help the pain, but when the wound care NP did his wound visits he used lidocaine spray, so she did not apply the lidocaine to Resident #19's wound prior to wound care today (11/19/2024). LVN B said she did not notice the wound care NP did not spray Resident #19 with lidocaine. LVN B said since Resident #19 had been hollering with pain she should have contacted the doctor to have his pain during wound care addressed when she noticed he had increased pain. LVN B said Resident #19 had been complaining of having a burning type of pain and said it was a burning sensation. LVN B said the lidocaine gel helped with the burning sensation, but Resident #19 was still complaining of pain. LVN B said Resident #19's pain tolerance was not very good, and he had a low pain tolerance. LVN B said pain was what the resident said it was. LVN B said she had not reported to the doctor that Resident #19 was having a burning type of pain. LVN B said Resident #19's pain was better today (11/19/2024), but he was still hurting therefore the medication was not effective. LVN B said she would contact the doctor to let him know the medication was not effective during wound care. LVN B said it was important for pain to be adequately addressed because they did not want to hurt Resident #19 and it could cause depression, a decline, and his nutrition to decline. During an attempted phone interview on 11/19/2024 at 12:29 PM, the Medical Director did not answer the phone. During an interview on 11/19/2024 at 12:31 PM, RN D said Resident #19 received pain management prior to starting his wound care. RN D said Resident #19 had a low pain tolerance, and he did complain about pain during the wound care. RN D said she put the lidocaine on the wound prior to doing his wound care and he received hydrocodone 7.5 mg prior to his wound treatment. RN D said she barely removed the tape and Resident #19 hollered with pain, and she would ask him if he wanted her to stop and Resident #19 said to proceed. RN D said the lidocaine relieved some of Resident #19's pain. RN D said Resident #19 described the pain to the wound as sore. RN D said she did not report to the doctor Resident #19 was having pain because he had pain every single time they did the wound care. RN D said the doctor was notified initially and that was why they had the order for the lidocaine and hydrocodone. RN D said Resident #19 wanted them to continue with the wound care because he knew it had to be done. RN D said she stopped and asked him if he wanted her to stop, but he had been having pain with wound care since his admission to the facility. RN D said pain was uncomfortable and it affected someone intensely. RN D said it was not good for the residents to have pain and everybody had a different type of pain. During an interview on 11/19/2024 at 1:27 PM, the Wound Care NP's wound evaluation for 11/12/2024 was requested from the DON and not received upon exit of the facility. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	During an interview on 11/19/2024 at 2:11 PM, the DON said pain medications should be administered 30 minutes prior to wound care. The DON said lidocaine should be applied to Resident #19's wound bed prior to wound care. The DON said in the past she had assessed Resident #19's pain and talked to him about what he wanted them to do. The DON said Resident #19 was having pain and they increased his pain medication hydrocodone 5 mg to 7.5 mg a few days ago. The DON said it was hard to judge Resident #19's pain because even if they got a wipe and just touched him and started turning him, he had the same type of expression of pain as he did during wound care. The DON said ever since the wound was debrided last week (11/12/2024) the wound had been more sensitive and sharper. The DON said the pain medication was increased to 2 tabs today (11/19/2024). The DON said prior to today the nurses had not notified her Resident #19 was having increased pain to his wound. The DON said the nurses should have called the doctor and let him know he was debrided, and the pain medication was no longer sufficient. The DON said if there was a change in condition the nurses should notify the doctor. The DON said they were not going to stop Resident #19 from hollering out. The DON said if Resident #19 was saying the pain medication was not working, they needed to make sure the medication was changed. The DON said the nurses should be assessing the pain and asking the residents if it was something new, where the location was, had the intensity changed, if it was acute or chronic pain, and ask the resident if the medication was effective. The DON said they would also try alternatives for pain relief such as a low air loss mattress, ice pack, repositioning, pain patches. The DON said she did not think their pain assessment included the type of pain the patient was experiencing such as if it was throbbing or burning or what type of pain. The DON said it was hard with someone that was bedbound to do more interventions. The DON said Resident #19 was not receiving therapy for his wound, but he was receiving physical therapy to maintain his mobility. The DON said if a resident's pain was not managed properly, it could affect their mood and their day-to-day activity. During an attempted phone interview on 11/20/2024 at 11:49 AM, the Medical Director did not answer the phone. During an interview on 11/20/2024 at 12:06 PM, the Wound Care NP said last Tuesday (11/12/2024) was the first time he had seen Resident #19, and he may have debrided Resident #19's wound but he was not sure because he usually did not debride on the first visit. The Wound Care NP said Resident #19 had yelled out due to the pain during the first visit, but they asked him if he wanted them to stop and Resident #19 replied no. The Wound Care NP said the way Resident #19 acted during the wound visit this week (11/19/2024) was the example of how he had acted the previous week. The Wound Care NP said, not that I remember he did not have any pain. The Wound Care NP said he only used lidocaine spray when he debrided wounds, therefore he did not use the lidocaine spray on Resident #19 on 11/19/2024. The Wound Care NP said when people are premedicated they do a lot better. The Wound Care NP said Resident #19 had been premedicated on the visit for 11/19/2024. The Wound Care NP said when people received pain medications prior to the wound care visit they did better and were less sensitive. The Wound Care NP said if a person was reporting pain and burning pain, they needed to address the pain with medications. The Wound Care NP said the facility should consider giving Resident #19 pain medications prior to his treatment because he was sensitive to pain. The Wound Care NP said the mental anticipation of pain was making Resident #19's pain more severe. The Wound Care NP said if the current medications being used for pain during wound care were not working, they needed to see what we need to do, increase the dose or have additional medication to help the pain. The Wound Care NP said the facility was responsible for contacting the facility's medical director to obtain orders for pain medication. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	During an interview on 11/20/2024 at 3:22 PM, the Administrator said if a resident was having pain, he expected the nurses to contact the doctor. The Administrator said they wanted to keep pain as low as feasibly possible. The Administrator said some residents had concerns regarding the use of medications for pain, but they should give them over the counter medications and try to abide by their wishes. The Administrator said it was important for the residents' pain to be addressed because pain affected the resident's quality of life in a dramatic fashion. The Administrator said increased pain could be a sign of something emergent and that could be the only warning sign of a condition. Record review of the facility's policy titled, Pain Management Program Policy, revised 01/2023, indicated, The facility will ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management . 2. The facility will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. 3. The facility will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity .4. The facility will identify any situations or interventions where an increase in the resident's pain may be anticipated, for example, wound care, ambulation, or repositioning. Obtain orders for pharmaceutical interventions, pain medications, and or non pharmaceutical interventions such as heat, cold, massage and relaxation etc. and/or refer to therapy for skilled therapeutic interventions .For pain that is not managed through the current care plan, whether pharmaceutical or non-pharmaceutical, the resident should be assessed for new causes of the pain and/or the need for a change in frequency, dose or a new intervention. Break through pain may require the use of a PRN or additional type of pain medication .7. Resident pain should also be assessed prior to dressing changes (wound care) and properly medicated (typically 30 minutes or more before wound care) to reduce or alleviate pain appropriately. Resident may also benefit from Physical Therapy wound care modalities to reduce pain with wound care .With a new onset of pain, complete a pain evaluation in the EMR. Determine an appropriate pharmacological intervention under the direction of the physician or a non pharmacological intervention. Re-evaluate the resident after 45 min to one hour to determine if your intervention has been effective and document outcome in the EMR/Progress Notes and ensure new orders and updated care plan are completed .The ongoing evaluation of the status (presence, increase or reduction) of a resident's pain is vital, including the status of underlying causes, the response to interventions to prevent or manage pain, and the possible presence of adverse consequences of treatment .If pain has not been adequately controlled, it may be necessary to reconsider the current approaches and revise or supplement them as indicated .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview and record review the facility failed to ensure residents who require dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 1 resident (Resident #13) reviewed for dialysis. The facility failed to keep ongoing communication with the dialysis facility for Resident #13 on 09/12/2024, 09/14/2024, 09/21/2024, 09/28/2024, 10/10/2024, 10/12/2024, 10/19/2024, 10/26/2024, 11/02/2024, and 11/09/2024. These failures could place residents at risk for complications and not receiving proper care and treatment to meet their needs. Findings included: Record review of a face sheet dated 11/20/2024 indicated Resident #13 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included end stage renal disease (kidneys cease functioning on a permanent basis). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #13 was usually understood by others and usually understood others. The MDS assessment indicated Resident #13 had a BIMS score of 10, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #13 required partial/moderate assistance with toileting, showering/bathing self, and supervision or touching assistance with personal hygiene. Resident #13's MDS assessment in Section O, 0110J1 did not indicate she received dialysis while a resident at the facility. Record review of Resident #13's Order Summary report dated 11/19/2024 indicated resident to receive dialysis 3 days a week on Tuesday, Thursday, and Saturday at the dialysis center with a start date of 08/24/2024. Record review of Resident #13's care plan reviewed 11/19/2024 indicated she required hemodialysis related to renal failure. Resident #13's care plan indicated to encourage resident to go for the scheduled dialysis appointments on Tuesday, Thursday, and Saturday. Record review of Resident #13's Dialysis Communication Forms for September 2024, October 2024, and November 2024 indicated there was no communication forms for 09/12/2024, 09/14/2024, 09/21/2024, 09/28/2024, 10/10/2024, 10/12/2024, 10/19/2024, 10/26/2024, 11/02/2024, and 11/09/2024. During an interview on 11/19/2024 at 4:33 PM, Dialysis RN F said she was the charge nurse at the dialysis clinic, and Resident #13 received treatments on Tuesday, Thursday, and Saturday. Dialysis RN F said sometimes they received a communication sheet for Resident #13 and sometimes they did not. Dialysis RN F said the dialysis communication sheets were completed to communicate with the facility if there were any problems with the patient during dialysis and any changes with orders. Dialysis RN F said vital signs (blood pressure, heart rate) and weights were also wrote on the communication sheet to monitor the patient for changes and so the facility had an accurate weight for the patient. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/2024 at 9:43 AM, LVN A said Resident #13's dialysis communication sheets should be completed every time she went to dialysis. LVN A said the dialysis communication sheets were used to communicate with the dialysis clinic regarding Resident #13's dialysis treatments. LVN A said Resident #13's scheduled dialysis days were Tuesday, Thursday, and Saturday. LVN A said about three weeks ago Resident #13 had been moved rooms to her side, and she may have missed some (missed filling out dialysis communication sheets) when she was moved over. LVN A said it was important for the dialysis communication sheets to be filled out, so the dialysis clinic knew who Resident #13's nurses were in case they needed something or needed to report anything abnormal and for the dialysis clinic to know who they needed to get in touch with for any questions. During an interview on 11/20/2024 starting at 11:32 AM, LVN G said she completed dialysis communication sheets for Resident #13. LVN G said she did not remember if she had missed some or not, but if she had missed some it might have been a mistake. LVN G said it was important for them to use the dialysis communication sheets to ensure they were not missing anything, for any changes in orders, and to see if Resident #13 had any changes from her baseline. During an interview on 11/20/2024 at 10:44 AM, Dialysis RN F said in September 2024, October 2024, and November 2024 the only missed treatments for Resident #13 were on 09/03/2024, 09/07/2024, and 11/14/2024. During an interview on 11/20/2024 at 2:45 PM, the DON said the nurses should be sending the dialysis communication form for proper communication with the dialysis clinic, so they knew what was going on with the resident. The DON said she did not have a monitoring system in place to ensure this was being done. The DON said if communication with the dialysis clinic was not occurring the dialysis clinic would not know if there were any changes with the residents. During an interview on 11/20/2024 at 3:20 PM, the Administrator said the nurse on the hall was responsible for sending the communication form and communicating with the dialysis clinic. The Administrator said the DON was over the nurses and should monitor this. The Administrator said it was important for the dialysis communication forms to be completed to ensure they were aware of the residents' condition if the appointment went bad or if they were having issues, it gave them information to better prepare the residents for the next treatment. Record review of the facility's policy titled, QA-Dialysis Protocol, revised 08/11/2020, indicated, The following steps are being taken to ensure that the facility has an effective and functional protocol . 2. When a resident is sent to dialysis center, a transfer sheet (communication sheet) will accompany the resident to dialysis center . 3. On completion of the treatment at dialysis center a communication form will be sent with resident on return .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interviews and record review, the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 2 residents (Resident #35) reviewed for trauma-informed care The facility failed to adequately assess Resident #35's history of trauma. This failure could place residents at an increased risk for severe psychological distress due to re-traumatization. The findings included: Record review of Resident #35's face sheet dated 11/20/24, indicated a [AGE] year-old male who admitted to the facility initially on 08/24/22 and readmitted on [DATE]. Resident #35 had diagnosis of paranoid schizophrenia (mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs), post-traumatic stress disorder (a mental health condition that's caused by an extremely stressful or terrifying event), personality disorder (mental health condition that involves long-lasting, disruptive patterns of thinking, behavior, mood and relating to others) and major depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Record review of Resident #35's quarterly MDS assessment dated [DATE], indicated Resident was usually understood and usually understood others. The MDS assessment indicated Resident #35 had a BIMS score of 13, indicating his cognition was intact. The MDS assessment indicated Resident #35 had a diagnosis of Post Traumatic Stress Disorder. Record review of Resident #35's comprehensive care plan revised on 11/19/24, indicated Resident #35 had the potential to be physically aggressive related to anger (PTSD), and poor impulse control. The care plan interventions included for psychiatric consult as indicated, and to document observed behavior and attempted interventions in behavior log. The care plan did not address Resident #35's triggers for his PTSD. Record review of the psychiatric progress notes dated 10/28/24, indicated Resident #35 had a medical necessity related to anxiety disorder, paranoid schizophrenia, personality disorder, and post-traumatic stress disorder. The progress note indicated the goals were to reduce anxiety through weekly psychotherapy with emphasis on coping with depression and anxiety, while identifying triggers. Record review of Resident #35's initial social history assessment with an effective date of 08/24/22 and completed by the previous SW, indicated Resident #35 had a psychiatric history and had a psychiatric admission 7 months previously for a crisis regarding his family member's health. The social history assessment did not indicate his PTSD diagnosis or his triggers. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/24 at 2:37 PM, Resident #35 said he had a diagnosis of PTSD because in 1978 he was at a party, had been intoxicated and some men took him to a room and held him down. He said they blindfolded him, was given a gun and was told to shoot. Resident #35 said he heard screaming and was extremely bothered by it. Resident #35 said his triggers were that he could not stand being in an enclosed area, the blinds being closed, or being by himself . Resident #35 did not indicate if he had any triggers while at the facility. During an interview on 11/19/24 at 2:52 PM, LVN A said she was unsure if Resident #35 had a diagnosis of PTSD. LVN A reviewed Resident #35's EMR and said Resident #35 did have a diagnosis of PTSD. LVN A said there were no documented triggers on Resident #35's care plan and she was not aware of any triggers Resident #35 had. LVN A said Resident #35 was being seen by psychiatric services for his schizophrenia diagnosis and behaviors. LVN A said the trauma assessments were completed by the social worker. LVN A said she would assume if a resident had a diagnosis of PTSD, then his triggers should be documented so staff was aware. LVN A said failure to identify Resident #35's triggers could cause him to become unsafe, agitated, and potentially become a danger to himself. During an interview on 11/19/24 at 3:03 PM, the SW said she had been working at the facility for 11 months. The SW said the trauma assessments were completed on admission and as needed. The SW said she was aware of Resident #35's diagnosis of PTSD but was unfamiliar with his triggers. The SW said staff should be aware of Resident #35's triggers to know how to handle them. The SW said the MDS Coordinator was responsible for updating the care plans. The SW said the identified triggers should be on the care plan so the behavior could be prevented. During an interview of 11/19/24 at 3:11 PM, the MDS Coordinator said she was responsible for updating the care plans. The MDS Coordinator said she was aware of Resident #35's diagnosis of PTSD but was unsure of his triggers. The MDS Coordinator said if a resident had a diagnosis of PTSD, then the identified triggers should be on their comprehensive care plan to ensure the staff knew what set them off and how to care for the resident. During an interview on 11/20/24 at 12:09 PM, CNA N said she was unaware of Resident #35's diagnosis of PTSD or any triggers. CNA N said staff should be aware of any triggers so they could know how to care for the resident. CNA N said the nurse was responsible for relaying any identified triggers to the CNAs. During an interview on 11/20/24 at 1:55 PM, the DON said Resident #35 had never said anything to her about trauma or triggers in his life at any time. The DON said staff needed to be aware of any triggers so Resident #35 could have a good quality of life. The DON said trauma assessments were completed by the SW on admission. The DON said it was never brought to her attention Resident #35 had a diagnosis of PTSD and if they had known, they would have put the proper measures in place. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 2:15 PM, the Administrator said he was not personally aware of Resident #35's diagnosis of PTSD. The Administrator said Resident #35 had attention seeking behavior and had a tendency of making up a lot of things . The Administrator said Resident #35 had said some things he was unsure of if they were factually correct or were told to just get a rise out of someone. The Administrator said Resident #35 had never spoken to him about any triggers. The Administrator said he took mental distress very seriously. He said it was important to identify someone's triggers so they could know what to avoid and be ready for when those triggers occurred to provide the resident with comfort and solace. The Administrator said social services was responsible for ensuring the trauma assessments were completed with the updated care plan with triggers in place. The Administrator said he was unsure of when the trauma assessments were to be completed but assumed on admission or during annual review. Record review of the facility policy Trauma-Informed and Culturally Competent Care reviewed January 2023, indicated . To guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice. To address the needs of trauma survivors by minimizing triggers and/or re-traumatization . Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful, or life threatening and that has lasting adverse effects on the individuals functioning and mental, physical, social, emotional, or spiritual well-being Resident screening. 1. Perform universal screening of residents, which includes a brief, non-specialized identification of possible exposure to traumatic events . 3. Screening may include information such as: a. trauma history, including type, severity and duration . f. historical mental health diagnosis . 4. Utilize initial screening to identify the need for further assessment and care. Resident Care planning. 1. Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. 2. Identify and decrease exposure to triggers that may re-traumatize the resident .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview and record review, the facility failed to ensure that residents were free of significant medication errors for 2 of 6 residents (Resident #13 and Resident #41) reviewed for pharmacy services. The facility failed to ensure Resident #13's amlodipine (medication that lowers blood pressure) was not administered when her blood pressure was outside of the ordered parameters on 11/16/24. The facility failed to ensure Resident #41's carvedilol (medication that lowers blood pressure) was not administered when her blood pressure was outside of the ordered parameters on 11/09/24. These failures could place residents at risk of medical complications and not receiving the therapeutic effects of their medications. Findings included: 1. Record review of a face sheet dated 11/20/2024 indicated Resident #13 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included end stage renal disease (kidneys cease functioning on a permanent basis) and hypertension (high blood pressure). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #13 was usually understood by others and usually understood others. The MDS assessment indicated Resident #13 had a BIMS score of 10, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #13 required partial/moderate assistance with toileting, showering/bathing self, and supervision or touching assistance with personal hygiene. Record review of Resident #13's Order Summary report dated 11/19/2024 indicated an order for amlodipine 10 mg give 1 tablet by mouth one time a day hold for systolic blood pressure (top number and refers to the amount of pressure experienced by the arteries when the heart beats) <100 (less than 100) or diastolic blood pressure (bottom number and refers to the amount of pressure while the heart is resting) <60 (less than 60). Record review of Resident #13's care plan reviewed 11/19/2024 did not address management of Resident #13's hypertension. Record review of Resident #13's November 2024 MAR indicated: Amlodipine 10 mg give 1 tablet by mouth one time a day hold for systolic blood pressure <100 or diastolic blood pressure <60 with an order date of 09/09/2024. On 11/16/2024 Resident #13's blood pressure was 99/71, which indicated the systolic blood pressure was less than 100. The medication was marked as administered by LVN G. 46928 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #41's face sheet dated 11/20/24, indicated an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included cerebral infarction (condition that occurs when blood flow to the brain is blocked, resulting in brain tissue death), atrial fibrillation (irregular heart rhythm), essential hypertension (high blood pressure), and hyperlipidemia (excess of lipids or fats in the blood). Record review of Resident #41's quarterly MDS assessment dated [DATE], indicated Resident #41 was sometimes understood and sometimes understood others. The MDS assessment indicated Resident #41 had a BIMS score of 02, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #41 had an active diagnosis of hypertension. Record review of Resident #41's comprehensive care plan dated 09/23/24, indicated Resident #41 had altered cardiovascular status related to atrial fibrillation, hypertension, and hyperlipidemia. The care plan interventions indicated to give carvedilol as ordered. Record review of Resident #41's order summary reported dated 11/20/24, indicated Resident #41 had an order for carvedilol 25 mg tablet give one tablet two times a day related to essential hypertension and to hold if systolic blood pressure less than 100, diastolic blood pressure less than 60, or heart rate less than 55 with an order date of 06/19/24. Record review of Resident #41's medication administration record dated 11/1/24- 11/30/24, indicated Resident #41 had orders for carvedilol 25mg one tablet by mouth two times a day for essential hypertension with instructions to hold for SBP less than 100, DBP less than 60, or HR less than 55. * On 11/09/24 for AM dose, Resident #41's blood pressure was 95/65. The medication administration record had a check mark which indicated Resident #41 was administered a carvedilol 25mg tablet outside the ordered parameters by LVN G. During an interview on 11/20/2024 starting at 11:32 AM, LVN G said she did not hold Resident #13's amlodipine. LVN G said she administered Resident #13's blood pressure medication when Resident #13's blood pressure was 99/71 on 11/16/2024. LVN G said she was aware Resident #13's orders were to hold for systolic blood pressure <100. LVN G said she administered the amlodipine even though Resident #13's blood pressure was low because she knew when Resident #13 went to dialysis her blood pressure went up, so she needed it. LVN G said she had administered Resident #41's carvedilol when her blood pressure was 95/65. LVN G said she was aware Resident #41's orders instructed to hold blood pressure for systolic blood pressure <100. LVN G said she administered the carvedilol because Resident #41's blood pressure went up later in the day. LVN G said the nurses that had trained her instructed her to give blood pressure medication if the resident's blood pressure was out of parameters, but it was borderline. LVN G said to her knowledge Resident #13 and Resident #41 had not been affected by her administering the blood pressure medications with their blood pressures out of the required parameters. LVN G said it was different nurses who trained her. LVN G said if residents received blood pressure medication when the blood pressure was lower than the required parameters, their blood pressures could go down more, they might have to go to the ER, or get even more sick. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/2024 at 3:04 PM, the DON said if during medication administration a resident's blood pressure was low the nurses could call the doctor, and he could advise them or they could hold the medication, go back later, and check the blood pressure to see if it had gone up. The DON said if the resident's blood pressure was not within parameters, the nurses should not give the medication, they should hold it. The DON said Resident #13's amlodipine besylate should not have been administered if her blood pressure was 99/71, and the doctors order was to hold for systolic blood pressure <100. The DON said Resident #41's carvedilol should not have been administered if her blood pressure was 95/65, and the doctors order was to hold for systolic blood pressure <100. The DON said in the past she had in serviced the nurses and let them know that they should follow the parameters ordered by the doctor. The DON said she did not review resident's MARs, and she had no system in place for monitoring the nurses to ensure they were administering medications within the required parameters. The DON said administering blood pressure medications when the blood pressure was not within the required parameters could result in the blood pressure being lowered more and in lethargy (drowsy, tired, decreased alertness) and syncope episodes (fainting). During an interview on 11/20/24 at 3:42 PM, the Administrator said he expected the nurses to follow proper administration protocols for all medications. If the blood pressure was out of range the nurses should not give the medication until the blood pressure was back in range. The Administrator said the DON was responsible for providing oversight to ensure the nurses were properly administering medications. The Administrator said on the weekend the RN supervisor should monitor the nurses and report to the DON any issues. The Administrator said it was important for the parameters to be followed because it can throw it (blood pressure) in the opposite direction. The Administrator said if the blood pressure was high or low it could cause the opposite problem for the resident. Record review of the facility's policy Medication Administration dated 07/08/24, indicated . Medications are administered in a safe and timely manner, and as prescribed . 11. The following information is checked/verified for each resident prior to administering medications: a. allergies to medications; and b. vital signs, if necessary .

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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** 46892 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. The facility failed to ensure: the toaster was clean. the fryer and oil were clean. An opened loaf of bread was labeled and stored properly. Opened enchilada sauce was stored properly. An opened box of corn dogs was stored properly. An opened box of bacon was stored properly. A container of leftover beans dated [DATE] was discarded. An opened ,d+[DATE] gallon of chocolate milk with a best by date of [DATE] was discarded. The temperature of the top freezer in the dining room was monitored. The top freezer did not have brown residue in it. These failures could place residents at risk for foodborne illness. Findings included: During an observation of the kitchen on [DATE], starting at 9:14 AM, accompanied by the Dietary Manager the following observations were made: Cooking area the fryer had oil that was dark with many crumbs in the oil and around the fryer. the toaster had many crumbs in the bottom and around it. Dry storage room an opened loaf of bread with no open date on it, the end of the bag had been tucked up underneath it, it was not sealed properly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	opened enchilada sauce container dated ,d+[DATE] (no year) label instructed to refrigerate after opening. Right Freezer opened corn dog box was not sealed properly, corn dogs had freezer burn on them. Refrigerator in the kitchen opened box of bacon not properly sealed. container with leftover beans dated [DATE]. Milk box ,d+[DATE] gallon of chocolate milk opened with a best by date [DATE]. During an observation and interview on [DATE] at 11:52 AM, the refrigerator in the dining room did not have a thermometer in the top freezer. There were 18 loaves of frozen bread in the top freezer. There was thick brown residue inside the top freezer on the second shelf of the door which had also leaked onto the bottom of the top freezer. Dietary Aide K said there was not a thermometer in the top freezer, and there had not been one in there. Dietary Aide K said they had been checking the temperature of the bottom part of the refrigerator but not the top freezer. The Dietary Manager said the dietary staff should be monitoring the temperature of all the freezers and refrigerators daily. The Dietary Manager said she thought the dietary aides were checking the temperature of the freezer. The Dietary Manager said she was not aware the freezer did not have a thermometer, but it should have its own separate thermometer for the dietary staff to monitor the temperatures. The Dietary Manager said she was not aware of the top freezer having brown residue, and that the dietary staff should be cleaning the top freezer and refrigerator. The Dietary Manager said she would take care of it. During an attempted phone interview on ,d+[DATE] at 2:37 PM, Dietary Aide K did not answer the phone. During an attempted phone interview on [DATE] at 2:38 PM, [NAME] L did not answer the phone. (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 2:29 PM, the Dietary Manager said the fryer and oil were dirty because they only cleaned it once a week, and she had cleaned it last week. The Dietary Manager said all the cooks were responsible for cleaning the fryer and oil, but she was the one that cleaned it. The Dietary Manager said it was important for the fryer and oil to be clean so the food would taste better. The Dietary Manager said if food was labeled to refrigerate after opening it should be placed the refrigerator after opening it. The Dietary Manager said it was important to follow the instructions to prevent the residents from getting sick. The Dietary Manager said everything in the freezer and refrigerator that had been opened should be stored in a Ziploc bag or something closed, it should not be left exposed. The Dietary Manager said it was important to ensure food was stored sealed to prevent freezer burn and because it could make someone sick and freezer burn did not taste good. The Dietary Manager said whoever opened the item should make sure it was stored properly, and that it was a team effort. The Dietary Manager said ultimately, she was supposed to make sure food was stored properly. The Dietary Manager said she was supposed to check every day, but if she was the cook, she did not have the time to check. The Dietary Manager said the person that opened the food should label it, seal it, and date it. The Dietary Manager said it was important to open it, seal it, and date it to prevent rodents and bugs. The Dietary Manager said they had a milk man that brought them milk and placed it in the milk box. The Dietary Manager said he took out the old milk and replaced it with new milk, but they should not have trusted him to do that. The Dietary Manager said she could not say they had been checking the milk for expiration dates. The Dietary Manager said she thought they could store leftovers for 7 days that she was not aware it was 72 hours. The Dietary Manager said it was important to discard food because it could cause people to be sick. The Dietary Manager said she went through the fridge daily to ensure everything was discarded promptly. The Dietary Manager said the toaster was cleaned weekly, but it should be cleaned before if they noticed it was dirty. The Dietary Manager said it was important for the toaster to be clean to prevent buildup because it could catch on fire and to prevent pests. The Dietary Manager said she was not thinking about the refrigerator and freezer in the dining room being separate and requiring separate temperature checks. The Dietary Manager said proper temperatures and monitoring the temperatures was important to prevent freezer burn and for food not to thaw out and go bad. The Dietary Manager said the temperatures not being monitored could result in the residents getting bad food and they could have diarrhea, vomiting, and e. coli (bacteria can cause serious food poisoning or other diseases). During an interview on [DATE] at 3:31 PM, the Administrator said anytime the fryer was visibly splashed, it should be cleaned. The Administrator said the frying oil should be clean. The Administrator said he expected for the food to be covered and sealed, and if possible dated. The Administrator said it was important for the food to be protected from direct exposure. The Administrator said milk should be thrown out past its best by date. The Administrator said he expected for all items in the kitchen to be dated when opened, so if anything went past the date where there was a risk for contamination, they should get rid of it and replace it. The Administrator said he expected for temperatures on the freezer and refrigerators to be monitored and each to have its own thermometer. The Administrator said this allowed them to better safeguard the resident's health by preventing serving them anything spoiled and unsanitary. The Administrator said it was important to check the temperatures to ensure they were kept below the FDAs regulated safe temperatures. The Administrator said it was important for there to be cleanliness in the kitchen to ensure it was a sanitary environment and keeping the area free of crumbs and dirt avoided attracting vermin and insects to keep the kitchen a more sanitary area. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Weekly Cleaning Log for [DATE], indicated there were no initials listed next to the fryer to indicate it had been cleaned in the month of [DATE], and the toaster was not listed on the cleaning log. Record review of the facility's undated policy titled, Dry Storage, indicated, .9. If an item is opened, the food must be tightly sealed. It should be dated with the date that it was opened. If the product was removed from its original container, then the product should also have the name of the product. If using large bags to seal open items in their original packaging, the bag maybe reused, but needs to be re-dated. IF the food is directly in the bag, the bag must be labeled and dated, and when the bag is emptied, it should be discarded. Bags must be sealed .11. Bags of bread products should be closed and dated with the date that it was opened . Record review of the facility's undated policy titled, Refrigerator and Freezer Storage, indicated, .All left over foods should be labeled and dated with the date in and the date out (date the food is to be discarded) -this date can be no more than 72 hours after it was put in the refrigerator .All expired foods must be removed from the refrigerator and freezer .If an item is opened, the food must be tightly sealed. It should be dated with the date that it was opened .The refrigerator and freezers should have inside thermometers. The temperature should be recorded twice a day . Record review of the facility's undated policy titled, Developing A Cleaning Schedule, indicated, Purpose: To establish and maintain the kitchen in a sanitary manner. Procedure: Manager will use either the approved [NAME] cleaning schedule Form that has been modified to meet their facility, or develop a cleaning schedule for their facility. Must have a form for Daily, Weekly and monthly, to assure that all areas of the kitchen are cleaned .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675051	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Rehabilitation & Healthcare Center	502 East Coke Rd Winnsboro, TX 75494

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46892 Based on observation, interview, and record review the facility failed to 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 1 of 1 linen cart reviewed for infection control. The facility failed to ensure Laundry Aide H completely covered the linen cart while delivering the residents clean clothing on 11/20/2024. This failure could place residents at risk for cross-contamination and the spread of infection. Findings included: During an observation on 11/20/2024 at 8:10 AM, Laundry Aide H was observed going down the hallway passing out the residents clean clothing with the clothing exposed. Laundry Aide H had the linen cart halfway uncovered with a blanket. During an interview with the Housekeeping Supervisor and Laundry Aide H on 11/20/2024 at 11:56 AM, Laundry Aide H said when she was passing the clean laundry, she should make sure the linen cart was completely covered and the clothes were not exposed. Laundry Aide H said she thought the blanket she had used over the linen cart had covered the clothes enough. Laundry Aide H said the linen cart with the clean clothes should be covered because of germs. The Housekeeping Supervisor said when the laundry aides were passing the clean laundry out to the residents, they should make sure the linen cart was completely covered. The Housekeeping Supervisor said they should use a flat white sheet to ensure the clothes were completely covered to prevent cross contamination. During an interview on 11/20/2024 at 3:28 PM, the Administrator said when the residents' clothes were passed on the linen cart it should be covered. The Administrator said they did not want clothes exposed to pathogens, dirt or anything that was going to undermine the sanitization process in between the laundry room and getting to the residents' closets. Record review of the facility's policy titled, Departmental (Environmental Services) - Laundry and Linen, reviewed January 2023, indicated, Purpose The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen . Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts .