STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675076	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Llano Nursing and Rehabilitation Center	800 W Haynie St Llano, TX 78643

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 - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097 Based on observations, interviews, and record review the facility failed to ensure residents received services in the facility with reasonable accommodations of resident's needs and preferences except when to do so would endanger the health and safety of the resident or other residents for 5 of 5 residents (Resident #6, Resident #8, Resident #11, Resident #13, and Resident #23) reviewed for resident rights. The facility failed to ensure Resident #6, Resident #8, Resident #11, Resident #13, and Resident #23's call lights was within reach on 08/05/2024, 08/06/2024 and 08/08/2024. This failure could place residents at risk of needs not being met. Findings included: Record review of Resident #6's Admission Record dated 08/06/24 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included Cerebral palsy (a group of conditions that affect movement and posture), Other specified disorders of teeth and supporting structures, Unsteadiness on feet, Weakness, seasonal allergies, severe protein-calorie malnutrition, Constipation, Cognitive communication deficit (problems with communication), insomnia (difficulty sleeping), quadriplegia (paralyzed), Spastic quadriparesis(a form of cerebral palsy that affect all four limbs), iron deficiency, anemia (not enough healthy red blood cells), lack of coordination, muscle wasting, muscle weakness, lack of coordination, dizziness and giddiness, Dysarthria and anarthria (severe speech sound disorder), symbolic dysfunctions (disorder that affects social skills), muscle spasm, heartburn, dysphagia (difficulty swallowing, hypertension (high blood pressure),hyperlipidemia (high cholesterol), and major depressive disorder. Record review of Resident #6's Quarterly MDS dated [DATE] revealed Resident #6 had a BIMS score of 11, indicating resident understood and could make self-understood most of the time. Resident #6's MDS also revealed that the resident needed extensive assistance with bed mobility, transfers, and toileting. Record Review of Resident #6's care plan 06/26/2024 revealed keep call light and personal items within reach. Keep call light within reach when sitting up in her room in her motorized scooter and when in bed. Encourage use of call light. (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 - Some	Record review of Resident #8's Admission Record dated 08/06/24 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (memory loss), dementia (memory, thinking, difficulty), Psychotic disturbance (altered perception, thinking, and behavior), mood disturbance, anxiety, hypertension (high blood pressure), muscle weakness, tachycardia (high resting heart rate), bipolar disorder (extreme mood swings), type 2 diabetes mellitus with diabetic chronic kidney disease (kidney disease due to high blood sugar), cholangitis (swollen bile duct), difficulty walking, unsteadiness on feet, muscle wasting, depressive episodes, Cognitive communication deficit (problems with communication), allergies, hyperosmolality (severe complications from diabetes), hypernatremia (high concentration of sodium in the blood), anxiety, behavioral syndromes, seizures, insomnia (difficulty sleeping), lack of coordination, and dysphagia (difficulty swallowing). Record review of Resident #8's Quarterly MDS dated [DATE] revealed Resident #8 had a BIMs score of 01 indicating that the resident cannot understand or make self-understood. Resident #8's MDS also indicated the resident is dependent on staff for toileting, transfers, and bed mobility. Record review of Resident #8's care plan dated 05/08/2024 stated encourage use of call light, always keep call light in reach. Advanced dementia unaware of how or when to use call light make frequent checks to meet needs. Record review of Resident #11's Admission Record dated 08/06/24 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included dementia (memory, thinking, difficulty), psychotic disturbance (altered perception, thinking, and behavior), mood disturbance, anxiety, hyperlipidemia (high cholesterol), urinary tract infection, major depressive disorder, dysphagia (difficulty swallowing), difficulty walking, unsteadiness on feet, Alzheimer's disease (memory loss), transient cerebral ischemic attack (brief stroke like attack), Cognitive communication deficit (problems with communication), respiratory disease, protein-calorie malnutrition, seasonal allergies, insomnia (difficulty sleeping), partial loss of teeth, glaucoma (eye disease), depressive episodes, constipation, anxiety, muscle weakness, muscle wasting, abnormalities of gait and mobility, lack of coordination, chronic pain, and gastroesophageal reflux disease without esophagitis (reflux). Record review of Resident #11's Quarterly MDS dated [DATE] revealed Resident #11 had a BIM score of 12 indicating the resident could understand and could make self-understood. The MDS also revealed that the resident needed supervision and touching assistance when toileting, bed mobility and transfers. Record review of Resident #11's care plan dated 05/15/2024 stated keep call light within reach at all times. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #13's Admission Record dated 08/06/24 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included dementia (memory, thinking, difficulty), psychotic disturbance (altered perception, thinking, and behavior), mood disturbance, nasal congestion, cough, dysphagia (difficulty swallowing), protein-calorie malnutrition, insomnia (difficulty sleeping), Cognitive communication deficit (problems with communication), dysuria (pain or burning when pee), muscle wasting, depression, constipation, muscle wasting, bipolar disorder (extreme mood swings), anxiety, abnormalities of gait and mobility, lack of coordination, glaucoma (eye disease), hypertension (high blood pressure), hyperlipidemia (high cholesterol), disorder of thyroid, type 2 diabetes mellitus without complications (high blood sugar), aphasia (unable to comprehend due to damage to the brain) and symbolic dysfunctions (disorder that affects social skills). Record Review of Resident #13's Quarterly MDS dated [DATE] revealed Resident #13 had a BIM score of 14 indicating resident could understand and make self-understood. Resident #13's MDS also revealed that Resident #13 needed supervision and touching assistance with toileting, transfers, and bed mobility. Record review of Resident #13's care plan dated 05/22/2024 stated encourage use of call light. Keep call light and personal items within reach. Record review of Resident #23's Admission Record dated 08/06/24 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included dementia (memory, thinking, difficulty), metabolic encephalopathy (change in brain function), dysphagia (difficulty swallowing), obsessive-compulsive disorders, difficulty in walking, aphasia (unable to comprehend due to damage to the brain), cough, muscle weakness, lack of coordination, osteoarthritis (joint disease), altered mental state, Cognitive communication deficit (problems with communication), abnormalities with gait and mobility. malaise (feeling of general discomfort), adult failure to thrive, hyperlipidemia (high cholesterol), muscle wasting, gout (swollen arthritis), kidney failure, visual field defect, hearing loss, hypertension (high blood pressure), hyperthyroidism (excessive production of thyroid hormones), protein-calorie malnutrition, and respiratory disease. Record Review of Resident #23's Quarterly MDS dated [DATE] revealed Resident #23 had a BIM score of 13 indicating the resident could understand and make self-understood. Resident #23's MDS also revealed that the resident needed assistance with set up and clean up for toileting, bed mobility and transfers. Record review of Resident #23's care plan dated 07/03/2024 stated keep call light in reach and encourage resident to request assist for toileting assist. Keep personal items and call light within reach. Observation of Resident #8's call light on 08/05/2024 at 10:34am revealed it was not in reach of the resident. Resident #8 was laying in her bed watching television. Her call light was hanging straight down to the floor. Attempted to interview Resident #8 and was unsuccessful. Observation of Resident #23's call light on 08/05/2024 at 10:40am revealed the call light was hanging straight down. Resident #23 was asleep in the bed the call light was approx. three feet away. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident #13's call light on 08/05/2024 at 10:43am revealed it was tucked under the mattress and the button was hanging down towards the floor. Resident was sleeping in her bed and call light was approx. 3 feet away. Observation of Resident #11's call light on 08/05/2024 at 2:22pm revealed that her call light was hanging straight down behind furniture. Resident was sitting on her bed approx. 2 feet from the call light. Observation of Resident #6's call light on 08/06/2024 at 10:36am revealed that her call light was hanging down the wall to the floor. Resident was sitting in her wheelchair approx. 3 feet from the call light. Observation of Resident #6, Resident #8, Resident #13, and Resident #23's call lights on 08/08/2024 at 2:24pm revealed that the call lights were not in the residents reach. The call lights were in the same position as they had been when first observed them on 08/05/2024. An interview with Resident #11 on 08/05/2024 at 2:55pm revealed that she does not know if staff would answer her call light. She also stated she did not know where her call light was. An interview with Resident #6 on 08/06/2024 at 10:37am revealed her call light is normally hanging on her bed but sometimes it is not in her reach. She said it takes staff a long time to answer when she does have her call light. An interview with CNA C on 08/08/2024 at 3:07pm revealed she had been trained on resident rights. She said the training covered the resident's right to dignity and privacy. She stated the call lights were to be always within the resident's reach. She said that if the resident is in a wheelchair in their room the call light was to be on the bed within reach of the resident. She said that it was important to have the call light within the resident's reach so the resident could call staff if they need anything or in case of an emergency. She said that if the call light is not in the resident's reach they may try to get up on their own and fall and break a hip. She said she did not know why the residents call lights were not within reach. An interview with CNA D on 08/08/2024 at 3:22pm revealed that she had been trained on resident rights. She said the training covered the rights of the residents that live in the facility. She stated the policy for call light placement was the call light should be always in the resident's reach. She said that the aides were responsible for ensuring the call light was in the resident's reach. She said it was important for the call light to be in the resident's reach so the resident could call staff when they needed help. She said if the call light were not in the resident's reach the resident could fall or something happen and not be able to get help from staff. She said she did not know why the call lights were not in the reach of the residents. An interview with RN G on 08/08/2024 at 3:44pm revealed she had been trained on resident rights. She said the training covered the resident's right to refuse treatment, DNR and right to privacy. She said the policy for call light placement was to be in the resident's reach. She said it was everyone's responsibility to ensure the call light was in the reach of the resident. She stated it was a safety issue and the resident's right to have the call light within their reach. She said if the call light is not in the resident's reach the resident could fall. She said that it was possible that the call light was in the resident's reach and the resident knocked it down. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with MA E on 08/08/2024 at 4:12pm revealed that she had been trained on resident rights. She said the training covered the residents right to be treated with respect. She said the call light should be placed on the bed or where the resident could get to it. She said it was important to ensure the call light was in reach of the resident in case something happened to them, or the resident needed assistance. She stated if the call light were not in reach of the resident staff could get into trouble and that something could happen to the resident. She said she did not know why the call lights were not within the reach of the resident. An interview with the DON on 08/08/2024 at 4:26pm revealed he had been trained on resident rights. He said the training covered all the rights according to HHSC regulations. He stated call lights were to be kept in the reach of the resident. He said staff are expected to make sure the call lights are in the reach of the resident before they leave the resident's room. He said all staff members were responsible for placing the call lights in the reach of the residents. He said it was important for the call light to be in reach so the resident could get assistance when they need it. He said that if the call light were not in the reach of the resident, the resident could not get help when they need it. He said he did not know why the call lights were not in the reach of the residents. An interview with the ADM on 08/08/2024 at 4:40pm revealed she had been trained on resident rights. She said the training covered every right that the resident had while living at the facility. She stated residents are to have their call light within reach to always utilize it. She said if the resident required a special call light the facility was to provide it for the resident. She said all staff were responsible for ensuring that the call light was in the reach of the resident. She said that it was important for the call light to be in reach for resident's to get help when they need it. She said if the call light were not in reach the resident would not get their needs met and the resident could hurt themselves. She said that the call lights were not in reach of the residents because staff did not make sure to put it in reach before they left the resident's room. Record review of Answering the Call Light Policy dated March 2021 revealed if the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097 Based on observation, interview, and record review, the facility failed to ensure residents had comfortable temperatures in the building, putting residents at risk of heat related illnesses. The facility failed to maintain comfortable and safe temperature levels when the temperatures in the facility exceeded 81 degrees. These failures could place residents at risk due to being in an environment that is unsafe or uncomfortable. The findings included: Observation of resident living room, dining room, resident rooms, hallway temperatures taken by the surveyor on the state issued Smartro SC42, on 08/05/2024 beginning at 2:20pm reflected a temperature of 82 degrees Fahrenheit in the east hallway, 82 degrees Fahrenheit in the west hallway, 83 degrees Fahrenheit in the conference room, 84 degrees Fahrenheit in a resident's room. Observation of the med room temperature revealed it was 83 degrees and 84 degrees if the door is closed. Observation of residents 0n 08/05/2024 at 1:00pm revealed that residents were not being offered water or assessing the residents for heat exhaustion. An interview with MS on 08/05/2024 at 3:21pm revealed the inside room temperature will stay between 83 to 85 degrees in the heat of the day and drops down to 80 degrees inside towards the end of the day. He stated that the ac subtracts on about 20 degrees of the outdoor temperature on average and that staff try not to keep residents in the main area due to it getting too hot. He stated that the system just cannot keep up and they are still working to try to resolve it. He said he did not have a temperature log. He said he would randomly check temperatures but did not record them. An interview and observation with Resident 23 on 08/05/2024 at 3:28pm revealed that it was hot. She stated that she walked down the hall to get the temperature. She stated the thermostat said it was 78 degrees. She stated that that was too hot. When surveyor check with our thermometer it read it was 83 degrees. An interview on 08/05/2024 at 3:44pm LVN stated that she had been working at the facility for [AGE] years and they have always had problems with the AC. She stated that currently this has been going on for months. She stated she had complained to the DON. She also said all staff have complained but nothing had been done. She stated she was not sure how hot it had gotten. LVN told the surveyors to wear something cool tomorrow because it will be hot tomorrow in the building. An interview with the MS on 08/05/2024 at 4:25pm and asked him to take temperatures with his thermometers, revealed that he did not know where they were. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the ADM on 08/05/2024 at 4:30pm revealed that the maintenance supervisor informed her (right before Surveyor did the interview) the temperature was above 82 degrees . She stated that she has already started to reach out to local vendors to check the units and get portable fans. She stated one unit was replaced and she did not know that there was an issue with the other one until the maintenance supervisor told her. She stated staff have complained it was hot after the ac was replaced but the issue was the temperature was turned up to 75 degrees. She stated no staff had complained about it being hot. She also said that maintenance is responsible for monitoring temperatures. An interview with the RN on 08/05/2024 at 5:00pm revealed that it would be too hot in the medication room and the AC does not flow. She said if she did not need to go in there she would not. She stated that it was hotter in the medication room earlier in the day. She also said that it was hot sitting at the nurse station even with the fan and that at times it would be unbearable. She stated that maintenance was working on it and had already replaced one unit. An interview with Resident #6 on 08/06/2024 at 10:39am revealed that she was hot and complained to nursing staff. She said the facility took over a week to get her a fan. She said she had not said anything since she had gotten the fan because she figured staff already knew it was hot in her room. An interview with Resident #17 on 08/07/2024 at 1:01pm revealed that he had complained to the nurse several times that it was hot in his room. He said he sweats all night long and that maintenance opened his ac vent, but it does not work. He said he had asked for a fan but had not gotten one. Surveyor requested policies requested Temperature policy, Maintenance policy and Emergency policy for a/c outage , resident rights and homelike environment. Record review of the Weather Channel Ten Day Forecast for [NAME] revealed 08/06/2024 the high was going to be 100 and 08/07/2024 was going to be105 and 08/08/2024 was going to be 104 . Actual high temperatures for 08/06/2024 was 100, on 08/07/2024 was 104 and on 08/08/2024 was 102. An interview with Resident #17 on 08/07/2024 at 1:01pm revealed he was sweating all night long. He said maintenance opened the ac vent, but it did not work. He said he never got a fan and the facility had not done anything for him in terms of helping reduce the heat. He said he got ice from the hallway himself, and that staff did not offer ice often. He did state staff had been offering ice and water since the night before. Staff had been checking on his vitals and making sure he did not get dehydrated. The inside temperature had been the same as before and he said he liked to keep his room door shut. He said staff told him to leave it open for the airflow come in. He said he had his own AC vent that needed to be fixed. He stated he wanted a fan so that he could continue to have his privacy with his door closed. Record review of Homelike Environment Policy dated February 2021 revealed the facility staff and management maximizes, the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics included: comfortable and safe temperatures (71 - 81 degrees Fahrenheit). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Maintenance Service Policy dated November 2021 revealed the maintenance department was responsible for maintaining the building, grounds, and equipment in safe and operable manner always. Function of maintenance personnel include, but not limited to maintaining the heating/cooling system, plumbing fixtures, wiring, in good working order.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097 Based interviews and record review, the facility failed to ensure each resident was free from abuse, neglect, exploitation, and misappropriation of resident property for one (1) of five (5) residents reviewed. The facility failed to prevent the misappropriation of Resident #1's Ozempic 4MG/3ML Pen (1MG). Ozempic is a GLP-1 agonist that assists with weight loss and blood sugar regulation. This failure placed the resident at risk for not receiving their prescribed medication. Findings Include: Record review of Resident #1, on August 5, 2024, through August 7, 2024, reflected a 55yo male who was admitted to the facility on [DATE], with diagnoses including in part: Cellulitis, Diarrhea, Vitamin D deficiency, Hyperlipidemia, Morbid (severe) Obesity due to excess calories, Type 2 Diabetes with unspecified complications, Pain, and Muscle Wasting and Atrophy. Review of Resident #1 TL's most recent MDS, dated [DATE], revealed a BIMS score of 15, and no significant cognitive impairment. Review of Resident #1's Care Plan, last reviewed/revised on June 6, 2024, showed the resident was at risk for malnutrition related to prescribed weight loss regime. The approach included administering Ozempic as prescribed, Ozempic .5mg weekly, with the goal being that the resident not exhibit signs of malnutrition or dehydration. Additionally, a problem area identified in the Care Plan reviewed/revised on June 6, 2024, was the diagnosis of diabetes, with the goal being that the resident will have no complications due to diabetes and medication use, and the approach being in part, meds as ordered. In an interview on August 5, 2024, at 3:40PM, Resident #1 stated that he has never missed prescribed doses of ordered medications due to misappropriation of his medications, the medication not being available, and/or oversight by facility staff. Record review of the facility's investigation into Resident #1's missing Ozempic medication showed that on July 3, 2024, RN K administered the ordered medication to Resident #1 as ordered. On or about July 10, 2024, RN K noted that the medication could not be located. Nursing staff searched the medication room, medication cart, and disposed of medications. The missing medication was not found. Resident #1's PCP was notified and a new order for the medication was requested. On July 11, 2024, the NP came to the facility and assessed the resident. According to the investigation record, the charge nurse checked the resident's blood sugar, which was within a normal range and no concerns were noted. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation records revealed a written statement by MA J, which stated in summary that on July 7, 2024, MA J went to dispose of another resident's discontinued medications when she saw what she thought to be Resident #1's new insulin syringe. MA J wrote that she questioned to herself the presence of a new medication in the discontinued medication box but writes that she failed to outwardly question this. Review of the facility's investigation records revealed that an Inservice Training session was conducted by the ADM to include the prohibition of resident abuse/neglect, GLP-1 class medications, storage and count sheet process, and a new facility policy which states, .All GLP-1 class of medications must be stored in narcotic box in the medication room fridge. A medication count sheet must be initiated upon receiving these medications immediately. In an interview with the facility ADM on August 7, 2024, the ADM stated that immediately upon learning of the missing medication, an investigation was initiated, and Resident #1 was assessed, and the resident suffered no ill effects from the missing medication. The ADM stated that the medication was immediately re-ordered and received. The administration of the medication was immediately resumed with the resident's weekly administration of the medication delayed, but not missed. The ADM stated that during this time the facility had primarily utilized agency nursing staff and she believes this contributed to the misappropriation of the medication, but she cannot conclusively say what happened to the medication. A review of the facility's records show a Packing Slip Proof of Delivery dated July 13, 2024, in which Ozempic 4MG/3ML PEN (1MG) was received (as a replacement) for Resident #1. 50042

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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** 37435 Based on observation, interview, and record review the facility failed to ensure the resident assessment accurately reflected the resident's status for 2 of 9 residents (Resident #21 and Resident #12) who were reviewed for accuracy of assessments. Resident #21's MDS was coded as having an indwelling catheter which had been discontinued. This failure placed residents at risk of incorrect care and services necessary for their physical, mental, and psychosocial well-being. Findings included: Record review of Resident #21's undated face sheet indicated Resident #21 was a [AGE] year-old male, who admitted to the facility on [DATE]. He was diagnosed with Cerebral Infarction (which was a pathologic process that resulted in necrotic tissue in the brain, caused by disrupted oxygen and blood supply,) Alzheimer's disease, Urinary retention, Diabetes mellitus type 2, and a Cognitive communication deficit. Record review of Resident #21's Quarterly MDS, dated [DATE], reflected in Section H Bowel and Bladder that Resident #21 had an indwelling catheter. Record review of Resident #21's Care Plan dated 6/05/24 reflected Urinary incontinence/bowel and bladder incontinence/catheter care, and resident would establish an individual bowel/bladder routine. Record review of Resident #21's Physician Orders reflected, Foley catheter care every shift was initiated on 04/23/24 and discontinued on 06/10/24, and Foley catheter: Change catheter and drainage bag as needed for indications of blockage, increased sediment, infection, displacement as needed was initiated on 04/30/24 and discontinued on 06/10/24. Observation and interview on 08/05/24 at 11:08 AM with Resident #21 revealed he did not have an indwelling catheter. Interview on 08/08/24 at 02:40 PM with MDSN revealed she started work in facility two months ago. MDSN stated the MDS nurse was responsible for updating the residents MDS. Changes in resident condition were communicated by nursing staff in 24-hour report, change in conditions, and change of status from hospitalization which should be reviewed in morning meetings. MDSN stated she would then re-open a new quarterly MDS and make changes. MDSN stated she had not gone in to edit the MDS for Resident #21, and stated it was more like a modified assessment to reflect accuracy. MDSN further stated they don't always make changes to an MDS for a foley catheter. A review of orders, medication administration records, treatment notes, and progress notes should be made daily. MDSN stated it was a human error for not updating a Resident's MDS for presence or discontinuation of an indwelling catheter, and a negative outcome - it could affect the president's health and well-being. MDSN stated MDS nurses follow CMS and RAI guidelines as Policy and Procedure for all residents' MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/08/24 at 04:19 PM with the DON revealed he had been in facility as an interim DON for two weeks. The DON stated the MDS nurse was responsible for communicating changes/updates that needed to be made to a resident MDS, and updates in resident status were communicated verbally in morning meetings, staff meetings, or via email, and that was why we have morning meetings. The DON stated the MDS nurse was responsible for making changes and updates to the resident MDS, and his expectation was for changes and updates to the MDS to be made timely and accurately. The DON stated his expectation was for physician orders, indwelling catheter care, and wound care to be followed timely and accurately as well. Interview on 08/08/24 at 04:35 PM with ADM revealed she had worked at the facility for the past 8 months. The ADM stated the responsibility for communicating changes and updates that need to be made to a resident MDS started with charge nurses doing their documentation, and when they capture documentation in progress notes, physician orders and the 24-hour report, the ADON and DON can communicate changes and updates to the CCM/MDS nurse. The ADM stated there should be an RN that oversees the MDS nurse, and the RN would be responsible when changes and updates were not made to a resident's MDS. The ADM further stated her expectation for accuracy of the MDS was for the person who was doing the assessment lay eyes on the resident, and review the documentation supplied by providers caring for resident. Record review on 08/08/24 of the facility's MDS Assessment Coordinator Policy, dated November 2019, indicated, A registered nurse shall be responsible for conducting and coordinating the development and the completion of the resident assessment (MDS). The center staff must follow the MDS 3.0 RAI manual current version. 1. A Registered Nurse (RN) shall be designated the responsibility of conducting and coordinating each resident's assessment (MDS). 2. The Resident Assessment Coordinator must date and sign each assessment (MDS) to certify that the assessment has been completed. 3. Each individual who completes a portion of the assessment (MDS) must certify the accuracy of that portion of the assessment by: a. Dating and signing the assessment (MDS), and b. Identifying each section completed. 4. Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to disciplinary action and such incident must be promptly reported to the Administrator. Record review on 08/08/24 of the facility Policy and Procedure for MDS completion and Submission Timeframes reflected, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. 1. The Assessment Coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument [NAME]. 3. Submission of MDS records to the QIES ASAP is electronic. A hard copy7of each record submitted is maintained in the resident's clinical record for a period of fifteen (15) months from the date submitted. 49097

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097 Based on observations, interviews, and record review,The facility failed to provide 1 of 3 (Resident #9) with care and services related to activities of daily living. Resident #9 had to wait an extended amount of time to get assistance with feeding. The facility failed to ensure that Resident #9 was feed his lunch in a timely manner. This failure placed residents at risk for not receiving adequate care and services to prevent infection, injury, and diminished quality of life. Findings included: Record review of Resident #9's Admission Record dated 08/05/2024 revealed the resident was a [AGE] year-old male, who was admitted to the facility on [DATE]. Resident #9's medical diagnoses included Cerebral palsy (a group of conditions that affect movement and posture), hypertension (high blood pressure), urinary tract infection, neuromuscular dysfunction of bladder (lack of bladder control), Dysuria (painful, uncomfortable urination), severe protein-calorie malnutrition, restless legs syndrome, functional quadriplegia (complete inability to move due to severe disability), epiphora due to insufficient drainage (watery eyes), stenosis of right lacrimal punctum (narrowing of the tear ducts), stenosis of left lacrimal punctum (narrowing of the tear ducts), insomnia (difficulty sleeping), seasonal allergies, constipation, dry eye, age-related nuclear cataract (cloudiness in the middle of the eye), contracture left knee (permanently bend), contracture right ankle (permanently bend), contracture left ankle (permanently bend), major depressive disorder, anxiety disorder, developmental disorders of speech and language, seizures, low back pain, muscle wasting, muscle weakness, dysphagia (difficulty swallowing, abnormalities of gait and mobility, lack of coordination, and dysarthria and anarthria (severe speech sound disorder). Record review of Resident #9's Quarterly MDS dated [DATE] revealed that Resident #9 had a BIMS score of 9 indicating the resident had a hard time understanding and make self-understood at times. The MDS also revealed that Resident #9 was total dependent on staff for eating. Record review of Resident #9's care plan dated 05/06/2024 revealed Resident #9 eats all meals in room and requires physical assist with all meals. Check mouth after meals or meds for pocketing of food. Observation of lunch hall tray pass on 08/05/2024 at 11:41am revealed that CNA A was went into Resident #9's room and put his meal tray on his bed side table in front of him. CNA A was then observed walking out of Resident #9's room and continued to pass meal trays. CNA A did not return to Resident #9 room until 12:02pm to feed him. An interview with Resident #9 on 08/05/2024 at 12:00pm revealed that staff always take a long time to feed him. He also said that sometimes the food is cold by the time staff feed him. He also said he gets upset when it takes a long time for them to feed him. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of lunch hall tray pass on 08/07/2024 at 11:55am revealed that CNA C put Resident #9's meal tray on his bed side table in front of him. CNA C was then observed walking out his room and finished passing trays. CNA C returned to Resident #9's room at 12:00pm to feed him. Observation of lunch hall tray pass on 08/08/2024 at 11:45am revealed CNA D put Resident #9's meal tray on his bedside table in front of him. CNA D was then observed walking out the room and finished passing meal trays. CNA D return to Resident #9's room at 11:54am to feed him. Temperatures were checked and food was still warm. An interview with CNA C on 08/08/2024 at 3:13pm revealed that when staff are passing hall trays, the staff will pass all trays to the ones who could feed themselves. She said then they would pass the meal trays to the residents who needed assistance with feeding. She said it was important to feed the resident when staff give them their tray so that their food will not get cold. She said if staff did not feed the resident when their tray was delivered the resident could knock over the tray. She said that by placing the tray in front of the resident and walking out and not feeding the resident could make the resident feel bad. She stated that the facility passes all meal trays and then goes back to feed the residents who need assistance. She said she does not know why Resident #9 had to wait so long for staff to come back and feed him. An interview with CNA D on 08/08/2024 at 3:25pm revealed that staff are to feed the residents as soon at their tray was delivered. She said that residents who feed themselves usually get their meal trays first. She said it was important to feed the resident when they get their meal tray so the resident's food would be warm. She stated that the facility had passed all the meal trays out and then go back after to feed resident's. She said that it does not make the resident feel good if a staff member puts their tray down in front of them and walk out. She said she did not know why Resident #9 had to wait so long for staff to come back and assist him. An interview with RN G on 08/08/2024 at 3:49pm revealed that staff were to feed the resident when the staff gave the resident his or her tray. She said usually the residents who feed themselves get their trays first then the residents who needed assistance would get their tray. She said if staff did not feed the resident when he or she got their meal tray the resident may try to feed themselves or could choke or aspirate. She said the resident might feel like staff do not care about them if they just left their meal tray in front of them and walked out without feeding the resident. She said she did not see anyone leave a meal tray in front of a resident without feeding them. She said a resident that needed assistance feeding should never be left alone with their meal tray. She said that there were three or four residents that required feeding assistance. she said they just look and see who still needs assistance with feeding when all meal trays are passed. An interview with the DON on 08/08/2024 at 4:29pm revealed that hall trays were to come out first. He said that after handing out the trays the staff were to assist the residents that needed assistance eating. He stated staff were to pass the meal trays and then go back and feed the residents who needed assistance. He also said that it was important to feed the resident when staff gave them their tray so that the resident's food would be warm . He said that if staff placed the food down and walked off without feeding the resident might not eat. He also stated he did not know how it would make the resident feel if staff put the resident's meal tray down in front of the resident and walked off without feeding the resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the ADM on 08/08/2024 at 4:45pm revealed that best practice was if staff were taking the resident his or her meal tray then staff stay and feed the resident. She said staff were expected to feed the resident when he or she took the meal tray to the resident. She said it was important to feed the resident when he or she got her meal tray to ensure the food was at the correct temperature. She also said it did not make sense to have the resident's tray sitting in front of them and give them the desire to eat and they could not eat. She said the resident could attempt to feed him or herself, may spill the food or the resident could attempt to feed his or herself, choke, and staff not there to see the problem. She said the resident may feel like staff do not care if they put his or her tray in front of them and not feed them. She said the staff had an order they followed as to hand out the meal trays. She said the order staff was doing the meal trays were not the correct process and there was no excuse for staff putting a meal tray in front of a resident and making them wait to be feed. Record review of Assistance with Meals Policy dated March 2022 revealed that residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Facility staff will serve resident trays and will help resident who require assistance with feeding.

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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** 49097 Based on observation, interview, and record review, the facility failed to ensure that 1 of 2 residents (Resident #12) reviewed for Foley catheter care received appropriate treatment and services to prevent urinary tract infections. The facility failed to follow infection control protocols while providing Foley catheter care for Resident #12. This failure placed residents at risk for urinary tract infections, urosepsis, and even death. Findings: Record review of Resident #12's undated face sheet indicated Resident #12 was a [AGE] year-old female, who admitted to the facility on [DATE]. She was diagnosed with Alzheimer's disease, urinary retention, neuromuscular dysfunction of bladder, chronic kidney disease, urinary tract infection, and chronic atrial fibrillation. Record review of Resident #12's Quarterly MDS, dated [DATE] reflected in Section H Bowel and Bladder that Resident #12 did not have an indwelling catheter. Record review of Resident #12's Care Plan dated 6/1024 reflected Resident #12 required an indwelling urinary catheter due to neurogenic bladder. Resident #12 will have catheter care managed appropriately as evidenced by not exhibiting signs of infection or urethral trauma. Record review of Resident #12's Physician Orders reflected, Foley Catheter: Provide catheter care every shift and as needed was initiated on 06/05/24 and was a current order, and Foley catheter: Change catheter and drainage bag as needed for indications of blockage, increased sediment, infection, displacement as needed was initiated on 06/05/24 and was current order. Observation and interview on 08/06/24 at 11:37 AM with Resident #12 revealed she did have an indwelling catheter, which was covered with a privacy bag. Observation on 08/06/24 at 11:37 AM of peri-care and indwelling catheter care for Resident #12 with CNA B who sanitized bedside table with sanitizing wipes, and then donned gown for Enhanced Barrier Precautions due to presence of an indwelling catheter and conducted handwashing and donned gloves. Resident #12 was repositioned in bed and brief removed. CNA B cleansed the peri-area with wipes on each side and down the middle of peri area. CNA B then cleansed the tubing of indwelling catheter with a wipe with a back-and-forth motion from meatus and out approximately 6 inches two times during indwelling catheter care. CNA B then rolled Resident #12 on her side and place a new brief. There was no observation of hand sanitization or glove change done before CNA B began cleansing Resident #12's bottom with a wipe. CNA B then conducted handwashing, bedside table was disinfected, gown removed, and trash removed from room. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/06/24 at 11:56 AM with CNA B revealed she would work on practicing better infection control when providing resident care, and not practicing good infection control put residents at risk for infection in the facility. CNA B stated a negative outcome for Resident #12 would be a urinary tract infection. Interview on 08/08/24 at 03:07 PM with CNA C who stated she had [AGE] years employment with the facility, and had received several in-services on enhanced barrier precautions, and on Foley catheter care. She further stated it was important to follow infection control practices to avoid giving someone a raging UTI. Interview on 08/08/24 at 03:19 PM with CNA D who stated she had worked in facility for about 1.5 years and stated she had received training on Foley catheter care and Infection control practices about 5 months ago. She further stated the importance of following infection control practices when providing resident care, so we don't spread any infections to them and other residents. CNA stated that she was responsible, and each of us were responsible for following infection control protocols. Interview on 08/08/24 at 03:30 PM with RN G who stated infection control protocols should be followed when caring for residents to help keep them from getting infections and becoming septic. She stated the importance of following infection control protocols when performing Foley catheter care is because urinary tract infections are the most common nosocomial infections. An infection in the resident's urinary tract can cause acute kidney injury and sepsis which can lead to hospitalization and even death. RN G further stated that Foley catheter care should be done every shift by cleaning the tube from the meatus (urethral opening) and out, and change wipe with each swipe. Interview on 08/08/24 at 04:06 PM with MA E who stated it was important to follow infection control protocols when caring for residents to help protect the residents from infection, and making sure infection will not be transferred to the next person. MA further stated it was the responsibility of all staff to prevent the spread of infection. Interview on 08/08/24 at 04:19 PM with DON revealed he had been in facility as an interim DON for two weeks. The DON stated it was important to follow infection control precautions when caring for residents, so we don't give them infection, or if they have an infection, we don't spread it to everyone else. DON stated the negative outcomes of not following infection control protocols include prolonged decline in residents, hospitalization , or even death, and all staff were responsible for following infection control protocols in the facility. Interview on 08/08/24 at 04:35 PM with ADM revealed she had worked at the facility for the past 8 months. The ADM stated it was important to follow infection control protocols because we don't want to spread viruses or bacteria to our residents or to ourselves, and a negative outcome of not following infection control protocols would be a resident could end up with another's infection which could cause a decline in their health and well-being. The ADM stated all staff who were working in facility that have been trained were responsible for infection control protocols, including the DON and herself. The ADM stated her expectation for staff following infection control protocols were that we have an obligation to provide training and validate staff understanding, and then we have obligation to monitor. Furthermore, staff have an obligation to carry out infection control protocols when providing resident care. Review on 08/08/24 of Policy and Procedure for Indwelling Catheter Use and Removal reflected: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include but are not limited to: d. Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevention control procedures.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37435 Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater for when the facility had a medication error rate of 7.14% based on 2 of 28 opportunities, which involved 2 of 4 residents (Resident #24 and Resident #1) and 1 of 2 MA's (MA E) observed during medication administration. A) Resident #24 had a physician order for Lisinopril 20mg 1 tablet by mouth every day, with special Instructions to hold the medication if his systolic blood pressure was less than 110 and hear rate less than 60. MA E failed to check Resident #24's vital signs before administering the medication. B) Resident #1 had a physician order for Losartan Potassium tablet 50mg 1 tablet by mouth every day with a parameter to hold medication if her blood pressure was less than 140/90. MA E failed to check Resident #1's vital signs before administering the medication. These deficient practices could place residents at risk of not receiving therapeutic dosage of medications, could cause a decrease in blood pressure and/or pulse, a decline in resident health, hospitalization , and even death. Findings: Record review of Resident #24's undated face sheet indicated Resident #24 was a [AGE] year-old male, who admitted to the facility on [DATE]. He was diagnosed with Diabetes mellitus type 2, dementia, cognitive communication deficit, hypertension, difficulty walking, cellulitis left lower limb, and pressure ulcer left ankle stage 4. Record review of Resident #24's Quarterly MDS, dated [DATE], reflected a BIMS Score of 6/15 in Section C, which reflected a moderate to severe cognitive deficit, and a diagnosis of Hypertension in Section I. Record review of Resident #24's Care Plan dated 6/05/24 reflected ADLs Functional Status/Rehabilitation Potential - Resident #24 had self-care deficits due to increased weakness, impaired mobility, and impaired memories. Long-term goal was Resident #24's care needs would be met daily, and PRN by staff approaching him in a calm manner, explaining what they intend to do while providing care using simple communication and yes/no questions as able, and allow Resident #24 to make choices. Record review of Resident #24's Physician Orders dated 02/17/24 reflected, Lisinopril 20mg 1 tablet by mouth every day, with Special Instructions to hold the medication if his systolic blood pressure was less than 110 and hear rate less than 60. Record review of Resident #1's undated face sheet indicated Resident #1 was a [AGE] year-old female, who admitted to the facility on [DATE]. She was diagnosed with unspecified intellectual disabilities, hypertension, mixed incontinence, acute kidney failure, diabetes mellitus type 2, and cognitive communication deficit. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Quarterly MDS, dated [DATE], reflected a BIMS Score of 13/15 in Section C, which reflected a mild cognitive impairment, and a diagnosis of Hypertension in Section I. Record review of Resident #1's Care Plan dated 6/10/24 reflected she had self-care deficits due to impaired mobility, impaired cognition, impaired memories, and disorientation to time due to intellectual disability, with a goal that all care needs would be met daily and PRN and Resident #1 would maintain an optimal level of functioning. Record review of Resident #1's Physician Orders dated 05/08/24 reflected, Losartan Potassium tablet 50mg 1 tablet by mouth every day with a parameter to hold medication if her blood pressure was less than 140/90. Observation on 08/07/24 at 09:18 AM of medication pass for Resident #1 with MA E revealed she did not check her vital signs including a blood pressure before administration of Losartan Potassium (a blood pressure medication) 50mg 1 tablet by mouth every day, with a parameter to hold the medication if Resident #1's blood pressure was over 140/90. Observation on 08/07/24 at 09:41 AM of medication pass for Resident #24 with MA E revealed she did not check his vital signs including a blood pressure or pulse before administration of Lisinopril (a blood pressure medication) 20mg 1 tablet PO QD for hypertension, with physician orders to hold medication for a systolic blood pressure less than 110, and a heart rate less than 60. Interview on 08/07/24 at 02:51 PM with MA E revealed she had not taken blood pressure per physician orders for Resident #24 and Resident #1. MA E stated she had forgotten to take the blood pressure for Resident #24 and the nurse had checked Resident #1's blood pressure earlier in the morning. MA E pulled up the vital signs for each resident in electronic health records and neither resident had a blood pressure documented for 8/07/24. MA E stated the importance of following physician orders was to ensure resident safety, and a potential outcome of not checking blood pressure before administering a blood pressure medication could be a decrease in blood pressure and pulse. Observation at 08/07/24 at 03:10 PM with MA E revealed she re-checked a set of vital signs for the following residents: Resident #24 - Blood pressure 149/73, Pulse 75 Resident #1 - Blood pressure 145/97, Pulse 92 Interview on 08/08/24 at 03:30 PM with RN G who stated it was important to follow physician orders because if we do not it can injure the resident and have a negative impact on the resident. RN G further stated if there were a question about a physician order, she would call the physician. RN G stated it was important to follow orders for blood pressure parameters when giving residents blood pressure medication because you could bottom their blood pressure out and it would have a negative impact on the resident. RN G stated all nurses were responsible for following physician orders and stated to not take another nurse's word for vital signs taken, and to check vital signs as part of the resident's assessment. (continued on next page)

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	675076	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Llano Nursing and Rehabilitation Center	800 W Haynie St Llano, TX 78643

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/08/24 at 04:06 PM with MA E stated it was important to follow physician orders to ensure you are doing everything the physician wants you to do, and if physician orders were not followed it could lead to having to send a resident out to the hospital, especially if their blood pressure or blood sugar were out of range. MA E further stated it was important to follow physician orders for blood pressure parameters when administering blood pressure medications to resident, because if you check their vital signs including blood pressure before giving the medication it ensures the resident is safe and their blood pressure won't drop. MA E further stated nurses and medication aides were responsible for following physician orders. Interview on 08/08/24 at 04:19 PM with DON revealed he had been in facility as an interim DON for two weeks. DON stated it was important to follow physician orders, so the resident gets the appropriate treatment. DON stated some blood pressure medications require blood pressure/pulse check before administering because the resident could have a decline in condition. DON stated nurses, aides, and med aides were responsible for following physician orders, and all staff that have access to and provide care to the resident were responsible. DON stated the negative outcomes of not following a resident's physician orders could be a prolonged decline in residents, hospitalization , or even death, and all staff providing resident care were responsible for following physician orders in the facility. The DON stated his expectation was for physician orders to be followed timely and accurately as well. Interview on 08/08/24 at 04:35 PM with ADM revealed she had worked at the facility for the past 8 months. She stated it was important to follow physician orders because the doctor knows what is best for the resident, and if physician orders were not followed it can lead to serious negative outcomes. The ADM stated the DON has oversight on ensuring physician orders were followed, however, every charge nurse has a responsibility to follow all doctor's orders. The ADM stated her expectation for following physician orders was when the physician gives us an order, we should carry it out with no deviations, and for nurses to contact the physician if there are any questions or need for clarification. Review on 08/08/24 of Policy and Procedure for Medication Administration reflected under Preparation and General Guidelines reflected, Medications shall be administered in safe and timely manner and as prescribed .medications must be administered in accordance with the orders, including any required time frame .The individual administering the medications must check the label carefully to verify the right resident, right medication, right dosage, right time and right method of administration before giving the medication . B. Administration 2. Medications are administered in accordance with written orders of the prescriber. D. Documentation (including electronic) 7. if an electronic Medication Administration System is used, specific procedures required for resident identification, identifying medications due at specific times, and documentation of administration, refusal, holding of doses, and dosing parameter such as vital signs and lab values are described in the system's user manual . 49097

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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** 49097 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 for one (1) of one (1) kitchen reviewed for food safety and sanitation The facility failed to ensure food storage containers were properly secured, sealed, and labeled. This failure placed residents at risk of foodborne illness. Findings include: Observation of the kitchen pantry on [DATE], at 9:11AM revealed that one (1) of three (3) plastic dry food storage container lids was not secured and labeled. Observation of the kitchen pantry on [DATE], at 9:11AM revealed that two (2) of two (2) individually wrapped Glazed Honey Buns were not labeled and dated. Observation of the kitchen pantry on [DATE], at 9:11AM revealed that four (4) of four (4) bags of dehydrated smooth refried beans were expired. The manufacturer's Best If Used By date on each of the four (4) bags was [DATE]. One (1) of the four (4) bags of dehydrated smooth refried beans was opened and re-packaged in a Ziploc bag with the date of ,d+[DATE] written on the bag. Observation of the kitchen pantry on [DATE], at 9:13AM revealed an opened box containing individual bags of Roasted Turkey Gravy Mix with the date of ,d+[DATE] written on the outside of the box. Inside of the box, one (1) of one (1) package of Roasted Turkey Gravy Mix inspected was expired. The manufacturer's printed use by date was [DATE]. Observation of the kitchen pantry on [DATE], at 9:14AM revealed an opened box containing individual bags Pork Roast Gravy Mix that were not labeled or dated by facility staff. Inside of the box, one (1) of one (1) package of Pork Roast Gravy inspected was expired. The manufacturer's printed use by date was [DATE]. Observation of the kitchen pantry on [DATE], at 9:15AM revealed an opened box containing individually packaged bags of Peppered Biscuit Gravy Mix with the date of ,d+[DATE] written on the outside of the box. Inside of the box, two (2) of two (2) packages of Peppered Biscuit Gravy Mix inspected were expired. The manufacturer's printed use by date on each package was [DATE]. Observation of the kitchen pantry on [DATE], at 9:15AM revealed an opened box containing individual bags [NAME] Sauce Mix with the date of ,d+[DATE] written on the outside of the box. Inside of the box, two (2) of two (2) packages of [NAME] Sauce Mix inspected were expired. The manufacturer's printed use by date on each package was [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the kitchen pantry on [DATE], at 9:16AM, revealed an opened bag of Two-Way Yellow Cake Mix with the date of ,d+[DATE] written in black marker on the outside of the bag. The opened bag was improperly sealed and secured in a manner that would prevent contamination in that the bag was less than half full, folded close, and only secured with a piece of clear tape on the outside of the fold. Observation of the kitchen pantry on [DATE], at 9:16AM revealed an opened bag of Gingerbread Mix with the date of ,d+[DATE] written in red marker on the outside of the bag. The opened bag was improperly sealed and secured in a manner that would prevent contamination in that the bag was less than half full and only folded close. Observation of the kitchen pantry on [DATE], at 9:16AM revealed a round storage bin with contents inside that were improperly labeled and dated. A piece of clear tape, which appeared old, was affixed to the top of the lid that was not entirely legible. Legible writing on the tape read Cookies ,d+[DATE]. This did not correctly identify the contents inside of the container. Observation of the kitchen pantry on [DATE], at 9:18AM revealed an opened bag of breadcrumbs improperly sealed and secured in a manner that would prevent contamination in that the opened bag was less than half full, not dated, and folded close with a piece of clear tape adhering the package partially closed. Observation of the kitchen on [DATE], at 9:19AM revealed an opened bag of Tostitos Crispy Rounds Tortilla Chips improperly sealed and secured in a manner that would prevent contamination in that the opened bag was merely folded close. In addition, the date written on the outside of the package by kitchen staff read , d+[DATE]. Observation of the kitchen refrigerator on [DATE], at 9:20AM revealed miscellaneous opened bags of food on a plastic tray improperly sealed, secured, and/or dated in a manner that would prevent contamination. An opened bag of Classic Mashed Potato (flakes) with the date of ,d+[DATE] written on the outside of the bag was observed. The bag was only folded closed. Also, two (2) of two (2) instant pudding mix package was observed to be opened, unlabeled, not dated, and improperly secured. Observation of the kitchen refrigerator on [DATE], at 9:21AM revealed sliced turkey sandwich meat that was improperly stored in that the opened package of turkey meat was placed in a Ziploc bag that was not sealed close. Observation of the kitchen refrigerator on [DATE], at 9:21AM revealed shredded cheese in a Ziploc bag that was open and not properly sealed, and that had not been dated. Observation of the kitchen freezer on [DATE], at 9:24AM revealed bags of frozen cauliflower florets and frozen broccoli that were undated. Observation of the kitchen freezer on [DATE], at 9:24AM revealed two(2) bags of unidentified meat products improperly stored in undated and unlabeled freezer bags with items in each of the bags containing ice crystals indicating freezer burn. Observation of the ice machine in the kitchen on [DATE], at 9:27AM revealed improper cleaning and sanitizing of the ice machine as evidenced by mold observed growing under the lid. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with KS I, on [DATE], at approximately 9:35AM revealed that the dietary manager is responsible for auditing the facility's food supply for expired goods and food items. KS I stated that the dietary manager was responsible for ordering food and supplies for the kitchen. KS I indicated that she was not aware that there were expired items in the kitchen pantry. KS I stated that all staff were responsible for sanitary practices within the kitchen, including keeping surfaces and equipment clean, but the dietary manager oversees the kitchen. KS I stated that the dietary manager does not work on Mondays and thus was not available for interview on this date. Interview with the DM on [DATE], at 9:41AM revealed that DM is responsible for the overall care and functioning of the kitchen, kitchen equipment and supplies. The DM stated that he was made aware of the expired items in the kitchen pantry that were observed by survey staff during the initial kitchen tour/observation, and he has now thrown those items in the trash. The DM stated the proper procedure for the storage and use of food is that items are labeled upon receipt and not used beyond the expiration date. The DM stated that he audits the kitchen pantry items weekly and uses the FIFO (first-in, first-out) method. When the DM was told that expired items in the kitchen pantry were well past their expiration dates, the DM provided no further explanation for this. The DM stated that his usual practice when preparing for the weekly menu preparation is looking at items on the menu two (2) days in advance to make sure he has all the menu items needed and that they are not expired. If he does not have the items needed for a scheduled menu, he will properly substitute the item(s) according to the kitchen's menu substitution approved list. Record review of the facility's Food Storage policy, Policy Number 03.003, states the following in part: Dry storage rooms To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. Refrigerators Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for storage. 50042

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37435 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 (Resident #12, Resident #24, and Resident #21) of 6 residents reviewed for infection control. A) The facility failed to maintain infection control for Resident #12 during Foley catheter care by failing to perform appropriate hand hygiene while providing care. B) The facility failed to maintain infection control for Resident #24 during wound care by failing to perform appropriate hand hygiene while providing care. C) The facility failed to maintain infection control for Resident #21 while passing lunch trays on the hallway by failing to perform appropriate hand hygiene while providing care. These deficient practices could place residents in the facility at risk for infections that could lead to other facility-acquired infections, stalled wound healing, sepsis, hospitalization s, a diminished quality of life, and even death. Findings: Record review of Resident #12's undated face sheet indicated Resident #12 was an [AGE] year-old female, who admitted to the facility on [DATE]. She was diagnosed with Alzheimer's disease, urinary retention, neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), chronic kidney disease, urinary tract infection, and chronic atrial fibrillation (a type of heart arrhythmia that causes the top chambers of your heart, the atria, to quiver and beat irregularly). Record review of Resident #12's Quarterly MDS, dated [DATE] reflected in Section H Bowel and Bladder that Resident #12 did not have an indwelling catheter. Record review of Resident #12's Care Plan dated 6/10/24 reflected Resident #12 required an indwelling urinary catheter due to neurogenic bladder. Resident #12 will have catheter care managed appropriately as evidenced by not exhibiting signs of infection or urethral trauma. Record review of Resident #12's Physician Orders reflected, Foley Catheter: Provide catheter care every shift and as needed was initiated on 06/05/24 and was a current order, and Foley catheter: Change catheter and drainage bag as needed for indications of blockage, increased sediment, infection, displacement as needed was initiated on 06/05/24 and was current order. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #24's undated face sheet indicated Resident #24 was a [AGE] year-old male, who admitted to the facility on [DATE]. He was diagnosed with Diabetes mellitus type 2, dementia, cognitive communication deficit, hypertension, difficulty walking, cellulitis left lower limb (a skin infection caused by bacteria), and pressure ulcer left ankle stage 4 (full-thickness tissue loss with exposed bone, tendon, or muscle). Record review of Resident #24's Quarterly MDS, dated [DATE], reflected a BIMS Score of 6/15 in Section C, which reflected a moderate to severe cognitive deficit, and a diagnosis of Hypertension in Section I. Record review of Resident #24's Care Plan dated 6/05/24 reflected ADLs Functional Status/Rehabilitation Potential - Resident #24 had self-care deficits due to increased weakness, impaired mobility, and impaired memories. Long-term goal was Resident #24's care needs would be met daily, and PRN by staff approaching him in a calm manner, explaining what they intend to do while providing care using simple communication and yes/no questions as able, and allow Resident #24 to make choices. Record review of wound care orders dated 7/26/24 reflected: Cleanse Left Posterior Ankle with wound cleanser and pat dry. Apply calcium alginate (cut to wound size) and cover with dry dressing. M-W-F. Record review of Resident #21's undated face sheet indicated Resident #21 was a [AGE] year-old male, who admitted to the facility on [DATE]. He was diagnosed with Cerebral Infarction (which was a pathologic process that resulted in necrotic tissue in the brain, caused by disrupted oxygen and blood supply,) Alzheimer's disease, Urinary retention, Diabetes mellitus type 2, and a Cognitive communication deficit. Record review of Resident #21's Quarterly MDS, dated [DATE], reflected in Section H Bowel and Bladder that Resident #21 had an indwelling catheter. Record review of Resident #21's Care Plan dated 6/05/24 reflected Urinary incontinence/bowel and bladder incontinence/catheter care, and resident would establish an individual bowel/bladder routine. Record review of Resident #21's Physician Orders reflected, Foley catheter care every shift was initiated on 04/23/24 and discontinued on 06/10/24, and Foley catheter: Change catheter and drainage bag as needed for indications of blockage, increased sediment, infection, displacement as needed was initiated on 04/30/24 and discontinued on 06/10/24. Observation and interview on 08/06/24 at 11:37 AM with Resident #12 revealed she did have an indwelling catheter, which was covered with a privacy bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/06/24 at 11:37 AM of peri-care and indwelling catheter care for Resident #12 with CNA B who sanitized bedside table with sanitizing wipes, and then donned gown for Enhanced Barrier Precautions due to presence of an indwelling catheter and conducted handwashing and donned gloves. Resident #12 was repositioned in bed and brief removed. CNA B cleansed the peri-area with wipes on each side and down the middle of peri area. CNA B then cleansed the tubing of indwelling catheter with a wipe with a back-and-forth motion from meatus and out approximately 6 inches two times during indwelling catheter care. CNA B then rolled Resident #12 on her side and place a new brief. There was no observation of hand sanitization or glove change done before CNA B began cleansing Resident #12's bottom with a wipe. CNA B then conducted handwashing, bedside table was disinfected, gown removed, and trash removed from room. Interview on 08/06/24 at 11:56 AM with CNA B revealed she would work on practicing better infection control when providing resident care, and not practicing good infection control put residents at risk for infection in the facility. CNA B stated a negative outcome for Resident #12 would be a urinary tract infection. 08/06/24 12:04 PM Lunch tray passed to Resident #21 by CNA A, and no hand sanitization observed before the tray was passed nor afterward. Observation on 08/08/24 at 01:30 PM of wound care for Resident #24 with RN G. Wound was documented in physician orders as a pressure ulcer to left posterior ankle, stage 4. The old dressing was removed and discarded immediately, which displayed the date 08/07/24 and initials CAR. Dirty gloves were removed and discarded. Hand hygiene was not performed properly before accessing clean supplies . Interview on 08/08/24 at 03:07 PM with CNA C who stated she had [AGE] years employment with the facility, and had received several in-services on enhanced barrier precautions, and on Foley catheter care. She further stated it was important to follow infection control practices to avoid giving someone a UTI. Interview on 08/08/24 at 03:19 PM with CNA D who stated she had worked in facility for about 1.5 years and stated she had received training on Foley catheter care and Infection control practices about 5 months ago. She further stated the importance of following infection control practices when providing resident care, so we don't spread any infections to them and other residents. CNA stated that she was responsible, and each of us were responsible for following infection control protocols. Interview on 08/08/24 at 03:30 PM with RN G who stated infection control protocols should be followed when caring for residents to help keep them from getting infections and becoming septic. She stated the importance of following infection control protocols when performing Foley catheter care is because urinary tract infections are the most common nosocomial infections. An infection in the resident's urinary tract can cause acute kidney injury and sepsis which can lead to hospitalization and even death. RN G further stated that Foley catheter care should be done every shift by cleaning the tube from the meatus (urethral opening) and out, and change wipe with each swipe. Interview on 08/08/24 at 04:06 PM with MA E stated it was important to follow infection control protocols when caring for residents to help protect the residents from infection, and making sure infection will not be transferred to the next person. MA further stated it was the responsibility of all staff to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/08/24 at 04:19 PM with the DON revealed he had been in facility as an interim DON for two weeks. He stated it was important to follow infection control precautions when caring for residents, so we don't give them infection, or if they have an infection, we don't spread it to everyone else. The DON stated the negative outcomes of not following infection control protocols include prolonged decline in residents, hospitalization , or even death, and all staff were responsible for following infection control protocols in the facility. The DON stated his expectation was for physician orders, indwelling catheter care, and wound care to be followed timely and accurately as well. Interview on 08/08/24 at 04:35 PM with ADM revealed she had worked at the facility for the past 8 months. She stated it was important to follow infection control protocols because we don't want to spread viruses or bacteria to our residents or to ourselves, and a negative outcome of not following infection control protocols would be a resident could end up with another's infection which could cause a decline in their health and well-being. The ADM stated all staff who were working in facility that have been trained were responsible for infection control protocols, including the DON and herself. The ADM stated her expectation for staff following infection control protocols were that we have an obligation to provide training and validate staff understanding, and then we have obligation to monitor. Furthermore, staff have an obligation to carry out infection control protocols when providing resident care. Review on 08/08/24 of facility Policy and Procedure for Infection Control dated 03/2011 reflected, To maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public and To prevent, detect, investigate, and control infections in the facility. 49097

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097 50042 Based on observations, record reviews and interviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents for one (1) of one (1) facility reviewed for environment The facility failed to repair a cracks or gaps between the wall and floor moldings in a resident's room, failed to repair a penetration (hole) in a resident's bedroom wall, clean dust particles and dirt from the ceiling of a resident's room, replace a missing toilet tank lid in a resident's room, remove and replace molded flooring in a resident's bathroom that was warped and folding away from the walls due to liquid saturation from urine, water or both. This deficient practice could place residents at risk of not living in a safe, functional, sanitary, and comfortable environment. Findings included: During an observation of Resident #2's room on [DATE], at 4:42PM, and again on [DATE], at 1:12PM, a hole on the wall behind Resident #2's bedroom door was observed. The hole appeared to be the size and shape of the bedroom door handle and at the point where the handle met the wall. During an observation of Resident #2's room on [DATE], at 4:42PM, and again on [DATE], at 1:12PM, the toilet in the resident's room was observed to be missing the tank lid. During an observation of Resident #2's room on [DATE], at 1:12PM, dust particles and dirt was observed on the resident's bedroom ceiling near or coming out of the vent in the resident's bedroom. During an observation of Resident #2's room on [DATE], at 4:42PM, and again on [DATE], at 1:12PM, the bathroom flooring in the resident's bathroom was observed to be warped, pulling away from the walls, and penetrated and covered in mold underneath and around the toilet. A strong odor of urine could be smelled coming from the resident's bathroom. During an interview with Resident #2 on [DATE], at 4:42PM, the resident stated that his room has been in disrepair since he was admitted to the facility. The resident stated that he has made the facility ADM and maintenance aware of the problems in his room, but no repairs have been made. The resident also complained about the temperature in his room. The resident stated that he prefers his privacy, so he often keeps his bedroom door shut and he rarely gathers or socializes outside of his bedroom with others, including staff and other residents. An interview with the facility ADM was conducted on [DATE], at 11:47AM. the ADM stated that Resident #2 was the type of resident who often makes complaints and rejects the resolutions offered. The ADM stated that if resolutions are offered that require entrance into the resident's room, the resident will refuse to allow staff entry. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675076	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Llano Nursing and Rehabilitation Center	800 W Haynie St Llano, TX 78643

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews with the MS on [DATE], through [DATE], the temperature and condition of Resident #2's room was discussed. The temperature was addressed and remedied , but no immediate remedies for the other issues identified offered. Review of facility records, including Grievance Logs from [DATE], through [DATE], reflected no grievances or complaints filed by Resident #2 WM regarding the environmental concerns in the resident's room. Review of the facility's Resident Rights policy was conducted. The policy states that Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include (in part) the resident's right to: a. a dignified existence.