STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675105	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Nursing and Rehabilitation	1900 N Frances St Terrell, TX 75160

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on interviews and record review, the facility failed to ensure residents and/or the residents' representatives the right to participate in the development and implementation of his or her person-centered plan of care for 1 of 18 residents (Residents #19) reviewed for care plans. The facility failed to invite and include the input of the resident (Resident #19) and/or resident's representatives as members of the interdisciplinary team in the Care Plan Conference meetings on 4/19/24 and 7/19/24. These failures could place residents at risk of not having needs met by depriving them the opportunity to participate in the decision making regarding their care. Findings included: Record review of Resident #19's face sheet dated 07/30/24 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses of dementia (disease characterized by general decline in cognitive ability to perform everyday activities), cerebrovascular disease (disease that affects the blood vessels in the brain and cerebral circulation), heart failure (condition in which the heart does not pump blood as it should), and high blood pressure. Record review of Resident #19's quarterly MDS assessment dated [DATE] indicated she made herself understood and understood others. The MDS also indicated she had a BIMS score of 3 which indicated she had severe cognitive impairment. Record review of Resident #19's care plan revised on 07/12/24 indicated she required total assistance from staff with transfers and requires 1 staff for toileting, bathing, bed mobility, and cueing for eating. Record review of Resident #19's care plan conference dated 04/19/24 indicated her representative attended the meeting, and the resident did not want to attend. Record review of Resident #19's care plan conference dated 07/16/24 indicated she attended the meeting, and her representative was unable to be reached with no documentation of when Resident #19's representative was called. (continued on next page)

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

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/29/24 at 05:00 PM Resident #19's family member said she had been requesting a care plan meeting since the resident admitted to the facility 12/2023 and an unknown head nurse told her they were behind schedule and would get one completed. The family member was worried that Resident #19 had discharged from hospice services, and she would not be able to keep up with her care She said she had never attended a care plan meeting in person or over the phone. During an interview on 07/30/24 at 02:16 PM the Hospice RN Q said Resident #19's family had reached out to her about the concern of not having care plan meetings. She said she was unaware of a care plan meeting. Hospice RN Q said when she reached out to the facility for the family an unknown person at the facility told her the facility did not have care plan meetings. She said it was important to keep residents and family involved in care. During an interview on 07/30/24 at 02:37 PM the MDS Nurse said she was responsible for care plan meetings and notifying the families about care plan meetings. She said they completed the care plan meetings quarterly and she calls the families to notify. The MDS nurse said sometimes she charts that she notified the family and sometimes she did not. She also said at times she placed a note in the chart in the care conference. She said she notifies hospice as well to notify of care plan meetings. She said she had notified Resident #19's family by phone about the care plan meetings. She said Resident #19's family was difficult to get a hold of. Resident #19's family was called on the phone for the meeting on 4/19/24 because she lives out of the country. She said she was unsure of why the documentation on the care plan conference had her attending the meeting because she did not attend. The MDS Nurse said she was unable to reach the family for the meeting 7/16/24. The MDS Nurse said she was unsure of the exact date she attempted to call Resident #19's representative and did not document the call. She said the hospice nurse said the family member wanted to talk to her about nursing, but she had not reached out to her yet. She said she invited the residents to the care plan meetings as well and the care plan meeting should have been documented to ensure the families are called. She said the facility had never mailed letters. She said she would have another care plan for the family because it was important since she knew that there were nursing concerns. During an interview on 07/30/24 at 06:34 PM The ADON said the MDS Nurse was responsible for care plan meetings and invitations for families and residents. She said she was not aware of ever having a care plan meeting for Resident #19. She said the care plan meetings were important for residents and family to discuss grievances, plan of care, and for family and resident to have input with the care. The care plan was also important to ensure medications and code statuses were correct. During an interview on 07/30/24 at 07:41 PM the DON said the MDS Nurse was responsible for care plan meetings and social worker if they had one. The DON said the care plan meetings should be completed quarterly and with significant changes. The DON said it was important the family and residents were invited and documented as invited to care plan meetings. She said the failure placed a risk for the family not being involved and placed a possibility of the facility not being able to meet expectations of the family. During an interview on 07/30/24 at 08:47 PM the Administrator said the MDS Nurse was responsible for care plan meetings and invitations of residents and families. He said Resident #19's family does not answer facility calls. The Administrator said he expected the MDS Nurse to document that the family was invited to the care plan meetings. He said the failure placed a risk to the resident and family to not be aware of the care changes or direction things are going with care. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the undated facility policy Comprehensive Care Planning indicated: The facility will develop and implement a comprehensive person-centered care plan for each resident . Through the care planning process, facility staff will work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices, and goals during their stay at the facility.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on observations, interviews, and record reviews the facility failed protect and promote the rights of the residents for 1 of 11 residents (Resident #27) reviewed for resident rights. The facility failed ensure LVN N provided privacy when she provided wound care to Resident #27 on 07/28/2024. This deficient practice could place residents at risk for loss of dignity. Findings included: Record review of Resident #27's face sheet dated 07/30/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), type 2 diabetes mellitus (long term condition in which the body has trouble controlling blood sugar and using for energy), malignant neoplasm of lung (lung cancer) and weakness. Record review of Resident #27's order summary report dated 07/20/2024, indicated Resident #27 had an order dated 01/24/2024 to cleanse wound to lower back with normal saline, pat dry, apply Triad paste and dry dressing one time a day for wound healing. Record review of Resident #27's comprehensive care plan dated 07/25/2024, indicated Resident #27 had a patchy area to lower back that, at times, she will scratch and cause it to open. The care plan interventions included follow facility protocols for treatment of injury and ongoing treatment in place. Record review of Resident #27's quarterly MDS assessment dated [DATE], indicated Resident #27 was able to understand others and was able to be understood. The MDS assessment indicated Resident #27 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #27 required substantial/maximal assistance with toileting, showering, lower body dressing and personal hygiene. Resident #27 required partial/moderate assistance with upper body dressing. During an observation and interview on 07/28/2024 at 01:35 PM, LVN N entered Resident #27's room to perform wound care on Resident #27. LVN N provided Resident #27's wound care by raising up the back side of her gown while Resident #27 sat on the side of the bed. LVN N failed to ensure Resident #27 had privacy when she left the door to her room open and did not pull the curtain around. LVN N completed Resident #27's wound care. LVN N said she forgot to close the door and/or pull the curtain. LVN N said by closing the door and pulling the curtain Resident #27 could have had privacy and would have felt more comfortable with care. LVN N said she was responsible for ensuring privacy was maintained during care. LVN N said by not providing privacy anyone could have walked in or by and viewed Resident #27 undressed and the wound care treatment. During an interview on 07/28/2024 at 02:35 PM, Resident #27 said it would have bothered her if someone she did not know walked in while wound care was performed because her back side was hanging out. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/30/2024 at 01:58 PM, the ADON said she expected privacy to be maintained when providing care to a resident. The ADON said it was her responsibility for ensuring the staff maintained privacy when providing care. The ADON said failure to provide privacy, when care was being provided, would place residents at risk for being seen by other people. During an interview on 07/30/2024 at 02:20 PM, the Regional Corporate Compliance Nurse said she expected LVN N to have closed the door and pulled the curtain when she provided wound care treatment for Resident #27. The Regional Corporate Compliance Nurse said it was the aides', nurses' and management's responsibility to ensure privacy was being maintained when providing care. The Regional Corporate Compliance Nurse said it was a dignity and privacy issue by not maintaining privacy with care. During an interview on 07/30/2024 at 09:10 PM, the Administrator said he expected staff to close the door and pull the curtain around when providing care to a resident. The Administrator said the person completing the task was responsible for ensuring the resident's privacy was maintained. The Administrator said management staff was responsible for ensuring the staff was knowledgeable in providing privacy to the residents. The Administrator said failure to provide a resident with privacy while providing care, was a privacy and dignity issue. Record review of the facility's policy and procedure Respect and Dignity: Resident's Rights for revised on 04/25/2022, indicated . The resident has a right to be treated with respect and dignity, including .7. Provide privacy and modesty by closing the door and/or curtain.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 33249 Based on observation, interview, and record review, the facility failed to implement their written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident's property of 1 of 1 resident reviewed for abuse, neglect, and exploitation. (Resident #17) The facility did not implement their policy to report to HHSC when Resident #17 sustained a severe coffee burn on 8/16/23. This failure could place the residents at risk for further potential abuse, neglect, and injuries of unknown origin. Findings included: Record review of an Abuse/Neglect policy dated 2003 and revised on 5/09/2017 indicated the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals . 2. Adverse event. An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof C. Prevention 4. The facility will be responsible to identify, correct, and intervene in situations of possible abuse/neglect. The facility has in place a method to identify events such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse. All occurrences of potential abuse or criminal behavior will be investigated by the abuse preventionist and/or designee E. Reporting 3. Facility employees must report all allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown sources to the facility administrator. The facility administrator or designee will report the allegation to HHSC. A. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation F. Investigation Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist. All allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source will be investigated. Record review of a face sheet dated 7/30/2024 indicated Resident #17 was a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses heart failure, quadriplegia (paralysis of all four limbs), and other muscle spasms, contractures of the left and right hands (a condition where the one or more fingers bend toward the palm of the hand), lack of coordination, muscle weakness, muscle wasting and atrophy. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Comprehensive Care Plan dated 11/02/2023 indicated Resident #17 was at risk for burns due to hot liquids. The goal of Resident #17's care plan was he would not suffer any injury related to hot liquids. The interventions included coffee and other hot liquids should not be served if over 140 degrees, if hot liquid was spilled on self, staff should pour room temperature or lower temperature liquid over the affected area, he was to use his dominant hand for drinking, and should be seated in upright position with table or overbed table when hot liquids were being consumed. The Comprehensive Care Plan failed to indicate there was a hot liquid deficit prior to 11/02/2023. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #17 understood and was understood by others. The MDS indicated Resident #17's BIMS score was 15 indicating he had no cognitive deficits. Record review of a nursing progress note dated 8/16/2023 at 12:31p.m., RN F documented Resident #17 said he had a dry area to his right thigh. RN F documented upon assessment she noted a dry scabbed area measuring about 3.5 x 5 (no documented measurement system). The note indicated Resident #17 indicated he had a coffee cup sitting by the side of his wheelchair and it poured on him while he was trying to sit up. The note indicated RN F notified the nurse practitioner, and a new order was received to apply triple antibiotic ointment and cover with a dressing daily until resolved. Record review of a Nurse Practitioner Progress Note dated 8/21/2023 at 10:20 a.m., the nurse practitioner documented the chief complaint was a burn to the right upper thigh. The History of Present Illness section indicated Resident #17 was a [AGE] year old male The nurse practitioner note indicated Resident #17 was seen as requested by the DON due to a new wound to upper thigh. The note indicated Resident #17 said he spilled hot coffee and got burned. The note indicated Resident #17 said it was excruciating. The note indicated the burn was treated with the over-the-counter triple antibiotic cream and covered with a dressing daily. The note in the Section Current Problems: Burn of third degree of right thigh . Review of Systems section labeled Wounds: complaints of wound redness, discharge, pain, and opening of the wound. The note in Section Wound indicated: Traumatic burn to upper thigh right leg with the onset date of 8/14/2023, measuring 5.5 centimeters, 2.5 centimeters width, 0.3 centimeters depth. The note indicated the wound base was slough, with a small amount of serosanguinous drainage. The note indicated Resident #17's burn exposed the adipose tissue and was considered a full thickness wound. The note indicated Resident #17's burn was 51-75% slough; and 25-50% epithelialization and erythema present. The nurse practitioner note indicated Resident #17 was ordered cleanse the wound with normal saline, apply Silvadene, cover with a foam dressing twice daily. The note indicated the nurse practitioner applied a topical anesthetic, after explaining the risks and benefits of debridement (removal of dead tissue using a sharp instrument), debridement was performed without complications. During an attempted interview on 7/29/2024 at 11:36 a.m., the previous DON was called but she had her telephone going to voice mail and a message was left to return the call related to the investigation. During an observation and interview on 7/29/2024 at 11:45 a.m., Resident #17 said he had previously had a coffee spill that caused a burn to his leg. Resident #17 said he had received treatment for the burn. Resident #17 was drinking coffee from a spill proof coffee cup with a lid and a straw. Resident #17 said he had not had any other burns. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the state agency reporting system for abuse and neglect revealed from 8/16/2023 -8/21/2023 there were no reported incidents regarding Resident #17's burn. During an interview on 7/30/2024 at 6:57 p.m., the ADON said she was not a staff member at the facility when Resident #17 had the coffee burn. The ADON said a burn was a reportable incident to the state agency. The ADON said the Administrator was the abuse coordinator and was responsible for reporting to the state agency. The ADON said she expected the facility abuse policy to be followed and report according to the required time frame of within 2 hours. The ADON said monitoring for incidents and accidents requiring reporting was done through morning meeting and review of the 24-hour report in the computer system. During an interview on 7/30/2024 at 8:02 p.m., the RNC said she was not an employee of the facility when the incident occurred with Resident #17. The RNC said she was unable to comment why the incident was not reported to the state agency, but she agreed the incident should have been reported. The RNC said the state agency should have been made aware of the incident within the two-hour time frame for reporting abuse. The RNC said when an abuse allegation was not reported timely then abuse could continue. The RNC said in morning meeting the incidents and accidents were reviewed. The RNC indicated this incident was not documented on an incident report but should have been. The RNC said in morning meeting the team also reviews the computerized documentation that flows to the 24-hour report. During an interview on 7/30/2024 at 8:51 p.m., the Administrator said when Resident #17 had his coffee burn, he was not the Administrator. The Administrator said he was the abuse coordinator, and the incident required reporting within 2 hours. The Administrator said the incident was not reported through his review. The Administrator said when abuse was not reported timely this could delay the care and services the resident would receive.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 33249 Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to the State Survey Agency for 1 of 8 residents (Resident #17) reviewed for abuse and neglect. The facility failed to report to the State Survey Agency on 8/16/2023 immediately but no later than 2 hours after becoming aware Resident #17 sustained a severe coffee burn to his right thigh. This failure could place residents at risk of further potential abuse or neglect. Findings included: Record review of a face sheet dated 7/30/2024 indicated Resident #17 was a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses heart failure, quadriplegia (paralysis of all four limbs), and other muscle spasms, contractures of the left and right hands (a condition where the one or more fingers bend toward the palm of the hand), lack of coordination, muscle weakness, muscle wasting and atrophy. Record review of the Comprehensive Care Plan dated 11/02/2023 indicated Resident #17 was at risk for burns due to hot liquids. The goal of Resident #17's care plan was he would not suffer any injury related to hot liquids. The interventions included coffee and other hot liquids should not be served if over 140 degrees, if hot liquid was spilled on self, staff should pour room temperature or lower temperature liquid over the affected area, he was to use his dominant hand for drinking, and should be seated in upright position with table or overbed table when hot liquids were being consumed. The Comprehensive Care Plan failed to indicate there was a hot liquid deficit prior to 11/02/2023. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #17 understood and was understood by others. The MDS indicated Resident #17's BIMS score was 15 indicating he had no cognitive deficits. Record review of a nursing progress note dated 8/16/2023 at 12:31p.m., RN F documented Resident #17 said he had a dry area to his right thigh. RN F documented upon assessment she noted a dry scabbed area measuring about 3.5 x 5 (no documented measurement system). The note indicated Resident #17 indicated he had a coffee cup sitting by the side of his wheelchair and it poured on him while he was trying to sit up. The note indicated RN F notified the nurse practitioner, and a new order was received to apply triple antibiotic ointment and cover with a dressing daily until resolved. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Nurse Practitioner Progress Note dated 8/21/2023 at 10:20 a.m., the nurse practitioner documented the chief complaint was a burn to the right upper thigh. The History of Present Illness section indicated Resident #17 was a [AGE] year old male The nurse practitioner note indicated Resident #17 was seen as requested by the DON due to a new wound to upper thigh. The note indicated Resident #17 said he spilled hot coffee and got burned. The note indicated Resident #17 said it was excruciating. The note indicated the burn was treated with the over-the-counter triple antibiotic cream and covered with a dressing daily. The note in the Section Current Problems: Burn of third degree of right thigh . Review of Systems section labeled Wounds: complaints of wound redness, discharge, pain, and opening of the wound. The note in Section Wound indicated: Traumatic burn to upper thigh right leg with the onset date of 8/14/2023, measuring 5.5 centimeters, 2.5 centimeters width, 0.3 centimeters depth. The note indicated the wound base was slough, with a small amount of serosanguinous drainage. The note indicated Resident #17's burn exposed the adipose tissue and was considered a full thickness wound. The note indicated Resident #17's burn was 51-75% slough; and 25-50% epithelialization and erythema present. The nurse practitioner note indicated Resident #17 was ordered cleanse the wound with normal saline, apply Silvadene, cover with a foam dressing twice daily. The note indicated the nurse practitioner applied a topical anesthetic, after explaining the risks and benefits of debridement (removal of dead tissue using a sharp instrument), debridement was performed without complications. During an attempted interview on 7/29/2024 at 11:36 a.m., the previous DON was called but she had her telephone going to voice mail and a message was left to return the call related to the investigation. During an observation and interview on 7/29/2024 at 11:45 a.m., Resident #17 said he had previously had a coffee spill that caused a burn to his leg. Resident #17 said he had received treatment for the burn. Resident #17 was drinking coffee from a spill proof coffee cup with a lid and a straw. Resident #17 said he had not had any other burns. Record review of the state agency reporting system for abuse and neglect revealed from 8/16/2023 -8/21/2023 there were no reported incidents regarding Resident #17's burn. During an interview on 7/30/2024 at 6:57 p.m., the ADON said she was not a staff member at the facility when Resident #17 had the coffee burn. The ADON said a burn was a reportable incident to the state agency. The ADON said the Administrator was the abuse coordinator and was responsible for reporting to the state agency. The ADON said she expected the facility abuse policy to be followed and report according to the required time frame of within 2 hours. The ADON said monitoring for incidents and accidents requiring reporting was done through morning meeting and review of the 24-hour report in the computer system. During an interview on 7/30/2024 at 8:02 p.m., the RNC said she was not an employee of the facility when the incident occurred with Resident #17. The RNC said she was unable to comment why the incident was not reported to the state agency, but she agreed the incident should have been reported. The RNC said the state agency should have been made aware of the incident within the two-hour time frame for reporting abuse. The RNC said when an abuse allegation was not reported timely then abuse could continue. The RNC said in morning meeting the incidents and accidents were reviewed. The RNC indicated this incident was not documented on an incident report but should have been. The RNC said in morning meeting the team also reviews the computerized documentation that flows to the 24-hour report. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/30/2024 at 8:51 p.m., the Administrator said when Resident #17 had his coffee burn, he was not the Administrator. The Administrator said he was the abuse coordinator, and the incident required reporting within 2 hours. The Administrator said the incident was not reported through his review. The Administrator said when abuse was not reported timely this could delay the care and services the resident would receive. Record review of an Abuse/Neglect policy dated 2003 and revised on 5/09/2017 indicated the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals . 2. Adverse event. An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof C. Prevention 4. The facility will be responsible to identify, correct, and intervene in situations of possible abuse/neglect. The facility has in place a method to identify events such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse. All occurrences of potential abuse or criminal behavior will be investigated by the abuse preventionist and/or designee E. Reporting 3. Facility employees must report all allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown sources to the facility administrator. The facility administrator or designee will report the allegation to HHSC. A. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation F. Investigation Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist. All allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source will be investigated.

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Country View Nursing and Rehabilitation	1900 N Frances St Terrell, TX 75160

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview and record review, the facility failed to provide an ongoing program of activities based on the comprehensive assessment to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 7 of 12 residents (Resident #24, Resident #27, and 5 confidential residents) reviewed for activities. The facility failed to ensure quarterly activity assessments were completed for Resident #24, Resident #27, and 5 confidential residents to provide activities to meet their interests. This failure could place residents at risk for not having activities to meet their interests or needs and a decline in their physical, mental, and psychosocial well-being. Findings included: 1) Record review of a face sheet dated 7/30/2024 reflected Resident #24 was a 63 -year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of chronic kidney disease, dependence on renal dialysis, and heart failure. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #24 understood and was understood by others. The MDS indicated Resident #24's BIMS score was 12 indicating moderate cognitive impairment. The MDS indicated Resident #24 was able to feed himself. Resident #24's activities were not addressed on the Quarterly MDS assessment. Record review of the comprehensive care plan dated 4/22/2022 and revised on 1/05/2023 indicated Resident #24 needed out of room social, spiritual, and stimulus activities and mental stimulation. The care plan goal was Resident #24 would attend activities of his choice, watch television, read, or socialize with other residents at least 2 times weekly. The care plan interventions included the activity director will encourage and remind the resident of current activities, the activity director will provide the resident with reading material for mental stimulation, and the activity director will praise the resident for attending activities of their choice. During an observation and interview on 7/28/2024 at 11:09 a.m., Resident #24 was sitting in his wheelchair in his room. Resident #24 said he was so bored. Resident #24 said there was only so much bingo and dominoes a person could play. Resident #24 said the resident council had asked the Activity Director for more activities and even some outings but nothing had transpired. Resident #24 said he had not been assessed for his desired activity needs by the activity director. Record review of the Activity Calendar dated July 2024 indicated: Sunday 7/28/2024: 10:00 a.m. word search; 11:00 a.m. puzzles; and 2:00 p.m. dominos Monday 7/29/2024: 8:30 a.m. Devotionals; 10:00 a.m. morning exercise; 11:00 a.m. Tasty Appetizers; 2:00 p. m. Fancy nails; 3:30 p.m. one on one (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tuesday 7/30/2024: 8:30 a.m. pass out daily devotionals; 10:00 a.m. morning exercise; 11:00 a.m. Tasty Appetizers; 2:00 p.m. juice pong; 3:00 p.m. Skip-Bo; 6:00 p.m. arts and crafts. During an observation on 7/29/2024 at 10:05 a.m., there was no exercise activity happening in the dining room. During an observation and interview on 7/29/2024 at 10:11 a.m., the RNC said the exercise activity usually occurred in the main dining room. The RNC began looking for the AD. The RNC said the AD had run to the store and she should be back soon. During an observation on 7/29/2024 at 11:16 a.m., there was not a tasty appetizer activity in the dining room. During an observation and interview on 7/30/2024 at 7:31 a.m., the AD was walking in the hallway with a handful of papers. The AD said she was supposed to fill these forms out. The form for the month of July only had resident names listed. The AD provided a list activities for the month of July. The AD said she had not documented the individual residents who attend any activities. The AD said she often was pulled to work in the dietary department and other areas. During an interview on 7/30/2024 at 9:03 a.m., the AD said she had been in her position since March 2024. The AD said with the bedridden residents she does 1:1 activity, some residents do better in small groups, and the larger groups for the more outgoing residents. The AD said she had not been documenting when a resident attended activities in the computer charting area or on a log. The AD said she had just this weekend taken two residents to Walmart one on Saturday and one on Sunday. The AD said every time she had a planned outing there were not enough CNAs to go, the driver had to work the floor, or the van was scheduled for doctor appointments. The AD said she had mentioned these issues to the Administrator, and they had been trying to work through them. The AD said she had her family purchase board games as a donation but had not had the opportunity to go and obtain them. The AD said she often was pulled from her activity position to help with transportation in the past and in the dietary department. The AD said she had a budget for the activity department but it was based on census and was not much now. During a confidential interview on 7/30/2024 at 2:00 p.m., 5 residents said the activity program was terrible. The residents said they felt as though they were in prison. The residents said there used to be outings such as going out to eat at a local restaurant, there was family night, and there had been times when they were invited to other senior facilities for a game night. The residents said it has been a year since they were able to go out to eat, on an outing of any sort, or have a game night with other seniors. The residents said they had brought this up many times in the Resident Council Meetings and nothing has improved. Another resident said, we are in jail and we are still on lock-down. A resident said the Monopoly and checker game have missing pieces. Another resident said a chess game would be so nice. During an interview on 7/30/2024 at 7:07 p.m., the ADON said they should be providing 5 activities a day. The ADON said the activities should also be meaningful to the resident. The ADON said she expected the AD to preplan trips with the residents. The ADON said without meaningful activities a resident could become depressed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/30/2024 at 8:15 p.m., the RNC said the activities should be meaningful and what the residents desire. The RNC said when activities were not meaningful a resident could become bored, loose interest, and potentially become depressed. The RNC said the Administrator had oversight of the AD and the department. The RNC said usually the activity concerns from the resident council would go to him to resolve. The RNC said she was unaware of the resident's concerns. During an interview on 7/30/2024 at 9:08 p.m., the Administrator said there was a budget for the activity department and the board games the residents wanted could be easily obtained. The Administrator said the activity department was designed to be life enrichment and he expected the activity department to be such. 30527 2. Record review of Resident #27's face sheet dated 07/30/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), type 2 diabetes mellitus (long term condition in which the body has trouble controlling blood sugar and using for energy), malignant neoplasm of lung (lung cancer) and weakness. Record review of Resident #27's order summary report dated 07/20/2024, indicated Resident #27 had an order dated 04/05/2022 Resident #27 may participate in activities per care plan. Record review of Resident #27's quarterly MDS assessment dated [DATE], indicated Resident #27 was able to understand others and was able to be understood. The MDS assessment indicated Resident #27 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #27 required substantial/maximal assistance with toileting, showering, lower body dressing. Record review of the care plan with a target date of 08/09/2023 indicated Resident #27 needed out of room social, spiritual, and stimulus activities and mental stimulation. The goal was for Resident #27 to attend activities of her choice, will watch TV, read and socialize with other residents at least 2 times weekly by next update. The interventions included the following: the activity director will encourage and remind the resident of current activities, the activity director will provide the resident reading material for mental stimulation, the activity director will praise the resident for attending activities of their choice. Record review of Resident #27's electronic health record indicated Resident #27 had no completed activity assessments. During an observation and interview on 07/28/2024 at 10:15 AM, Resident #27 was sitting in her bed without any lights on or blinds open. Resident #27 stated she had always participated in activities, but now with the new activity director, the only activity provided was on Tuesday evenings by a volunteer. Resident #27 stated she would at least like something to read occasionally, but nothing had been offered. Resident #27 had the activities calendar from July 2024 posted on her wall. Resident #27 stated those activities did not occur. Resident #27 stated the Activity Director before would take the residents out to eat occasionally, but that has not happened in over 6 months although it had been scheduled but later canceled. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/30/2024 at 09:10 AM the Activity Director said she had been in the position as Activity Director since March of 2024. The Activity Director said she had not completed any documentation to show Resident #27 was provided or that she had offered any activities. The Activity Director stated she had failed to document the activity assessment information because she was often pulled to help in the kitchen area and did not have enough time to document. The Activity Director said it was important to complete the activity assessments and documentation to know the resident's likes or dislikes and to prevent them from declining and show that she had provided the activities. The Activity Director stated the resident outings had been canceled on several occasions for different reasons such as the previous Administrator told them they could not go any longer. Record review of the facility's undated policy titled, Activity Programming indicated, The Activity Director and staff will provide for ongoing Activity programs. PRACTICE GUIDELINES: 1. Recreation programs are based on the interest and needs of the residents expressed through the activity assessment .10. The opportunity is provided for regular community outings/trips .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on observation, interviews, and record reviews the facility failed to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 18 (Resident #1) residents reviewed for accidents hazards and supervision. The facility failed to ensure Resident #1 did not keep cigarettes in her purse. The CNA D failed to ensure Resident #1 smoked only in the designated areas of the facility. These failures could place residents at risk for injury. The findings included: Record review of Resident #1's face sheet dated 07/30/24 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses multiple sclerosis(autoimmune disease in which the immune system eats away at the protective covering of the nerves and causes disruption of communication), major depressive disorder, and dementia. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated she made herself understood and understood others. The MDS also indicated she had a BIMS score of 11 which indicated she had moderately impaired cognition. Record review of Resident #1's care plan revised on 07/28/24 indicated that she chose to sign herself out of the facility to go off of the premises to smoke with interventions in place to ensure smoking occurred in designated smoking area and no smoking materials or igniters would be stored in the resident rooms. Record review of Resident #19's safe smoking assessment dated [DATE] indicated she was a safe smoke but need to keep materials at the nurse's station. During an observation on 07/29/24 at 01:39 PM Resident #1 was in her motorized wheelchair out in the designated smoking area at the end of the 400 hall and had her cigarettes stored in her purse. During an observation on 07/29/24 at 08:35 PM CNA D and Resident #1 were sitting beside the facility wall next to the front parking lot smoking cigarettes. During an interview on 07/30/24 at 03:15 PM CNA D said he apologized for smoking outside of the building on 07/29/24 when he knew that no staff nor resident should smoke outside of designated smoke area at the end of the hall 400. He said he knew neither him, nor the resident were supposed to smoke out front. CNA D said he was trying to be a good aide and follow the rules, but he said he was stressed from work, school, and life. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/30/24 at 03:17 PM Resident #1 said she talked with the administrator that is here now about going to an assisted living because she was tired of all the restrictions at the facility, and she was in her right mind. Resident #1 said the smoking was the biggest issue, but she must go off of their property to smoke to ensure they were not responsible for smoking outside of the times and areas. She said she liked to smoke when she wanted to smoke. Resident #1 said she kept her cigarettes and lighter on her and she signs out and goes to smoke. She said the policy was for the residents to keep cigarettes and lighters in the lock box and they get them out when they go for assigned smoke breaks. She said she was not keeping her cigarettes and lighter in the box because they would come up missing. During an interview on 07/30/24 at 06:36 PM the ADON said the staff had just taken the cigarettes and lighter away from Resident #19 and she was expected to keep her cigarettes and lighter in the lock box and get the items from the nurse's station at designated smoking times. The ADON also said staff and residents were not allowed to smoke in the parking lot by the building. She said Resident #1 was non-compliant and may need to find another placement. The ADON said the failure could result in oxygen exploding and fires but she said Resident #1 thinks there was no risk and she would not let the facility staff check her personal items and take the cigarettes and lighters. During an interview on 07/30/24 at 07:38 PM the Regional Corporate Compliance Nurse said Resident #1 was not supposed to have the cigarettes and lighters in her possession and she was supposed to turn the cigarettes and lighters in after the completion of smoke breaks. She said Resident #1 was her own responsible party and could sign herself out to smoke off the property because she liked to smoke when she was ready and it was outside of the designated times. She said no staff or residents should have been smoking on the property except in designated areas. The Regional Corporate Compliance Nurse said all staff were responsible for ensuring residents did not have cigarettes and lighters in their possession or in their rooms. She said Resident #1 should turn cigarettes and lighters in when she completed smoking breaks. The Regional Corporate Compliance Nurse said the risk for the failure was fires. During an interview on 07/30/24 at 08:44 PM The Administrator said his expectation was for Resident #1 to keep the cigarettes and lighters in the lock box at the nurse's station and check them out as needed prior to smoke breaks. He said neither Resident #1 nor CNA D should have been smoking on the property outside of designated smoking areas. He said he had confiscated cigarettes and lighters in the past from Resident #1 and she would go and buy more. He said the failures placed a risk for other residents getting the cigarettes and lighters and having fun with them which caused issues like fires. The Administrator said the purpose of residents and staff using designated smoking area is for safety and the designated areas have smoke blankets and fire extinguishers available. Record Review of the facility's policy titled, Smoking Policy revised on 11/01/2017 indicated, Smoking policies must be formulated and adopted by the facility .The facility is responsible for enforcement of smoking policies which must include at least the following provisions: 1. Matches, lighters or other ignition sources for smoking are not permitted to be kept or stored in a resident's room. Smoking is only allowed in designated smoking areas. Smoking is prohibited in any area labeled No Smoking .

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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** 33249 Based on observation, interview, and record review the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 3 residents reviewed (Resident #12) for incontinent care, or catheter care. CNA L failed to perform hand hygiene during Resident #12's continent care. CNA L failed to perform catheter care when Resident #12 received incontinent care. This failure placed residents who required assistance with incontinent care at risk for urinary tract infections, skin breakdown, and hospitalization . Findings included: Record review of a face sheet dated 7/30/2024 indicated Resident #12 was a [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnoses of rheumatoid arthritis end-stage (a chronic inflammatory disorder that can affect more than just your joints), fractured right femur (upper leg bone), and multiple pressure ulcers. Record review of the consolidated physician's orders dated July 30, 2024, indicated on 5/19/2024 Resident #12 was ordered catheter care every shift. Record review of the undated Comprehensive Care Plan Indicated Resident #12 had an indwelling catheter related to pressure ulcers. The care plan indicated Resident #12 required ADL care with the goal of she will maintain or improve current level of function in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene. The interventions included Resident #12 required total assistance with personal hygiene care. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #12 was understood and understands others. The MDS indicated Resident #12's BIMS score was 15 indicating no cognitive impairment. The MDS indicated Resident #12 was dependent with toileting hygiene. The MDS in Section H-Bladder and Bowel indicated Resident #12 had an indwelling catheter. Record review of a CNA Proficiency Audit dated 4/23/2024 indicated CNA L was assessed in the area of hand washing, catheter care, infection control awareness, and perineal care scoring a satisfactory in skill level. (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 observation on 7/28/2024 at 11:37 a.m. - 12:00 p.m., CNA L entered the room, washed her hands, obtained a box of gloves, sat them on the foot of the bed, and obtained an under pad. CNA L donned another pair of gloves while LVN K held Resident #12's right leg, and RN P assisted Resident #12 to roll more toward her left side. CNA L cleaned Resident #12's peri area using a wipe with a wiping motion toward Resident #12's rectum. CNA L used another wipe and completed the wiping motion again. Resident #12 had a very small bowel movement, then CNA L grabbed a wipe and removed the bowel movement. CNA L then adjusted the draw sheet underneath Resident #12, then she took the disposable under pad, rolled the edge up, and tucked this pad underneath Resident #12. CNA L then removed her gloves, and her personal protective equipment, and washed her hands. CNA L failed to perform catheter care during the incontinent care process. During an interview on 7/28/2024 at 12:30 p.m., RN P said CNA L failed to change gloves and do hand hygiene between dirty and clean areas of incontinent care. RN P said she agreed she had not witnessed CNA L provide catheter care as well. RN P said she made a mistake by placing the dirty linen on the floor as well. RN P said Resident #12 was at risk for UTIs(urinary tract infection) when catheter care and incontinent care were not provided correctly. RN P said she was unaware she could have stopped the process and corrected the incontinent care procedure. During an interview on 7/28/2024 at 1:09 p.m., LVN K said CNA L should have performed hand hygiene and changed gloves between dirty and clean during incontinent care with Resident #12. LVN K said she was unaware she could have corrected CNA L during the incontinent care procedure. LVN K said Resident #12 was at risk for urinary tract infections when incontinent care was not performed correctly. During an interview on 7/30/2024 at 8:01 a.m., CNA L said she had forgotten to perform hand hygiene and change her gloves between dirty and clean during incontinent care. CNA L said she had though she had performed catheter care. CNA L said Resident #12 was at risk of urinary tract infections when incontinent care was not performed correctly. During an interview on 7/30/2024 at 6:41 p.m., the ADON said she expected the CNAs to clean their hands by performing hand hygiene between dirty and clean areas of incontinent care. The ADON said not performing hand hygiene could cause infections. The ADON said this was monitored by the performance of skill check offs and random checks while performing incontinent care on a resident or the use of a mannequin. During an interview on 7/30/2024 at 7:51 p.m., the RNC said she expected CNA L to perform hand hygiene when going from dirty to clean in the incontinent care process. The RNC said when this hand hygiene was not performed, and new gloves applied the resident was at risk of infection. The RNC said the nurse managers were responsible for ensuring appropriate incontinent care monitoring through the use of random check offs and annual check offs. During an interview on 7/30/2024 at 8:51 p.m., the Administrator said he expected the staff the perform hand hygiene between clean and dirty to prevent the spread of germs. The Administrator said the staff should be monitored by the nurse managers by competencies. Record review of the undated Hand Hygiene policy indicated you may use alcohol-based hand cleaner or soap/water for the following: When coming on duty (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Before and after performing any invasive procedure. Before and after entering isolation precautions settings. Before and after assisting a resident with personal care Before and after changing a dressing After contact with a resident's mucous membranes and body fluids or excretions . After removing gloves. You must use soap/water for the following: (alcohol based cleaner is not recommended) When hands are visibly soiled After personal use of the toilet Before and After assisting a resident with toileting (hand washing with soap and water) . Record review of the Perineal Care policy dated 4/25/2022 and effective as of 5/11/2022 indicated an incontinent resident of urine and or bowel should be identified, assessed and provided appropriate treatment and services to restore as much normal bladder/bowel function as possible. Procedure: .10.Perform hand hygiene 11. Donn gloves .17. Gently perform perineal care, wiping from clean, urethral areas to dirty, rectal area, to avoid contaminating the urethral area-clean to dirty. Female resident: working from front to back, wipe on side of the labia majora, the outside folds of the perineal skin that protect the urinary meatus and the vaginal opening. Continue perineal care to the inner thigh. If applicable, gently wash the juncture of the Foley catheter tubing from the urethra down the catheter about 3 inches. Then wipe the other side. Use a clean area of the washcloth or pre-moistened cleansing wipes for each stroke 24. Doff gloves and PPE 25. Perform hand hygiene. Important Points: Doffing and discarding of gloves are required if visibly soiled. Always perform hand hygiene before and after glove use.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review, the facility failed to ensure residents were offered sufficient fluid intake to maintain proper hydration and health for 1 of 1 resident (Resident #24) reviewed for fluid restriction. The facility failed to ensure Resident #24's 1 liter fluid restriction was monitored. This failure could place residents at risk for dehydration. Findings included: Record review of a face sheet dated 7/30/2024 reflected Resident #24 was a 63 -year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of chronic kidney disease, dependence on renal dialysis, and heart failure. Record review of a Dehydration Risk Screener dated 7/14/2021 indicated Resident #24 was a dehydration risk. The screen indicated Resident #24 was on diuretic therapy, received medications, had a terminal illness, was incontinent and required assistance with ADLs. Record review of the comprehensive care plan dated 7/27/2021 and revised on 1/05/2023 indicated Resident #24 had a potential for fluid deficit. The care plan goal was Resident #24 would be free of symptoms of dehydration, maintain moist membranes and good skin turgor (elasticity). The care plan interventions included encourage to drink fluid of choice. The care plan failed to address the fluid restriction and interventions. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #24 understood and was understood by others. The MDS indicated Resident #24's BIMS score was 12 indicating moderate cognitive impairment. The MDS indicated Resident #24 was able to feed himself. The MDS in Section O- Special Treatments, Procedures, and Programs indicated Resident #24 received dialysis. Record review of the consolidated physician orders dated 7/30/2024 indicated Resident #24 was ordered a fluid restriction of 1 liter daily starting on 5/28/2024. The consolidated physician's orders indicated for Resident #24 to have 1 cup of fluid each meal (240 milliliters) related to severe chronic kidney disease. Record review of a Nutritional Progress Note dated 5/24/2024 at 11:22 a.m., the dietician documented Resident #24 was on a 1-liter fluid restriction. The note indicated the fluid restriction should be 1 cup of fluid with each meal of 240 milliliters and 90 milliliters each shift for nursing. Record review of a progress note dated 5/28/2024 at 3:18 p.m., indicated the RNC documented a dietary recommendation was returned and signed by the physician regarding the fluid restriction and Resident #24 was made aware. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the medication administration record dated July 2024 indicated Resident #24 had a fluid restriction 1 liter daily for hydration monitoring. The entry for July 1- July 28 had a check mark for day shift and night shift. The entry had no numerical entries indicating the amount of fluids Resident #24 consumed. During an observation and interview on 7/28/2024 at 11:09 a.m., Resident #24 said he was on hemodialysis three times weekly. Resident #24 had a water pitcher with a drinking straw and 500 milliliters of ice water. Resident #24 said he will drink 1 to 1.5 of these water pitchers each day. Resident #24 said he gets a glass of juice on each tray from the dining room. Resident #24 said the nursing staff were not asking him how much he drank throughout the day. During an interview on 7/30/2024 at 9:45 a.m., LVN A said he was aware Resident #24 had a fluid restriction but was unsure of the amount of fluid Resident #24 was supposed to have in a day. LVN A said he thought at one time the medication administration record said how much nursing was to administer. LVN A said the electronic medical record had no numerical entries of the amounts of fluid intake for Resident #24. LVN A said monitoring fluid intake for a Resident #24 was important because he received dialysis. LVN A said Resident #24 could become hypotensive (low blood pressure) if he became dehydrated. During an interview on 7/30/2024 at 5:01 p.m., the Dietary Manager said she was unaware of Resident #24 having a fluid restriction. During an interview on 7/30/2024 at 7:21 p.m., the ADON said she expected the nurses to monitor a resident's fluid restriction. The ADON said the check marked boxes on the fluid restriction entry on the medication administration record was not truly monitoring. The ADON said Resident #24 could experience fluid overload or dehydration. The ADON said the nurses were responsible for monitoring fluid intake ensuring the fluid restriction. The ADON said the orders should be reviewed during morning meeting. During an interview on 7/30/2024 at 8:14 p.m., the RNC said nursing was responsible for following the physician's order for a fluid restriction. The RNC said the nurse managers were responsible for ensuring fluid restrictions were monitored. During an interview on 7/30/2024 at 9:13 p.m., the Administrator said not monitoring fluid restrictions was a risk to the resident. The Administrator said dehydration was a risk. The Administrator said the nurse was responsible for implementing the fluid restriction and the nurse managers were responsible for monitoring the fluid restriction. Record review of a Dialysis Policy dated November 2013 indicated: 14. Strict intake and output will be maintained on the resident according to the physician order. Daily weights will be maintained unless otherwise specified by the physician order. Fluid restrictions will be monitored as specified by the physician order. All documentation will be maintained in the resident's clinical record.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided such care consistent with professional standards of practice for 1 of 4 residents (Resident #8) reviewed for respiratory care and services. The facility failed to properly store Resident #8's nebulizer (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) mask while not in use. This failure could place residents who require respiratory care at risk for respiratory infections and exacerbation of respiratory distress. Findings include: 1. Record review of Resident #8's order summary report, dated 07/30/2024, indicated Resident #8 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (a group of lung diseases that blocks air flow and causes difficulty breathing), diabetes mellitus (a group of diseases that result in too much sugar in the blood), essential hypertension (high blood pressure), weakness. Record review of Resident #8's order summary report, dated 07/30/2024, indicated Resident #8 received Ipratropium- Albuterol solution 0.5-2.5 (3) mg/3ml via nebulizer every 4 hours prn for shortness of breath and/or wheezing. Record review of Resident #8's admission MDS assessment, dated 06/08/2024, indicated Resident #8 understood others and made herself understood. The assessment indicated Resident #8 was severely cognitively impaired with a BIMS score of 5. The assessment indicated Resident #8 did not reject care necessary to achieve the resident's goals for health or well-being. The MDS indicated Resident #8 required partial/moderate assistance for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. Record review of Resident #8's care plan, with a revision date of 06/16/2024, indicated Resident #8 had an impaired respiratory status related to chronic obstructive pulmonary disease. The care plan interventions included provide nebulizer therapy as ordered. During an observation on 07/28/2024 at 10:15 a.m., Resident #8 was not in her room. Resident #8's nebulizer mask was laying on the table at bedside uncovered. During an observation on 07/28/2024 at 11:15 AM., Resident #8 was sitting in her wheelchair. The nebulizer mask was laying on the table at bedside uncovered. During an observation on 07/28/2024 at 4:11 PM., Resident #8 was asleep in bed. The nebulizer mask was laying on the table at bedside uncovered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 07/28/2024 at 4:16 PM., LVN N stated she was Resident #8's 6am-6pm charge nurse. LVN N stated Resident #8 had an order for PRN nebulizer treatments. LVN N observed with the surveyor Resident #8's nebulizer mask on the bedside table not covered. LVN N stated Resident #8's nebulizer mask should be covered when not in use. LVN N stated she had administered Resident #8's breathing treatments today and failed to place the pipe back in the plastic bag after usage. LVN N stated all nursing staff were responsible for ensuring infection control was provided for each resident. LVN N stated these failures could potentially put residents at risk for respiratory infection. During an interview on 07/28/2024 at 4:24 PM, the Regional Corporate Compliance Nurse said she expected Resident #8's nebulizer mask be stored in a bag when not in use. The Regional Corporate Compliance Nurse stated the charge nurses were responsible for nebulizers treatments and ensuring proper infection control precautions were utilized. The Regional Corporate Compliance Nurse said the charge nurses were responsible for monitoring to ensure respiratory equipment was returned to the designed bag after each use. The Regional Corporate Compliance Nurse stated, she and the ADON were responsible for monitoring the charge nurses. The Regional Corporate Compliance Nurse said these failures could potentially cause a decrease in respiratory status. During an interview on 07/30/2024 at 8:40 PM, the Administrator said he expected nebulizers stored in bags when not in use, tubing to be changed and dated per orders and filters to be placed on oxygen concentrators. The Administrator stated this was monitored by the clinical staffing. The Administrator stated these failures put residents at risk for respiratory infection due to particles that could accumulate on the mask. Record review of the facility's Medication Administration Procedures policy, revised October 2016, did not address storage of plastic equipment.

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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** 30527 Based on interview and record review, the facility failed to ensure residents who require dialysis services receive such services consistent with professional standards of practice for 2 of 2 residents reviewed for dialysis services. (Residents #23 and Resident #24) The facility failed to keep ongoing communication with the dialysis facility for Resident #23 and Resident #24. This failure could place residents who received dialysis at risk for complications and not receiving proper care and treatment to meet their needs. The findings included: 1)Record review of Resident #23's face sheet, dated 07/30/2024, indicated Resident #23 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of end stage renal disease (occurs when chronic kidney disease - the gradual loss of kidney function - reaches an advanced state), type 2 diabetes mellitus with diabetic neuropathy (high blood sugar that has caused nerve damage), and encephalopathy (a disease that impacts the functioning of the brain). Record review of the order summary report, dated 07/30/2024, indicated Resident #23 had an order, which started on 05/22/2024, that stated dialysis on Tuesday, Thursday, and Saturday days. Record review of Resident #23's pre and post dialysis communication forms for July 2024, showed the following: 1. No dialysis communication form on 7/04/2024, 07/06/2024, 07/09/2024, and 07/11/2024. 2. No post-dialysis vital sign documentation filled out on 07/02/2024, 07/13/2024, 07/16/2024, 07/18/2024, 07/20/2024, 07/23/2024 and 07/25/2024. Record review of the Comprehensive MDS assessment, dated 07/12/2024, indicated Resident #23 had clear speech and was understood by staff. The MDS revealed Resident #23 was able to understand others. The MDS revealed Resident #23 had a BIMS score of 11, which indicated moderate cognitive impairment. The MDS revealed Resident #23 received dialysis while a resident during the 14-day look-back period. Record review of the comprehensive care plan, last revised on 05/24/2024, revealed Resident #23 received dialysis three times a week for end stage renal disease. 33249 2) Record review of a face sheet dated 7/30/2024 reflected Resident #24 was a 63 -year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of chronic kidney disease, dependence on renal dialysis, and heart failure. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Dehydration Risk Screener dated 7/14/2021 indicated Resident #24 was a dehydration risk. The screen indicated Resident #24 was on diuretic therapy, received medications, had a terminal illness, was incontinent and required assistance with ADLs. Record review of the comprehensive care plan dated 7/27/2021 and revised on 1/05/2023 indicated Resident #24 had a potential for fluid deficit. The care plan goal was Resident #24 would be free of symptoms of dehydration, maintain moist membranes and good skin turgor (elasticity). The care plan interventions included encourage to drink fluid of choice. The care plan failed to address the fluid restriction and interventions. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #24 understood and was understood by others. The MDS indicated Resident #24's BIMS score was 12 indicating moderate cognitive impairment. The MDS indicated Resident #24 was able to feed himself. The MDS in Section O- Special Treatments, Procedures, and Programs indicated Resident #24 received dialysis. Record review of the Consolidated Physician's orders dated July 2024 indicated Resident #24 was ordered dialysis on Monday, Wednesday, and Friday. Record review of the Dialysis Communication Form: Facility assessment pre-dialysis included: temperature, pulse, respirations, and blood pressure, assessed the access site, assessed the thrill and bruit , assessed the dressing, documented any medication changes, documented any condition changes. The Dialysis Center Section indicated: Pre-Dialysis: weight; temperature, pulse, respirations, and blood pressure. Post-Dialysis: weight; temperature, pulse, respirations, and blood pressure. Nursing Facility Post-Dialysis Documentation: Assessment of temperature, pulse, respirations, blood pressure, access site, thrill (buzz sound of blood flowing) and bruit (whooshing sound), dressing clean dry and intact, assessment of the resident, and any new orders. Record review of the Dialysis Communication Forms for the month of July 2024 indicated: 7/01/2024: Resident #24's pre-dialysis assessment was completed by the facility; the dialysis unit section was completed by the dialysis center; and the third section Nursing Facility Post Dialysis Documentation section was blank. 7/03/2024: Resident #24's pre-dialysis assessment was completed by the facility; the dialysis unit section was completed by the dialysis center; and the third section Nursing Facility Post Dialysis Documentation section was blank. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/05/2024: Resident #24's pre-dialysis assessment was completed by the facility; the dialysis unit section was completed by the dialysis center; and the third section Nursing Facility Post Dialysis Documentation section was blank. 7/08/2024: Resident #24's pre-dialysis assessment was completed by the facility; the dialysis unit section was completed by the dialysis center; and the third section Nursing Facility Post Dialysis Documentation section was blank. 7/10/2024: no dialysis communication form was provided. 7/12/2024: Resident #24's pre-dialysis assessment was completed by the facility; the dialysis unit section was completed by the dialysis center and included an order for fluid restriction 1.5 liters for 24 hours; and the third section Nursing Facility Post Dialysis Documentation section was blank. 7/15/2024: Resident #24's pre-dialysis assessment was completed by the facility; the dialysis unit section was completed by the dialysis center; and the third section Nursing Facility Post Dialysis Documentation section was blank. 7/17/2024: Resident #24's pre-dialysis assessment was completed by the facility; the dialysis unit section was completed by the dialysis center; and the third section Nursing Facility Post Dialysis Documentation section was blank. 7/19/2024: Resident #24's pre-dialysis assessment was completed by the facility; the dialysis unit section was completed by the dialysis center; and the third section Nursing Facility Post Dialysis Documentation section was blank. 7/22/2024: Resident #24's pre-dialysis assessment was completed by the facility; the dialysis unit section was completed by the dialysis center; and the third section Nursing Facility Post Dialysis Documentation section was blank. 7/24/2024: Resident #24's pre-dialysis assessment was completed by the facility; the dialysis unit section was completed by the dialysis center; and the third section Nursing Facility Post Dialysis Documentation section was blank. 7/26/2024: Resident #24's pre-dialysis assessment was completed by the facility; the dialysis unit section was completed by the dialysis center; and the third section Nursing Facility Post Dialysis Documentation section was blank. Record review of Resident #24's blood pressures in the vital signs section of the electronic medical record for the month of July 2024 indicated: 7/01/2024: no blood pressure 7/03/2024: pre-dialysis at 9:47 a.m., 99/66 no other blood pressures documented. 7/05/2024: no pre-dialysis or post-dialysis blood pressure documentation. 7/08/2024: no pre-dialysis or post-dialysis blood pressure documentation. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/10/2024: no pre-dialysis or post-dialysis blood pressure documentation. 7/12/2024: pre-dialysis at 10:55 a.m., 140/70 no other blood pressures documented. 7/15/2024: no pre-dialysis or post-dialysis blood pressure documentation. 7/17/2024: pre-dialysis at 10:42 a.m., 118/62 no other blood pressures documented. 7/19/2024: no pre-dialysis or post-dialysis blood pressure documentation. 7/22/2024: post-dialysis at 5:18 p.m., 133/73 no other blood pressures documented. 7/24/2024: no pre-dialysis or post-dialysis blood pressure documentation. 7/26/2024: pre-dialysis at 10:57 a.m., 108/68 no other blood pressures documented. During an interview on 7/30/2024 at 9:45 a.m., LVN A said Resident #24 should be assessed prior to leaving for dialysis and after he returns from dialysis. LVN A said the dialysis communication form should be filled out pre-dialysis and post-dialysis by the nurses. LVN A said usually Resident #24 returns around dinner time, and he waves at them as he passes by the nurse's station. LVN A said the assessment of Resident #24 was important to ensure his blood pressure was stable and he was not having low blood pressure. During an interview on 7/30/2024 at 7:17 p.m., the ADON stated dialysis communication forms should have been completed by the nurses . The ADON stated the nurses were expected to ensure both the pre and post dialysis documentation was completed. The ADON stated she was not aware the wrong forms were being utilized and did not have a space for post dialysis documentation. The ADON stated the importance of ensuring dialysis communication forms were filled out was to ensure continuity of care and to catch potential problems early on such as hypotension (low blood pressure). During an interview on 07/30/2024 at 08:11 PM, the RNC stated the charge nurses were responsible for appropriately filling out the pre and post information on the dialysis communication form. The RNC said she had recently replaced the form when it was brought to her attention there was no place to document post dialysis vital sign information. The RNC said the dialysis communication forms were important to find out if there were any issues with the resident. The regional corporate compliance nurse said if the forms were not completed, then the resident's vital signs could be out of line and staff would not know about it or the resident could get ill from a low blood pressure. During an interview on 07/30/2024 at 08:42 PM, the Administrator stated he expected dialysis communication forms to be completed. The Administrator stated the charge nurses were responsible for ensuring the communication forms were filled out. The Administrator said he expected the ADON and DON to oversee this process. The Administrator stated the importance of ensuring dialysis communication forms were filled out was to ensure the residents received proper documentation of their care. The Administrator stated if the communication forms were not done appropriately, it could result in residents having adverse reactions. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the policy on Dialysis, revised November 2011 indicated, .19. The facility will monitor departures and returns from the dialysis center. The facility will document the resident's vital signs, general appearance, orientation and additional baseline data as needed. The resident clinical record will be documented with this information. The date and time of the resident's return to the facility will be recorded by the nurse. The facility will be observant of any of the following symptoms.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on interview and record review, the facility failed to ensure that licensed nurses were able to demonstrate the specific competencies and skill sets necessary to care for resident's needs for 1 resident's needs (Resident #192). Three Licensed Vocational Nurses (LVN A, LVN C, and LVN H) provided Intravenous (IV) therapy to Resident #192 during the month July 2024, without certification of training for Intravenous therapy. This deficient practice could place residents requiring Intravenous therapy at risk from adverse effect from improper Intravenous (IV) therapy techniques. Findings included: Record review of Resident #192's face sheet dated 07/30/24 indicated she was an [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses of acute and chronic respiratory failure, diabetes mellitus type 2, Hypertension (high blood pressure), peripheral vascular disease (circulation condition in which causes decreased blood flow to the limbs), and bacteremia(blood stream infection). Record review of Resident #192's MDS schedule indicated she did not have an MDS assessment completed because it was not due. Record review of Resident #192's care plan dated 07/28/24 indicated she had an IV access to be used for antibiotics. Record review of the facility MDS Resident Matrix dated 07/28/24 indicated Resident #192 had intravenous therapy. Record review of Resident #192's medication administration record dated 07/01/24-07/31/24 indicated LVN A, LVN C, and LVN H administered her IV antibiotics. On 07/30/24 at 11:48 a.m., surveyor requested LVN certifications for IV therapy training, and the ADON did not provide documents that prove LVN A, LVN C, and LVN H had the certification of IV therapy training to provide IV Medication for Resident #192. During an interview on 07/30/24 at 06:25 PM the ADON said the IV certifications should have been obtained prior to LVN A, LVN C, and LVN H starting to work at the facility. She said they should have had IV certification prior to giving medications by IV route. She said the DON and ADON were responsible for the IV certifications, but she thought the nurses had IV certifications and she was new to the ADON position. The ADON said the failure placed a risk for the resident to receive the incorrect IV administration. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/30/24 at 07:30 PM the Regional Corporate Compliance Nurse said the LVN should have had IV certification at some point in their career. She said the Human Resource director and ADON and DON were responsible for ensuring the LVNs had the IV certifications when they were hired. She said the failure placed the resident at risk for her medications being given incorrectly. During an interview on 07/30/24 at 08:35 PM the Administrator said the DON and ADON were responsible for ensuring the certifications are completed upon hire and completing monthly audits to ensure they were kept up to date. He said the DON was a travel DON and only been at the facility a few weeks and the ADON was new to the position as well. The Administrator said the failure placed a risk for the medications to be given improperly. Record review of the undated facility policy INTRAVENOUS MEDICATION POLICY 1. The Physician may order any IV fluids and IV medications for residents in the nursing facility. 2. IV insertion must be by an IV certified LVN or RN. 3. IV medication may be administered only by IV certified LVN or RN familiar with IV administration techniques.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, and dispensing of routine drugs and biologicals to meet the needs of each resident for 1 of 1 resident reviewed for pharmacy services. (Resident #17) The facility failed to ensure Resident #17's methocarbamol (treatment of muscle spasms/pain) 500 milligrams one tablet 3 times daily was available for administration for 2 of the 3 doses due on 7/29/2024. This failure could place residents at risk for unrelieved or increased pain from muscle spasms. Findings included Record review of a face sheet dated 7/30/2024 indicated Resident #17 was [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnosis diagnoses of heart failure, quadriplegia (paralysis of all four limbs), and other muscle spasms. Record review of the Quarterly MDS dated [DATE] indicated Resident #17 understood and was understood by others. The MDS indicated Resident #17's BIMS score was 15 indicating he had no cognitive deficits. The MDS in Section J-Heath Conditions indicated Resident #17 received as needed pain medication. The MDS in Section J0410 indictedindicated Resident #17 frequently had pain, and occasionally experienced pain over the last 5 days of the assessment period. The MDS indicated in Section J0600 Resident #17 experienced pain rated at 6 on a pain scale of 0-10. Record review of the Comprehensive Care Plan dated 1/06/2023 and revised on 4/18/2023 indicated Resident #17 had chronic pain related to muscle spasms. The goal of the care plan was Resident #17 would not have an interruption of his normal activities due to pain. The care plan interventions included to administer medications as ordered. Record review of the Quarterly MDS dated [DATE] indicated Resident #17 understood and was understood by others. The MDS indicated Resident #17's BIMS score was 15 indicating he had no cognitive deficits. The MDS in Section J-Heath Conditions indicated Resident #17 received as needed pain medication. The MDS in Section J0410 indicted Resident #17 frequently had pain, and occasionally experienced pain over the last 5 days of the assessment period. The MDS indicated in Section J0600 Resident #17 experienced pain rated at 6 on a pain scale of 0-10. Record review of the consolidated physician's orders dated 7/30/2024 indicated Resident #17 was ordered methocarbamol 500 milligrams give one tablet by mouth three times daily for muscle spasms. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Nursing and Rehabilitation	1900 N Frances St Terrell, TX 75160

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #17's the electronic medication administration record dated July 2024 indicated Resident #17 on 7/29/2024 the ordered methocarbamol oral tablet 500 milligrams one tablet by mouth three times daily was scheduled to be administered at 8:00 a.m., 4:00 p.m., and 9:00 p.m. The medication regimen indicated on 7/29/2024 no documented evidence the methocarbamol was not administered at 4:00 p.m., or the 9:00 p.m. administration times. The entry on the medication record at 4:00 p.m. and 9:00 p.m., indicated to see the nurse notes. Record review of the nursing progress notes dated 8/01/2023 to 7/29/2024 indicated there was not an entry for July 29, 2024, at 4:00 p.m., or 9:00 p.m. During an interview on 7/30/2024 at 7:27 a.m., Resident #17 said he had not received his muscle spasm medication. Resident #17 said when he asked the nurse yesterday (7/29/24), and he was told the medication was ordered but had not arrived. During an interview on 7/30/2024 at 8:01 a.m., LVN A said Resident #17's methocarbamol was not available for administration. LVN A said he reordered the medication on 7/29/2024. LVN A said nurses were responsible for reordering medications timely to ensure availability. LVN A said the medication card was marked by a colored line indicating the time for reorder. LVN A said Resident #17 could experience pain from muscle spasms when the medication was not administered. During an interview on 7/30/2024 at 7:02 p.m., the ADON said the nursing staff could have made her aware when Resident #17's methocarbamol was unavailable in so that she could intervene and get the medication delivered stat. The ADON said the nurse was responsible for the reordering of the medications timely to prevent residents from not having their medications available. The ADON said Resident #17 could suffer increased muscle spasms. The ADON said muscle spasms could be painful. During an interview on 7/30/2024 at 8:04 p.m., the RNC said she expected if there was an order for medications, she expected the medications to be available. The RNC said she expected the nurse to recognize the need to reorder the medications and reorder timely thru their computer system. The RNC said Resident #17 could experience pain with muscle spasms when not receiving his medications. Record review of a Medication Administration Procedures policy dated 2003 and revised 10/25/2017 failed toreflected it did not address ensuring availability of a resident's medication.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47708 Based on observation, interview and record review, the facility failed to ensure the meals served met the nutritional needs of residents for 1 of 3 meal (the lunch meal) reviewed for nutritional adequacy, as evidenced by: The facility failed to follow the menu for the noon time (lunch) meal served on 7/28/24. This failure could affect all residents in the facility by placing them at risk of not receiving adequate nutritive food value needed to promote/maintain health. Findings included: Record Review of the facility week 1 menu received on 7/28/24, indicated the lunch meal items included chicken fried chicken with cream gravy, mash potatoes, Mexicali corn, honey kissed roll, banana pudding with wafers and iced tea. During an observation on 7/28/24 at 12:31 p.m., revealed the residents were served chicken fried steak instead of chicken fried chicken, cream corn instead of Mexicali corn and cantaloupe instead of banana pudding with wafers for the lunch meal on 7/29/24. During an interview on 7/29/24 at 8:47 a.m., the Dietician stated she had been the full time Dietician for the past 4 years. The Dietician stated she oversaw the Dietary Manager. The Dietician stated the Dietary Manager oversaw the dietary staff. The Dietician stated the Dietary Manager was supposed to have given her a phone call regarding the menu changes for her to approve over the phone prior to serving any meal changes to the residents on Sunday (7/28/24). The Dietician stated sometimes the delivery truck did not bring what was the Dietary Manager had ordered to the facility. The Dietitian stated the Dietary Manager was supposed to fill out a substitution form. The Dietician stated when she approved the substituted food item over the phone that the Dietary could then serve that substituted food item to the residents. The Dietician stated during each of her monthly visits, she would sign the substitution forms in-person with the Dietary Manager. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/30/24 at 9:06 a.m., the Dietary Manager stated she had been the dietary manager for two weeks. The Dietary Manager stated the Administrator oversaw her at the facility. The Dietary Manager stated there was a substitution form that she was to fill out for food items that needed to be substituted. The Dietary Manager stated she would then notify the Dietician about meal changes and the Dietician would approve the meal changes by phone and sign the substation form when she came into the facility. The Dietary Manager stated she thought the Dietician was coming into the facility on Friday 7/26/24. The Dietary Manager stated she had planned to ask the Dietician in person on Friday (7/26/24) about changing the lunch menu for Sunday (7/28/24). The Dietary Manager stated she did not make calls to the Dietitian on the weekends because the Dietitian did not work on weekends. The Dietary Manager stated the Administrator did not work on the weekend, so she did not inform the Administrator about the meals changes on Sunday (7/28/24). The Dietary Manager stated in-services on meal changes had not been completed with the Dietary Staff. The Dietary Manager stated it was important to ensure that the dietary staff was following the posted approved facility menus for the residents' nutritional needs. During an interview on 7/30/24 10:15 am, the Administrator stated he had been the employed since May 2024. The Administrator stated he oversaw the Dietary Manager. The Administrator stated he was not aware of the dietary staff not following the menu on Sunday (7/28/24). The Administrator stated the Dietician was available whenever the Dietary staff needed her. The Administrator stated he was not aware of the dietician not working on the weekend, but he would follow up on that. The Administrator stated he would educate the staff to still communicate with the Dietician even on the weekend. The Administrator stated the Dietary Manager did not report the meal changes to him on Sunday (7/28/24). The Administrator stated he expected the Dietary Manager to follow the posted menu. The Administrator stated it was important for the dietary staff to follow the posted approved facility menus to ensure the substituted item had the same value as the actual item for a balanced meal. Record Review of the facility's menu policy titled, Resident Menus dated 2012, indicated, (3) Alternates for noon and evening meal will be planned and recorded. Alternates shall be of comparable nutritive value and the alternate food shall come from the same food group. If a resident does not want the food prepared on the menu, nor the alternate, then soup, salad, and/or sandwich will be offered. If the resident does not choose to eat any of the above, a glass of fortified milk or house supplement will be offered. If none of these is accepted, the resident will be allowed to choose not to eat the meal, and a larger snack may be offered at the next scheduled snack time; (4) If any meal served varies from the planned menu, the change and reason for the change shall be noted on the substitution log; (5) The menus will be prepared as written using standardized recipes. The Dietary Service Manager and cooks are trained and responsible for the preparation and service of therapeutic diets as prescribed; (6) The menu will be changed to reflect the resident's cultural and regional preferences. These menu changes are reviewed and signed by the Registered dietitian.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47708 Based on observation, interview and record review, the facility failed to provide food that was palatable, attractive and at a safe and appetizing temperature for 1 of 3 meals reviewed for palatability and temperature. The facility failed to provide food that was palatable and appetizing temperature for 1 of 3 meals observed on 7/29/24 (lunch) meal. These failures could place residents at risk of decreased food intake, hunger, and unwanted weight loss. The findings included: During an interview on 7/28/24 at 10:36 a.m., Resident #29 stated the food was not good at all, and no alternatives were offered. Resident #29 stated staff use to walk around and ask the residents for alternatives but did not walk around and ask the residents anymore. During an interview on 7/28/24 at 10:43 a.m., Resident #26 stated the dietary staff cooked too much chili powder and beans and her roll was burnt. During an interview on 7/28/24 at 12:44 p.m., Resident #15 stated her roll was burnt, the meat was hard, and the corn was cold. During an interview on 7/28/24 at 1:00p.m., Resident #27 stated the roll was burnt, the chicken fried steak was too hard to eat, and the facility alternatives were always bread and bologna. During an interview on 7/30/24 at 5:30 p.m., Resident #5 stated the tomato soup served on 7/30/24 for dinner was too salty. Record Review of the facility week 1 menu dated on 7/29/24, indicated the lunch meal (A) items included for the lunch meal Smashburger with grilled onions, waffle fries, zesty fry sauce, lettuce, tomato, pickles, ketchup, mustard, mayo, apple fried pie and iced tea; (Substitute) tuna sandwich, turkey sandwich, ham sandwich, grill cheese sandwich, chef salad and soup of the day. During an observation on 7/29/24 at 11:54 a.m., of food temperatures taken of the food on the steam table by [NAME] M revealed: the regular Smashburger with grilled onions was 195 F; the regular waffle fries were 138 F; the tomato soup was 63.5 F; the mechanical soft hamburger meat was 153 F; and the tea was 31 F. The zesty fry sauce, lettuce, tomato, pickles, ketchup, mustard, mayo, and regular apple fried pie were not temperature checked. During an observation, interview and test tray tasting revealed the Dietary Manager was observed tasting the regular lunch menu served on 7/29/24 at 12:51 p.m. The Dietary manager stated the regular waffle fries were cold. The Dietary manager stated the Smashburger was warm. The Dietary Manager stated the fried apple pie was cold. The Dietary manager stated the fried apple pie was supposed to be served hot. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/30/24 at 9:18 a.m., the Dietary Manager stated she had been employed as the dietary manager for two weeks. The Dietary Manager stated she worked Monday thru Friday and sometimes on weekends for any dietary staff that did not report on their scheduled day to work. The Dietary Manager stated the dietary staff, and the Dietary Manager was responsible for ensuring the food served was palatable, attractive, and at the correct temperature. The Dietary Manager stated the Administrator had not asked for test trays since she had been employed at the facility. The Dietary Manager stated, In the past when the dietary staff was cooking outside that the Administrator had come and grab a plate or something. The Dietary Manager stated she tasted the foods prior to serving at every meal. The Dietary Manager stated she had received food complaints last week from a resident stating their food was cold. The Dietary Manager stated she handled the complaints by ensuring the food was served hot by serving the trays to the resident personally. The Dietary Manager stated she encouraged the residents to try to make it to the dining room because she could not personally serve them their trays every day. The Dietary Manager stated sometimes resident's meals sat on the meal carts for 15 minutes or more before the nursing staff delivered it to the resident's room. The Dietary Manager stated she was not aware of the food needing to be temperature checked at 135 degrees (Fahrenheit) or higher for hot foods on the steam table. The Dietary Manager stated the dietary staff had not completed any in-services on palatability, attractiveness and serving at the correct temperatures. The Dietary Manager stated, If the food looked good it will taste good and it was very important for the residents. During an interview on 7/30/24 10:29 a.m., the Administrator stated he had been employed since May of 2024. The Administrator stated during resident counsel he had received complaints in the past about food being cold. The Administrator stated in the past the dietary staff had blamed the nursing staff about the food being delivered late. The Administrator stated since he had been the administrator he had not received any food complaints. The Administrator stated he asked some of the residents daily how the meal service was. The Administrator stated he did expect the dietary staff to ensure the food was served palatable, attractive and at the correct temperatures. The Administrator stated he had not received any test trays from the kitchen. The Administrator stated it was important to ensure the foods were palatable, attractive and served at the correct temperature for the residents because it was residents rights and courtesy that the food was palatable. The Administrator stated, Residents will not eat foods that was not palatable, attractive, and at the right temperature and that it could cause weight loss. Record review of the facility policy, titled, Resident Menus, dated 2012, indicated, We will strive to assure the resident's nutritional needs are provided based on the RDA. The standard menu will ensure nutritional adequacy of all diets, offer a variety of food in adequate amounts at each meal, and standardize food production. (1) Menus are planned to meet the Recommended Dietary Allowances of the Food and Nutritional Board, National Research Council, adjusted to the age, activity, and environment of the group involved . The Resident Menu policy did not address palatability, attractiveness or food temperatures.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview and record review the facility failed to ensure each resident received and the facility provided drinks, including water and other liquids consistent with resident needs and preferences for one of thirteen residents reviewed for hydration. (Resident #17). The facility failed to ensure Resident #17 was served cranberry juice with all meals and not tea. This failure could lead to dehydration and urinary tract infections. Findings included: Record review of a face sheet dated 7/30/2024 indicated Resident #17 was a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnosis heart failure, quadriplegia (paralysis of all four limbs), and other muscle spasms, contractures of the left and right hands (a condition where the one or more fingers bend toward the palm of the hand), lack of coordination, muscle weakness, muscle wasting and atrophy. Record review of the Quarterly MDS dated [DATE] indicated Resident #17 understood and was understood by others. The MDS indicated Resident #17's BIMS score was 15 indicating he had no cognitive deficits. The MDS indicated Resident #17 required set up or clean up assistance with eating. Record review of the Comprehensive Care Plan dated 5/28/2021 and revised on 10/25/2022 indicated Resident #17 had a potential for fluid deficit. The goal of Resident #17's care plan was he would be free of symptoms of dehydration and maintain moist mucous membranes and skin turgor. The care plan interventions included to encourage the resident to drink the fluids of choice. Record review of the Quarterly MDS dated [DATE] indicated Resident #17 understood and was understood by others. The MDS indicated Resident #17's BIMS score was 15 indicating he had no cognitive deficits. The MDS indicated Resident #17 required set up or clean up assistance with eating. During an observation and interview on 7/28/2024 at 1:21 p.m., revealed Resident #17 had a glass of iced tea on his lunch tray. Resident #17 said, I hate tea. Resident #17's tray card read witreflected the very last item under his dislike section said was tea, cold, and ice. Resident #17's tray card said reflected under special notes cranberry juice with all meals. LVN K said she agreed Resident #17 had iced tea on his tray and his tray card said he disliked tea and ice. LVN K also agreed there was no cranberry juice on Resident #17's tray. LVN K said the nurse was responsible for checking meal cards and trays prior to the resident receiving the tray. LVN K said the tea was missed. LVN K said when residents gotget fluids not according to their preference, they could experience dehydration. During an interview on 7/30/2024 at 7:02 p.m., the ADON said she expected the residents to receive their preferences of beverages. The ADON said the nurse was responsible for checking the trays prior to the resident receiving the tray. The ADON said when a resident's fluid preferences were not honored the resident was at risk to be unhappy and possibly dehydration. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/30/2024 at 8:06 p.m., the RNC said she expected the staff to follow the resident's orders and their tray cards. The RNC said the DM was responsible for the preference list. The RNC said the nurse checks the tray before passing the trays, then she expected the CNAs to check the tray prior to sitting it down with the resident. The RNC said the risk was the resident could not drink the beverage served due to dislike and this could lead to dehydration. During an interview on 7/30/2024 at 9:03 p.m., the Administrator said he expected the resident to get the desired beverage of choice with their meals. The Administrator said dietary should set up the tray, the nurse then checks the tray, and this should be where the nurse would blow the whistle and correct the tray. The Administrator said not getting the desired beverages places placed a resident at risk of dehydration. Record review of an undated Resident Meal Services and HS Snack policy FP00-5.0 indicated: We strive to provide meals and HS snacks to all residents in a timely manner. Resident meals will be served at regular hours with a maximum of fourteen hours between the evening meal and breakfast the following day. Mealtimes can be adjusted per resident preference at the direction of Resident Council. A bedtime snack is offered to all residents. Each facility has the ability to customize their menu through E-menu-manage ([NAME]) based on regional or resident preferences, after approval from the Registered or Licensed Dietitian. Procedure: Upon admission and periodically thereafter, the resident and/or family member will be interviewed by the dietary manager or designee to determine individual food preferences, dislikes and allergies. These will be recorded on their tray card and honored at mealtimes. If a resident makes food choices that do not include food items from all of the food groups, this will be addressed individually in the resident's care plan. However, resident preferences will be honored. If a resident wishes to not eat a meal, food substitutions will be offered first, then nutritional supplements. If the resident continues to refuse, this resident right will be honored. Beverage choices for lunch and dinner include tea, coffee, water, assorted fruit drinks, and milk. For lunch, iced tea is the default. For dinner, choice of beverage is the default. Residents are encouraged to consume 16 oz of milk per day. Upon admission and periodically, resident beverage preferences will be updated and the tray card will reflect the current preferences. For residents who eat in the dining room, the nurse aides will provide beverages of choice from the beverage bar. For those residents who eat in their room, the beverage choices listed on their tray card will be utilized and provided on their meal tray.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review, the facility failed to ensure that residents received and consumed foods with the appropriate nutritive content as prescribed by the physician for 2 of 2 resident (Resident #'s 31 and 16) reviewed for large protein portions for 2 of 2 meals observed. The facility failed to ensure Resident #31 received a large meat portion, per physician's orders, on his lunch tray on 7/28/2024. The facility failed to ensure Resident #16 received a large meat portion, per physician's orders, on his breakfast tray on 7/30/2024. This failure could place residents who require large servings of meat at risk of not receiving their daily protein requirements and weight loss. Findings included : 1)Record review of a face sheet dated 7/30/2024 indicated Resident #31 was an [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia (memory loss), heart failure, and high blood pressure. Record review of the Annual MDS dated [DATE] indicated Resident #31 was understood and understood others. The MDS indicated Resident #31's BIMS score was a 4 indicating he had severe cognitive impairment. The MDS indicated Resident #31 required supervision or touching assistance with eating. Record review of the consolidated physician's orders dated 7/30/2024 indicated Resident #31 was ordered a regular textured diet with large protein portions on 4/15/2024. Record review of the undated comprehensive care plan indicated Resident #31 had a regular textured diet. The goal of the care plan was Resident #31 would maintain an ideal body weight. The care plan interventions included to administer supplements and vitamins as ordered, and serve diet and snacks as ordered. During an observation on 7/28/2024 at 12:28 p.m., revealed Resident #31 was not provided his large meat portion. Resident #31 received a serving of meat appearing to be the same size as other resident trays. Record review of Resident #31's tray card on 7/28/2024 indicated he was to have a large portion of meat. 2) Record review of a face sheet dated 7/30/2024 indicated Resident #16 was an [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia (memory loss), respiratory failure, and urinary tract infection. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the consolidated physician's orders dated 7/30/2024 indicated Resident #16 was ordered a regular diet with large protein portions on 3/07/2024. Record review of the Quarterly MDS dated [DATE] indicated Resident #16 was usually understood and understands. The MDS indicated Resident #16's BIMS score was 4 indicating severe cognitive impairment. The MDS indicated Resident #16 was independent with eating. Record review of the comprehensive care plan dated 2/19/2024 indicated Resident #16 would receive a regular diet for unplanned weight loss or gain. The goal of Resident #16's care plan was he would maintain his ideal body weight over the next 90 days. The care plan interventions for Resident #16 included to determine food preferences and provide withing the dietary limitations, and to serve the diet as ordered. Record review of the consolidated physician's orders dated 7/30/2024 indicated Resident #16 was ordered a regular diet with large protein portions on 3/07/2024. During an observation and interview on 7/30/2024 at 7:44 a.m., revealed Resident #16 had oatmeal, 1 slice of toast cut in half, 1 sausage patty, and 1 serving of eggs. Resident #16's tray card reflectedread grits, scrambled eggs, sausage (large portion), and toast. The MDS nurse said she was checking breakfast trays. The MDS nurse said Resident #16 should have had a large portion of sausage. The MDS nurse went to the dietary department and obtained another sausage patty and provided it to Resident #16. The MDS nurse said Resident #16 was at risk to have weight loss when not receiving the large portions of meat. During an interview on 7/30/2024 at 7:23 p.m., the ADON said she expected the residents who required large portions of protein would receive those. The ADON said the physician's order must be followed. The ADON said the residents were at risk to have weight loss when the resident had not received the desired large meat portions. The ADON said she expected the nurse checking the trays and correct any issues. During an interview on 7/30/2024 at 8:17 p.m., the RNC said she expected the nurses to follow the orders and the tray cards. The RNC said the large protein was to increase the nutritional state of the resident. The RNC said the dietary staff would set up the tray, the nurse would check the tray for accuracy, then the CNAs should check the tray again prior to giving the tray to the resident. The RNC said the nurse managers were responsible for ensuring the process of tray checking. During an interview on 7/30/2024 at 9:13 a.m., the Administrator said he expected the staff to follow the tray. The Administrator said the dietary department sets up the tray, and the nurse checked the tray for accuracy. The Administrator said the resident required extra protein for weight gain. Record review of an undated Resident Meal Services and HS Snack policy FP00-5.0 indicated: We strive to provide meals and HS snacks to all residents in a timely manner. Resident meals will be served at regular hours with a maximum of fourteen hours between the evening meal and breakfast the following day. Mealtimes can be adjusted per resident preference at the direction of Resident Council. A bedtime snack is offered to all residents. Each facility has the ability to customize their menu through E-menu-manage ([NAME]) based on regional or resident preferences, after approval from the Registered or Licensed Dietitian. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Nursing and Rehabilitation	1900 N Frances St Terrell, TX 75160

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If a resident requests larger amounts of food for all meals, a large portions diet can be ordered and served. For occasional requests, a double portion of any meal component may be offered. If the resident requests seconds, an additional single serving may be offered. Due to resident health concerns, and to ensure that sufficient food is available for all residents, additional food above these levels will not be provided.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47708 Based on observation, interview, and record review, the facility failed to provide sufficient staff to effectively conduct food and nutrition services for the facility's main dining room. The facility failed to serve meals, at the specific times posted, in the main dining room. This failure placed residents at risk of increased hunger, thirst, frustration, and decreased feelings of self-worth. Findings included: Record review of the facility's posted meal service reflected the breakfast mealtime was 7:00 AM; the lunch mealtime was 12:00 PM; and the dinner mealtime was 5:00 PM. During an observation in the kitchen on 7/28/24 at 9:30 a.m., revealed only one Dietary Aide in the dining room; no other dietary staff were in the kitchen. During an observation and interview on 7/28/24 at 9:31 a.m., [NAME] A stated the Dietary Manager had gone on break. [NAME] A stated she called the Dietary Manager, and the Dietary Manager's spouse stated the Dietary Manager had gone to the grocery store. [NAME] A stated the Dietary Manager was supposed to be working on 7/28/24. [NAME] A stated she was the only dietary aide at the facility during this time. During an observation and record review on 07/28/24 at 11:30 AM, in the facility's dining room, revealed residents beginning to congregate for the lunch meal service. Residents were arriving on their own and residents were being assisted by staff. The meal hours posted on the wall just outside the dining room indicated lunch service was to begin at 12:00 PM. During an observation on 07/28/24 at 12:20 PM, in the facility's dining room, revealed the meal service had not begun and the residents had not begun to eat lunch. During an interview in the dining room on 7/29/24 at 12:01 p.m., Resident #18 stated that the lunch meal was always served late. Resident #18 stated breakfast meals were usually served on time. During an interview in the dining room on 7/29/24 at 12:01 p.m., Resident #15 stated breakfast was good for a change since state was in the building and the lunch was usually served late. During an observation on 7/2924 revealed the lunch meal was served at 12:10 p.m., in the dining room. During an observations on 7/30/24 at 7:30 a.m., reflected 4 residents waiting in the dining hall for breakfast. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 7/30/24 at 8:15 a.m., revealed hall 500's breakfast was leaving the kitchen. During an observation on 7/30/24 at 8:20 a.m., revealed hall 600's breakfast was leaving the kitchen. During an observation on 7/30/24 at 8:26 a.m., hall 800's and hall 900's breakfast was leaving the kitchen. During an observation and interview on 7/30/24 at 8:32 a., revealed CNA B was passing out the breakfast trays on hall 800 and hall 900. CNA B stated Resident #192's breakfast tray was missing. CNA B stated she informed the kitchen to make Resident #192's tray. CNA B stated the resident was not happy about not having her breakfast tray. During an observation on 7/30/24 at 8:36 a.m., revealed Resident #192 breakfast tray was delivered by CNA B to the resident's room. During observation on 7/30/24 at 8:37 a.m., Resident #37 walked from hall 900 where she resided and knocked on the kitchen door. Resident #37 asked the dietary staff where was her breakfast tray . The kitchen staff had informed Resident #37 that her breakfast tray was just delivered to her room. During an interview on 7/30/24 at 8:45a.m., Dietary Aide E stated the dietary kitchen was ready at 7am to serve breakfast on 7/30/24. Dietary Aide E stated she told the CNAs and nurses that the kitchen was ready to serve breakfast and she was told from a CNA it was going to be a minute because a resident had fallen on the900 hall. Dietary Aid E stated the CNAs and nurses showed up to the kitchen around 7:50 a.m. to start passing breakfast trays. Dietary Aide E stated she asked the ADON if she could come inspect the breakfast trays and the ADON had asked her, Where was the other nurses? Dietary Aide E stated the ADON did not help with getting the breakfast trays out on 7/30/24 after she had asked for help. Dietary Aide E stated she had been employed at the facility for 4 months. Dietary Aid E stated this was her second time being employed at the facility. Dietary Aide E stated she had worked previously in the facility in the past. Dietary Aid E stated in-services on getting the tray out timely was completed in morning meetings all the time. Dietary Aide E stated, It was important for the residents to eat timely because residents had feelings too and because the residents be ready to eat . (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/30/24 at 8:54 a.m., the Dietary Manager stated she had been the Dietary Manager for two weeks. The Dietary Manager stated the meals served on 7/28/24 for lunch was late because the surveyor was in the kitchen checking stuff. The Dietary Manager stated lunch was served on time at 12:01 p. m., on 7/29/24. The Dietary Manager stated during the lunch meal on 7/29/24 that she had to wait until the nurses came at 12:05 p.m., to check the trays before serving meals to the residents on 7/29/24 for lunch. The Dietary Manager stated on 7/30/24 for the breakfast meal that she did not get to work until 8 a.m., and as she walked into the facility, the ADON had stated she asked one of the dietary aides for jelly because jelly was not on the trays and the dietary aide got an attitude with her and also breakfast was late. The Dietary Manager stated she had not asked her staff about what happened yet about breakfast being late on 7/30/24 but had planned to after the interview with the surveyor. The Dietary Manager stated she did expect staff to ensure they were serving meals on time. The Dietary Manager stated breakfast was to be served at 7am, lunch was to serve at 12 p.m., and dinner was to be served 5 p.m. The Dietary Manager stated she was always told by nursing staff that the dietary staff had to wait until the med pass had been completed or other tasks that nurses were doing were completed before they pass meal trays to the residents. The Dietary Manager stated she had reported the nursing issues with the nurses showing up late to the Administrator many times and nothing had been done. The Dietary Manager stated the dietary staff just had to wait on the nursing staff. The Dietary Manager stated the facility did not complete any in-services on making sure the meals were served timely with the dietary staff and nursing staff. The Dietary Manager stated it was very important for the meals be served on time, because the meals served timely was what got the resident's going through day. During an interview on 7/30/24 9:54a.m., the Administrator stated he has worked at the facility since May of 2024. The Administrator stated he expected staff to serve at the posted times. The Administrator stated the Dietary had been late in the past with serving meals timely. The Administrator stated at times a dietary staff member would have to run to the store for items for meals which had cause delays in the past with meals not being served on time. The Administrator stated in the past when he was notified of meals not served timely that he would check to see if the Dietary staff needed help. The Administrator stated he was made aware of lunch being served late on Sunday (7/28/24) by the Corporate Clinician on Sunday. The Administrator stated he had not been informed that breakfast was served late on Tuesday (7/30/24). The Administrator stated in-services on serving meals on time had not been completed. The Administrator stated mealtime was important because Waiting around for food the residents could get cranky. The Administrator stated residents should be served on time. During an interview on 7/30/24 at 2:33 p.m., the ADON stated she had been the ADON and Administrator in training for 20 days. The ADON stated she was paid salary and worked all the time at the facility. The ADON stated she did not refuse to help the kitchen during breakfast mealtimes on 7/30/24. The ADON stated she did not feel good today on (7/30/24). The ADON stated she had taken a COVID test which came back negative. The ADON stated she did not want to be around the residents feeling sick. The ADON stated she had been trying to make sure the facility had enough staff. The ADON stated the facility had advertised bonuses for CNA's and LVN's and the facility had not been successful in getting people to apply. The ADON stated the facility did not have a lot of staff. The ADON stated she was second in command to the CNA's at the facility. The ADON stated the CNA's were to first report their charge nurse and then report to her last. The ADON stated the Administrator oversaw here. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility's Resident Meal Service and HS Snack policy, undated, indicated, We strive to provide meals and HS snacks to all residents in a timely manner. Resident meals will be served at regular hours with a maximum of fourteen hours between the evening meal and breakfast the following day. Mealtimes can be adjusted per resident preference at the direction of Resident Council. A bedtime snack is offered to all residents. Each facility has the ability to customize their menu through eMenuManage ([NAME]) based on regional or resident preferences, after approval from the Registered or Licensed Dietitian.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47708 Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in (1 of 1) kitchen reviewed for dietary services, in that: 1) The facility failed to label and date all food items. 2) Dietary staff failed to dispose of expired foods items. 3) Dietary staff failed to effectively reseal, label and date frozen food items. 4) Dietary staff failed to store dented cans on a separate shelf. 5) Dietary staff failed to remove scoop from sugar container. 6) Dietary staff failed to clean the deep fryer. These failures could place residents at risk for food contamination and foodborne illness. The findings included: During observations with [NAME] A on [DATE] beginning at 9:59 am, the following observations were made in the kitchen freezer (1 of 2): -(1) unopened 2 pound bag of yellow squash had no receive date. -(1) sealed gallon container of vanilla ice cream had no open date. -(1) sealed gallon size zip locked bag of an unlabeled food item had no open date, no expiration date and no receive date. -(1) unopened 3.5 pound bag of Italian breaded zucchini sticks had no receive date, no expiration date. -(1) opened bag of crinkled French fries was not placed in a sealed bag had no open date, no expiration date and no receive date. -(1) sealed bag of frozen biscuits prepared on [DATE] and had no expiration date. -(1) sealed bag of frozen kissed rolls prepared on [DATE] and had no expiration date. -(1) sealed bag of readymade frozen pancakes that had a preparation date of [DATE], no expiration date and receive date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-(1) sealed bag of frozen chicken nuggets had no label, no open date, no receive date and no expiration date. -(1) sealed frozen bag of steak fingers prepared on [DATE] and had no expiration date and no open date. -(1) sealed frozen bag of chicken not labeled, had no open date, no receive date and no expiration date. -(1) sealed zip locked bag of an unlabeled frozen food item that had no open date, no receive date and no expiration date. -(1) sealed bag of frozen meatballs prepared on [DATE] and had no open date and no expiration date. -(1) sealed bag of frozen ham prepared on [DATE] and had no open date and expired on [DATE]. -(1) unopened bag of a frozen food item not labeled, had no expiration date and no receive date. -(1) sealed zip locked bag of frozen chopped ham not labeled, had no open date, no receive date and no expiration date. -(1) frozen bag of chicken patties had a preparation date of [DATE] and had no open date and no receive date. -(1) sealed zip locked bag of corn dog that had no label, no open date, no receive and no expiration date. -(1) sealed zip locked bag of diced chicken that was not labeled, had no expiration date and no open date. -(1) bag of frozen chicken breast prepared on [DATE] and expired on [DATE]. During observations with [NAME] A on [DATE] beginning at 10:29 am, the following observations were made in the kitchen freezer (2 of 2): -(1) bag of frozen fish prepared on [DATE] and expired on [DATE]. -(1) bag of frozen meat of lunch that had a preparation date of [DATE] and expired [DATE]. -(1) zip locked bag of frozen mechanical soft meat prepared on [DATE] and expired on [DATE]. -(1) unopened bag of guacamole that was not labeled and had no receive date, no expiration date. -(2) unopened bag of frozen pork meat that had a receive date of [DATE] and expired on [DATE] During observations with the Dietary Manager on [DATE] beginning at 10:36 am, the following observations were made in the kitchen refrigerator (1 of 2): (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(1) clear package of thawed ham lunch meat unlabeled, no receive date and no expiration date. (1) clear package of thawed bologna lunch meat unlabeled, no receive date and no expiration date. (1) clear package of thawed salami lunch meat unlabeled, no receive date and no expiration date. (1) zip locked bag of turkey meat prepared on [DATE] and expired on [DATE]. During observations with the Dietary Manager on [DATE] beginning at 10:39 am, the following observations were made in the kitchen refrigerator (2 of 2): (1) zip locked bag of egg omelet not labeled, no preparation date and no expiration date. (1) gallon of whole milk that had no open date. (4) unopened gallons of whole milk that had no receive date. (1) container of minced garlic opened on [DATE], no receive date and no expiration date. During observations with the Dietary Manager on [DATE] beginning at 11:01 a.m., the following observations were made in the kitchen dry storage (1 of 1): -(2) 6 pound and 6 ounce cans of diced tomatoes that were dented on the undented can rack. -(1) 3.75 ounce bottle of sesame seed seasoning received on [DATE], and expired on [DATE]. -(1) 6 ounce bottle of rubbed sage seasoning received on [DATE], expired ono [DATE]. -(1) zip locked bag of marshmallows prepared on [DATE], no open date and no receive date. -(1) bag of cheese sauce prepared on [DATE] and expired on [DATE]. -(1) plastic wrapped bag of coffee creamer received on [DATE], not bagged, no open date and no expiration date -(1) unsealed packet of 3.2 ounce of [NAME] Farms Salad dressing that had no receive date, no open date and no expiration date. -(1) measuring cup found inside the sugar container bin. -(1) container of sugar that had a preparation date of 6//,d+[DATE] and no expiration date. -(1) container of flour that had a preparation date of [DATE] and no expiration date. During observation with the Dietary Manager on [DATE] at 11:30 a.m., revealed the deep fryer was not cleaned; the deep fryer grease was black in color and had bread crumps inside floating inside. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observations with the Dietary Manager on [DATE] beginning at 11:33 a.m., the following observations were made in the dining area (1 of 1): (1) container of Raisin Bran cereal had no open date and no expiration date. (1) container of honey nuts cereal had no open date and no expiration date. (1) pitcher of red juice that had no label, no open date and no expiration date. (1) pitcher of water that had no label, no open date and no expiration date. During an interview on [DATE] at 8:47 a.m., the Dietician stated she had been full time dietician for the past 4 years. The Dietician stated she oversaw the Dietary Manager. The Dietician stated the Dietary Manager oversaw the dietary staff. The Dietician stated she visited the facility once a month and today [DATE] was her monthly visit. The Dietician stated once a month she conducted walk throughs in the kitchen. The Dietician stated, not really, when asked if she had seen expired foods or foods not labeled correctly in the kitchen. The Dietician stated she was not aware of expired foods, non-labeled food items, dented cans with undented cans, and scoops in the sugar bin found in the kitchen on [DATE]. During an interview on [DATE] at 9:33 a.m., the Dietary Manager stated she had been the dietary manager for two weeks. The Dietary Manager stated in-services had not been completed on labeling and dating food items, disposing of expired food items, storing dented cans on another shelf, removing the scoop from sugar container and cleaning the deep fryer. The Dietary Manager stated was supposed to do walk throughs every morning, but she conducted walk throughs in the kitchen once a week. The Dietary Manager stated she was noticing that once a week walk throughs in the kitchen were too late. The Dietary Manager stated she needed to get back into a habit of walking through the kitchen every day. The Dietary Manager stated the Administrator never conducted walk throughs in the kitchen. The Dietary Manager stated the dietary staff were to clean the fryer and change the cooking grease every Monday. The Dietary Manager stated she agreed that the fryer grease needed to be changed due to how black in color it was. The Dietary Manager stated sometimes staff had the cooking grease up to high when cooking and this would burn the cooking grease. The Dietary Manager stated the Administrator oversaw her. The Dietary Manager stated it was important to ensure that the Dietary Staff was labeling and dating all food items and discarding expired foods because it was not healthy for the residents. During an interview on [DATE] at10:43 a.m., the Administrator stated he had been the Administrator since May of 2024. The Administrator stated he conducted weekly walk throughs in the kitchen. The Administrator stated he mainly went through dry storage and labeling and dating food items in the kitchen during his walk throughs. The Administrator stated in-services on labeling and dating had been completed. The Administrator stated he had not completed any in-services on using the fryer and cleaning the fryer recently. The Administrator stated hand sanitation in-services were completed on Sunday ([DATE]) and on Monday ([DATE]). The Administrator stated he expected staff to discard expired foods, label and date foods, reseal freezer food items and placing dented can with other dented can and to not leaving the scoop in the sugar container. The Administrator stated leaving the scoop in the sugar container was infection control. The Administrator stated, It was important for staff to label and date food items and dispose of expired food items to prevent health issues with residents because he does not want to serve expired foods to the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record Review of the facility's Dietary policy titled Food Storage and Supplies dated 2012, indicated, (3) Best practice is that scoops should not be left in food containers or bins, but if so, handles should be upright and not contacting the food item. Containers are cleaned regularly (4) Open packages of food are stored in closed containers with covers or in sealed bags and dated as to when opened. (6) when items are received from the vendor, they should be first examined for expiration date, and if an expiration date is present, it is beneficial to mark it by circling it so it is readily visible and noticeable. It is important to distinguish between an expiration date and a production date, or a best by or use by date. Production dates indicate when the product was manufactured, not when it expires and should not be interpreted as a best by or use by date. Best by or use by dates indicate when a product will have best flavor or quality and are not an indicator of the product's safety. As the quality may deteriorate after the date passes, the dietary manager should closely inspect any products that are past the best by date to determine if they are still good quality. If in doubt, discard the product. If any stamped date is unclear, contact the food vendor for clarification. -If an item does not have a date designated by the manufacturer as an expiration date, then the item should be dated as to when it is received, and shelf-stable items will be stored in a first in, first out manner, to be used within one year. After one year, any product that is shelf stable will be inspected by the dietary manager to ensure that it is good quality before it is used. Any product with a stamped expiration date will be discarded once that date passes. (10) Frozen items that should be thawed before preparation should be stored under refrigeration until thawed and should be dated with the date removed from the freezer and used within 7 days. Any frozen food more than one year old will be inspected for food quality and freezer burn before being used.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on interview and record review the facility failed to arrange an appointment with an outside resource for 1 of 6 residents (Resident #27) reviewed for the use of outside resources. The facility failed to ensure Resident #27's appointments with a dermatologist (specialty for skin disease, function) was scheduled after the order dated 11/25/2023 was received by the facility. This failure could place residents at risk of not receiving needed medical care. Findings included: Record review of Resident 27's face sheet dated 07/30/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), type 2 diabetes mellitus (long term condition in which the body has trouble controlling blood sugar and using for energy), malignant neoplasm of lung (lung cancer) and weakness. Record review of Resident #27's quarterly MDS assessment dated [DATE], indicated Resident #27 was able to understand others and was able to be understood. The MDS assessment indicated Resident #27 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #27 required substantial/maximal assistance with toileting, showering, lower body dressing and personal hygiene. Resident #31 required partial/moderate assistance with upper body dressing. Record review of Resident #27's order summary report dated 07/20/2024, indicated Resident #27 had an order dated 11/25/2023 refer to dermatology for non-healing sore on lower mid back. Record review of Resident #27's comprehensive care plan dated 07/25/2024, indicated Resident 27 had a patchy area to lower back that, at times, she will scratch and cause it to open. The care plan interventions included follow facility protocols for treatment of injury and ongoing treatment in place. Record review of Resident #27's comprehensive care plan with an initiated date of 04/06/2022 revealed it did not address referrals to dermatologist or appointments with dermatologist. During an interview on 07/28/2024 at 10:15 AM, Resident #27 stated she had requested to be seen by a dermatologist for the sore on her back. Resident #27 said the facility said they were working on the appointment several different times, but she felt like they forgot to complete the process. During an interview on 07/30/2024 at 08:17 a.m., the ADON said she was not aware Resident #27 had an order for a dermatologist appointment. The ADON said the nurses were responsible for scheduling referrals and appointments and the ADON assisted if needed. The ADON said it was important for referrals and appointments to get scheduled timely to ensure the treatment the residents were receiving was working, to help them improve, and so they could have necessary labs drawn for the appointments. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/30/2024 at 4:15 p.m., the ADON said as of right now she did not think Resident #27 had any appointments scheduled. The ADON said the nurses reviewed the discharge orders and follow-up appointments. The ADON said the DON looked over the orders after the orders were put in to ensure things were not missed. The ADON said she had reviewed Resident #27's discharge orders, and she was not aware of the follow-up appointments. The ADON said it got missed and she had not noticed the missed referral. During an interview on 07/30/2024 at 4:35 p.m., the Regional Corporate Compliance Nurse said the nurses received the orders, reviewed them, and put the orders into the residents' electronic medical records. The Regional Corporate Compliance Nurse said the orders were reviewed by the ADON on the same day or the next morning. The Regional Corporate Compliance Nurse said the transport aide was now scheduling the appointments for residents. The Regional Corporate Compliance Nurese not aware of the why the dermatologist referral had not been scheduled for Resident #27. The Regional Corporate Compliance Nurse said it was important for referrals, appointments and follow-up appts to be scheduled because if the residents had something going on the diagnoses needed to be addressed. The Regional Corporate Compliance Nurse said Resident #27's referral appointment to the dermatologist should have already been scheduled and completed by this time. During an interview on 07/30/2024 at 08:41p.m., the Administrator said he expected the nurses to follow orders and schedule all appointments. The Administrator said it was important for preventative and ongoing care of all residents to ensure a healthy outcome. Record review of the facilities policy implemented, 09/24/2022, titled, Medication Reconciliation, indicated, . compare orders to hospital records, home or orders from healthcare entity, etc. obtain clarification orders as needed c. transcribe orders in accordance with procedures for admission orders .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 2 of 2 residents (Residents #8 and #12) reviewed for hospice services. The facility failed to obtain Resident #8 and #12's most recent hospice plan of care. The facility failed to ensure Resident #8 and #12's hospice plans of care accurately reflected their medication regimen. This deficient practice could place Residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. Findings included: 1. Record review of Resident #8's face sheet, dated 07/30/2024, indicated Resident #8 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (a group of lung diseases that blocks air flow and causes difficulty breathing), diabetes mellitus (a group of diseases that result in too much sugar in the blood), essential hypertension (high blood pressure), weakness. Record review of Resident #8's order summary report, dated 07/30/2024, indicated Resident #8 had an order admitted to Hospice for 06/01/2024. Record review of Resident #8's admission MDS assessment, dated 06/08/2024, indicated Resident #8 understood others and made herself understood. The assessment indicated Resident #8 was severely cognitive impaired with a BIMS score of 5. The assessment indicated Resident #8 did not reject care necessary to achieve the resident's goals for health or well-being. The MDS indicated Resident #8 required partial/moderate assistance for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. Record review of Resident 8's care plan, with a revision date of 06//09/2024, indicated Resident #8 had a terminal prognosis and received hospice services. The care plan interventions included work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Record review of Resident #8's hospice binder on 07/29/2024 at 8:00 PM, indicated the last written certification was completed 04/24/2024 that was certified from 04/24/2024 - 07/22/2024. There was not a recent plan of care update noted in the facility's hospice binder. The last plan of care order noted was dated 04/24/2024. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #8's EMR on 07/29/2024 at 08:02 PM, indicated the hospice administration record and the facility's physician orders did not match. The following orders were noted on the hospice medication record and not in Resident #8's facility's order summary report: 1. Eliquis 2.5.mg orally two times daily for clotting preventative During an interview on 07/29/2024 at 8:05 p.m., LVN C said the residents' hospice records were kept in a binder at the nurse's station. LVN C said she was not aware if the facility had current notes or a plan of care from hospice on Resident #8. LVN C walked away from the surveyor. During an interview on 07/30/2024 at 11:20 AM, the Hopsice Nurse said the paperwork should be current in Resident #8's hospice binder because it was sent to the facility this AM. The hospice nurse said she thought she had already delivered the current plan of care to Resident #8's hospice binder last week. The hospice nurse said she thought all the medications were reconciled and the most recent plan of care would reflect those medication changes. The hospice nurse said it was important to have the residents' hospice records, so the facility staff knew what was going on and the hospice staff knew what was going on. The hospice nurse said the resident could go without necessary medications or treatments without proper collaboration between hospice and the facility. 33249 2. Record review of a face sheet dated 7/30/2024 indicted indicated Resident #12 was a [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnoses of rheumatoid arthritis end-stage (9a chronic inflammatory disorder that can affect more than just your joints), fractured right femur (upper leg bone)r , and multiple pressure ulcers. Record review of the consolidated physician's orders dated July 30, 2024, indicated on 5/30/2024 Resident #12 received an order for hospice services for the diagnosis of rheumatoid arthritis. The physician's orders indicated Resident #12 was ordered med pass supplement 120 ml twice daily, arginaid supplement one packet twice daily, aspirin 81 milligrams once daily, fentanyl 50 mcg (micrograms) every 72 hours, hydromorphone 4 milligrams every 3 hours, hyoscyamine sulfate 0.125 mg one tablet under the touch every 4 hours as needed for secretions, ibuprofen 200 milligrams one tablet every 8 hours as needed, lorazepam 1 milligram every 3 hours routinely and every 3 hours as needed for anxiety, morphine sulfate concentrate solution 20 milligram/milliliter give 2 milliliters/hour by mouth every hour for pain or shortness of breath, morphine sulfate extended release 100 milligrams 2 tablets by mouth two times a day for pain, sennosides-docusate sodium 8.6 mg-50 mg two tablets by mouth two times daily, and temazepam 7.5 milligrams 1 capsule at bedtime. Record review of the Quarterly MDS dated [DATE] indicated Resident #12 was understood and understands others. The MDS indicated Resident #12's BIMS score was 15 indicating no cognitive impairment. Section O-Special Treatments, Procedures, and Programs of the MDS indicated Resident #12 was receiving hospice services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the undated Comprehensive Care Plan indicated Resident #12 required hospice services as evidenced by the terminal diagnosis of rheumatoid arthritis. The care plan goal was Resident #12 would be maintained, kept comfortable, and pain free within one hour of interventions. The care plan interventions were to monitor for signs and symptoms of increased pain, monitor for decreased appetite, weight loss, skin breakdown, nausea, and vomiting. The care plan interventions included to assist with ADLs, and hospice staff would assist with the resident's care. Record review of the Quarterly MDS dated [DATE] indicated Resident #12 was understood and understands others. The MDS indicated Resident #12's BIMS score was 15 indicating no cognitive impairment. Section O-Special Treatments, Procedures, and Programs of the MDS indicated Resident #12 was receiving hospice services. Record review of the Aide Care Plan Report dated 5/28/2024 - 7/26/2028 indicated Resident #12 received hospice aide services. The hospice aide care plan indicated Resident #12 was to provide ADL care for Resident #12 5 times weekly. The services Resident #12 received every visit were turning/repositioning, transferring from bed/chair, hair care, skin care, perineal care, incontinent care, oral care, ear care, dressing, offering fluids, empty trash, change linen, aware fall risk, aware skin break down, aware of wound dressings, aware of fractured right leg, and used a wheelchair. Record review of the last IDG Comprehensive Assessment and Plan of Care Update Report was dated 6/27/2024. The IDG indicated Resident #12 received hospice services for rheumatoid arthritis. The hospice IDG note indicated the skilled nurse was seeing Resident #12 2 times weekly. The visit frequency for the next two weeks was the nurse visited 2 times weekly and the nurse aide 5 times weekly. The IDG report indicated Resident #12's medication regimen included: Aspirin 81 milligrams daily, hydromorphone 4 milligrams every 4 hours, lorazepam 1 milligram tablet every 4 hours, morphine concentrate 100milligram/5mililiters administered 1 ml 30 minutes prior to wound care, morphine sulfate 100 milligrams/5milliters 0.5 milliliters by mouth every 2 hours, morphine extended release 60 milligrams one table every 8 hours, promethazine 25 milligrams every 4 hours for nausea and vomiting, senna plus 8.6 milligrams-50milligrams 2 tablets 2 times daily, and temazepam 7.5 milligrams one capsule every bedtime. The medication report indicated the last medication review was on 6/12/2024 by the hospice nurse. During an interview on 7/30/2024 at 10:45 a.m., the Hospice Executive Director (ED) said she expected the hospice plan of care to be provided to the facility after each team meeting. The ED said the hospice team meets met every 2 weeks on Thursday. The ED said the last hospice team meeting reviewing the plan of care was on 7/25/2024. The ED said she expected the hospice medication regimen and the facility regimen to match to ensure Resident #12 received the most appropriate care. The ED said the hospice nurse was responsible for ensuring the collaboration of care. The ED said the hospice nurse should review the medication regimen at least weekly . During an interview on 7/30/2024 at 11:23 a.m., the hospice nurseHospice Nurse said the hospice plan of care including the medication regimen should be updated to ensure Resident #12's team of clinicians provides the care she needed. The hospice Hospice nNurse said she was supposed to review the medication regimen weekly to ensure the medication regimens match and were accurate. The hospice nurseHospice Nurse said the hospice plan of care should reflect a true picture of the care Resident #12 should receive. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/30/2024 at 7:25 p.m., the ADON said usually the nurses ensured the hospice provided the most up to date plans of care for the coordination of care. The ADON said the plan of care established which entity was responsible for which services of care. During an interview on 7/30/2024 at 8:18 p.m., the RNC said the hospice binder should have the most updated hospice plan of care. The RNC said the hospice plan of care and the facility plan of care should match. The RNC said she would hope the nurse and the nurse managers were monitoring the accuracy of the hospice plans of care. The RNC said she believed residents would receive the appropriate care although the care plans failed to match in care and services. During an interview on 7/30/2024 at 9:08 p.m., the Administrator said the hospice plan of care should match to ensure the residents received the care coordination. The Administrator said the nurse managers were responsible for ensuring the residents' hospice plans of care were accurate and timely. Record review of a Hospice Services Policy dated February 13, 2007 indicated as an ed of life measure, the resident or responsible family member may choose to use hospice services within the facility .The legally binding agreement will have provisions for joint procedures for ordering medications that ensure that the proper payer was billed and for reconciling billing between he nursing facility and the hospice .11. The DON or designee will be responsible for ensuring he documentation was a part of the current clinical record. Hospice plan of care, current interdisciplinary notes to include nurses notes/summaries, physician orders, and progress notes, and medications and treatment sheets during the hospice certification period.

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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** 45810 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 5 of 18 residents(Resident #192, Resident #30, Resident #34, Resident #12, and Resident #23) and 7 of 8 staff (LVN A, LVN C, CNA C, CNA L, LVN K, CNA B, and CNA O) reviewed for infection control practices and transmission-based precautions. 1. LVN A failed to ensure Resident #192 had the proper cap in place to prevent infection in PICC line. 2. LVN A failed to wash his hands while passing medications to Resident #30 and Resident #34. 3.The facility failed to ensure the EBP (enhanced barrier precautions) were in place for Resident #192 on 07/28/24. 4.LVN C failed to properly store urine obtained for urinalysis. 5.CNA L failed to perform hand hygiene during Resident #12's continent care. 6.CNA L failed to perform catheter care when Resident #12 received incontinent care. 7.LVN K failed to clean and treat Resident #12's 6 pressure wounds individually. 8.LVN K failed to perform hand hygiene during Resident #12's wound care. 9.LVN K failed to properly handle soiled linen from Resident #12's bed. 10.The facility failed to ensure CNA B and CNA O don(on) their PPE prior to entering Resident #23's room. 11.The facility failed to ensure CNA B and CNA O performed hand hygiene after removing their gloves while providing incontinent care to Resident #23. 12.CNA B failed to sanitize hand between delivering meal trays on hall 800 and hall 900. These failures could place residents at increased risk for serious complications from a communicable disease that could diminish the resident's quality of life. Findings included: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) Record review of Resident #192's face sheet dated 07/30/24 indicated she was an [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses of acute and chronic respiratory failure, diabetes mellitus type 2, Hypertension (high blood pressure), peripheral vascular disease (circulation condition in which causes decreased blood flow to the limbs), and bacteremia(blood stream infection). Record review of Resident #192's MDS schedule indicated she did not have an MDS completed because it was not due. Record review of Resident #192's care plan dated 07/28/24 indicated she had an IV access to be used for antibiotics with interventions to administer IV medications as ordered. Record review of the facility MDS Resident Matrix dated 07/28/24 indicated Resident #192 had intravenous therapy. Record review of Resident #192's order summary report dated as of 07/30/24 indicated she had an order for: Ampicillin Sodium Solution Reconstituted 2 GM Use 2 Gram intravenously every 4 hours for bacterial infection for 10 days with a start date of 07/27/24. During an observation on 07/28/24 at 10:16 AM revealed Resident #192 had no enhanced barrier precautions in place outside of her room. During an observation on 07/28/24 at 12:17 PM revealed Resident #192 had no enhanced barrier precautions in place outside of her room. During an observation on 07/29/24 08:30 AM revealed LVN A failed to complete hand hygiene. He then donned a gown and gloves and prepared IV antibiotics for Resident #192. LVN A went into Resident #192's room and hung the IV medication Ampicillin 2GM and then he said he forgot the most important step, washing his hands. He then went to wash his hands and completed the antibiotic administration. During an interview on 07/29/24 at 09:15 AM Resident #192 said none of the staff used gowns on yesterday (07/28/24), but the staff had been using gowns during care on that day (07/29/24). She said she did not recall her PICC line ever having a cap on it since she had been at the facility. Resident #192 said she just knew that LVN A had been hooking antibiotics to it. During an observation and interview on 07/29/24 at 10:27 AM revealed LVN A placed the red extension connector on the PICC line. He said the facility had not had the caps since Resident #192 entered the facility on 07/27/24 and that was the only thing he could find to place on the PICC line. He said the red extension connector would not prevent infection because it was still open on the end. LVN A said the cap the facility should have been using were usually yellow or green and it was capped off with alcohol inside. He said the failures placed a risk for infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Record review of a face sheet dated 08/05/2024, indicated Resident #34 was a [AGE] year-old male initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses which included cerebral infraction (stroke), unsteadiness on feet, osteoarthritis (degeneration of the bones), scoliosis (curvature of the back), diabetes mellitus (a lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar level), hyperlipidemia (high levels of fat participles in the blood). Record review of the Comprehensive MDS assessment dated [DATE], indicated Resident #34 was usually understood and sometimes understood by others. The MDS assessment indicated Resident #30 had a BIMS score of 7, which indicated his cognition was severely impaired. Record review of the care plan with revised date of 06/01/2024, indicated Resident #34 was care planned for hemiplegia/hemiparesis. The interventions included give medications per orders and monitor, document side effects and effectiveness. Record review of the order summary report dated 08/05/2024 indicated Resident #34 had an order for metoprolol tartrate oral tablet 50 mg give one tablet by mouth two times a day for hypertension with a start date of 06/01/2024. 3) Record review of a face sheet dated 08/05/2024, indicated Resident #30 was a [AGE] year-old male initially admitted to the facility on [DATE], with diagnoses which included left bundle branch block (a delay or blockage of electrical impulses to the left side of the heart), bradycardia (low heart rate), congestive heart failure (a chronic condition where the heart does not pump blood as well as it should), and hypertension (high blood pressure). Record review of the Comprehensive MDS assessment dated [DATE], indicated Resident #30 was sometimes understood and sometimes understood by others. The MDS assessment indicated Resident #30 had a BIMS score of 1, which indicated his cognition was severely impaired. Record review of the care plan with revised date of 01/01/2024, indicated Resident #30 was care planned for diuretic therapy. The interventions included give medications per orders and monitor, document side effects and effectiveness. Record review of the order summary report dated 08/05/2024 indicated Resident #30 had an order for Furosemide tablet 20 mg one tablet by mouth one time a day for congestive heart failure with a start date of 01/01/2024. During an observation on 07/29/24 at 08:08 AM LVN A prepared medications and gave them to Resident #30. LVN A failed to complete any hand hygiene before or after medications were given. During an observation and interview on 07/29/24 08:16 AM LVN A prepared medications and gave them to Resident #34. LVN A failed to complete any hand hygiene before or after medications were given. LVN A said he should have washed his hands or used hand sanitizer between the resident's medications. He said the failure placed a risk for cross contamination. 4) During an observation and interview on 07/29/24 at 08:29 PM revealed LVN C placed a specimen cup full of urine on the nurse's station desk with a paper towel covering it. LVN C said the specimen cup contained urine and then refused to answer any questions from the surveyor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/30/24 at 07:45 AM the Administrator said the nurses were responsible for ensuring they obtained urine and properly placed it in designated bags. He said the failure placed a risk for cross contamination. During an interview on 07/30/24 at 06:05 PM LVN C said she should have stored the urine in the proper bag and cooler. She said the failure placed a risk for contamination and infection. 33249 5) Record review of a face sheet dated 7/30/2024 indicated Resident #12 was a [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnoses of rheumatoid arthritis end-stage (a chronic inflammatory disorder that can affect more than just your joints), fractured right femur (upper leg bone), and multiple pressure ulcers. Record review of the Quarterly MDS dated [DATE] indicated Resident #12 was understood and understands others. The MDS indicated Resident #12's BIMS score was 15 indicating no cognitive impairment. The MDS indicated Resident #12 was dependent with toileting hygiene. The MDS in Section H-Bladder and Bowel indicated Resident #12 had an indwelling catheter. Record review of the undated Comprehensive Care Plan Indicated Resident #12 had an indwelling catheter related to pressure ulcers. The care plan indicated Resident #12 required ADL care with the goal of she will maintain or improve current level of function in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene. The interventions included Resident #12 required total assistance with personal hygiene care. Record review of the consolidated physician's orders dated July 30, 2024, indicated on 5/19/2024 Resident #12 was ordered catheter care every shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/28/2024 at 11:37 a.m. - 12:00 p.m., revealed CNA L entered the room washed her hands, obtained a pair of gloves, and obtained an under pad. LVN K indicated to CNA L one more person was required to assist with Resident #12's incontinent care due to having to hold Resident #12's fractured leg. CNA L removed her gloves and exited the room. CNA L returned to the room with RN P. CNA L donned another pair of gloves. CNA L cleaned Resident #12's peri area using a wipe with a wiping motion toward Resident #12's rectum. CNA L used another wipe and completed the wiping motion again. Resident #12 had a very small bowel movement, then CNA L grabbed a wipe and removed the bowel movement. CNA L then adjusted the draw sheet underneath Resident #12, then she took the disposable under pad, rolled the edge up and tucked the pad underneath Resident #12CNA L failed to provide catheter care during the incontinent care. CNA L then removed her gloves, and her PPE, and washed her hands. After CNA L performed incontinent care for Resident #12 LVN K began Resident #12's wound care. LVN K removed her gloves, then gathered dressing supplies from Resident #12's closet. The wound care supplies were in a shipping box sitting directly on the floor. LVN K obtained bordered dressings, 4x4 gauzes, calcium alginate sheets, and a bottle wound cleanser. LVN K then walked to Resident #12's dresser and obtained a box of gloves. LVN K then moved the trash container closer to her work area. LVN K opened each dressing sitting them on the package on Resident #12's bed. LVN K placed several opened dressings, opened calcium alginate sheets, a box of gloves, a bag of 4x4's gauze, and the wound cleaner bottle on the foot of Resident #12's bed. LVN K put on a pair of gloves, then removed the dressings to Resident #12's shoulder/back area. LVN K failed to perform hand hygiene. LVN K then obtained several 4x 4's sprayed them with wound cleanser and cleaned the wound on the shoulder discarded the 4x4's, obtained new 4x4's sprayed them with wound cleanser then cleaned the upper back wound area. LVN K then pushed the totality of 4x4's further down in the trash container. LVN K with her right hand obtained the calcium alginate and tore twos piece off and applied to the open wound bed of the shoulder/back wound then covered the wound with a bordered dressing. LVN K then removed the dressing to Resident #12's right hip and sacral wound. LVN K proceed to cleanse the sacral wound, the right hip and left hip with two wounds, applied calcium alginate to the wound beds, and covered each wound with a dry bordered dressing without changing her gloves or using hand sanitizer. After all the wound care was provided, Resident #12 was then repositioned for comfort, then LVN K removed her gloves, removed her PPE, and washed her hands. LVN K failed to perform hand hygiene during the wound care. During an interview on 7/28/2024 at 12:30 p.m., RN P said CNA L failed to change gloves and do hand hygiene between dirty and clean areas of incontinent care. RN P said she agreed she had not witnessed CNA L provide catheter care as well. RN P said she made a mistake by placing the dirty linen on the floor as well. RN P said Resident #12 was at risk for UTI's when catheter care and incontinent care was not provided correctly. RN P said putting soiled linen on the floor could cause infections to spread room to room. RN P said LVN K should have treated each wound independently of the others. RN P said LVN K should have changed her gloves and performed hand hygiene when she removed the dirty dressings, and after she cleaned the wound. RN P said she was unaware she could have stopped the process and corrected the incontinent care and wound care procedure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/28/2024 at 1:09 p.m., LVN K said CNA L should have performed hand hygiene and changed gloves between dirty and clean during incontinent care with Resident #12. LVN K said she was unaware she could have corrected CNA L during the incontinent care procedure. LVN K said Resident #12 was at risk for urinary tract infections when incontinent care was not performed correctly. LVN K said she was unaware each wound should have had care provided separately. LVN K said she thought she changed her gloves and performed hand hygiene during wound care. LVN K said hand hygiene during wound care would prevent wound infections. LVN K said she had been employed for six months but had not been checked off on wound care. During an interview on 7/30/2024 at 8:01 a.m., CNA L said she had forgotten to perform hand hygiene and change her gloves between dirty and clean during incontinent care. CNA L said she had though she had performed catheter care. CNA L said Resident #12 was at risk of urinary tract infections when incontinent care was not performed correctly. During an interview on 7/30/2024 at 6:41 p.m., the ADON said she expected the CNAs to clean their hands by performing hand hygiene between dirty and clean areas of incontinent care. The ADON said not performing hand hygiene could cause infections. The ADON said this was monitored by the performance of skill check offs and random checks while performing incontinent care on a resident or the use of a mannequin. The ADON said she expected each wound to be provided care to separately from the other wounds. The ADON said she expected hand hygiene to be performed when the soiled dressing was removed, after cleaning the wound, and after care of the wound. During an interview on 7/30/2024 at 7:51 p.m., the RNC said she expected CNA L to perform hand hygiene when going from dirty to clean in the incontinent care process. The RNC said when this hand hygiene was not performed, and new gloves applied the resident was at risk of infection. The RNC said the nurse managers were responsible for ensuring appropriate incontinent care monitoring using random check offs and annual check offs. The RNC said she expected wound care to be performed with each wound independent from the other wound. The RNC said she expected hand hygiene to be performed during the wound care to prevent the spread of infection from one wound to another wound. During an interview on 7/30/2024 at 8:51 p.m., the Administrator said he expected the staff the perform hand hygiene between clean and dirty to prevent the spread of germs. The Administrator said the staff should be monitored by the nurse managers by competencies. Record review of a CNA Proficiency Audit dated 4/23/2024 indicated CNA L was assessed in the area of hand washing, catheter care, infection control awareness, and perineal care scoring a satisfactory in skill level. Record review of a Nurse Proficiency Audit dated 7/01/2024 indicated LVN K had been assessed for competency in treatment procedures such as dressing changes and had a satisfactory score in the skill level. 30527 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10) Record review of Resident #23's face sheet, dated 07/30/2024, indicated Resident #23 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of end stage renal disease (occurs when chronic kidney disease - the gradual loss of kidney function - reaches an advanced state), type 2 diabetes mellitus with diabetic neuropathy (high blood sugar that has caused nerve damage), and encephalopathy (a disease that impacts the functioning of the brain). Record review of the MDS assessment, dated 07/12/2024, indicated Resident #23 had clear speech and was understood by staff. The MDS revealed Resident #23 was able to understand others. The MDS revealed Resident #23 had a BIMS score of 11, which indicated moderate cognitive impairment. The MDS assessment indicated Resident #23 was dependent with toileting, showering, and lower body dressing and personal hygiene. Resident #23 required substantial to maximal assistance with upper body dressing. Record review of Resident #23's comprehensive care plan revised on 06/04/2024, indicated Resident 23 was on enhanced barrier precautions related to pressure ulcer. The care plan interventions included gloves and gown should be donned if any of the following activities occur linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, bathing or high contact activity. During an observation on 07/28/2024 at 10:14 AM, revealed there was a sign indicating Resident #23 required enhanced barrier precautions on the door. During an observation on 07/29/2024 at 08:19 AM, revealed there was a sign indicating Resident #23 required enhanced barrier precautions on the door for contact isolation. During an observation on 07/29/2024 at 08:35 AM, revealed CNA B and CNA O went in Resident #23's room without a gown or gloves worn. CNA B repositioned Resident #23's pillow from her right back side. CNA O was standing at the left side of the bed waiting to assist CNA B. CNA B and CNA O provided incontinent care to Resident #23. CNA B cleansed Resident #23's front peri area removed her gloves and applied clean ones. CNA B did not perform hand hygiene after removing her dirty gloves, prior to applying clean gloves. CNA B and CNA O turned Resident #23 on her side. Resident #23's brief was soiled with feces. CNA B cleansed Resident #23's back peri area removed the soiled brief and handed it to CNA O. CNA O placed them in trash bags, removed her gloves, and applied clean ones. CNA O did not perform hand hygiene after removing her dirty gloves, prior to applying clean gloves. CNA B applied barrier cream to Resident #23's buttocks, removed her gloves, and applied clean ones. CNA O did not perform hand hygiene after removing her dirty gloves, prior to applying clean gloves. CNA B removed her dirty gloves and applied clean gloves. CNA B did not perform hand hygiene after removing her dirty gloves prior to applying clean gloves. CNA B and CNA O applied the clean brief, and repositioned Resident #23 in bed. CNA B and CNA O removed their gloves and performed hand hygiene. During an interview on 07/29/2024 at 09:00 AM, CNA B said hand hygiene should be performed in between glove changes. CNA B said she had not performed hand hygiene because she forgot due to being nervous. CNA B said it was important to perform hand hygiene during incontinent care for infection control. CNA B said this should be done to prevent cross contamination. When CNA B was asked why she did not don (put on) PPE prior to entering Resident #23's room, she stated I forgot. CNA B stated the risk associated with not wearing the correct PPE or performing hand hygiene was a 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	During an interview on 07/29/2024 at 09:00 AM, CNA O said when providing incontinent care, she was supposed to perform hand hygiene after removing her gloves. CNA O said she had not performed hand hygiene in between glove changes because she did not have any hand sanitizer in her pocket. CNA O said she should have washed her hands in the bathroom, but she was trying to help. CNA O said it was important to perform hand hygiene while providing incontinent care, so she did not pass germs. When CNA O was asked why she did not don (put on) PPE prior to entering Resident #23's room, she stated I don't think we are doing that anymore. CNA O stated the risk associated with not wearing the correct PPE or performing hand hygiene was a spread of infection. During an interview on 07/29/2024 at 3:34 PM, the Regional Corporate Compliance Nurse said hand hygiene should be performed in between glove changes. The Regional Corporate Compliance Nurse said she, the charge nurses, the ADON, and the DON were responsible for ensuring the CNAs were performing adequate hand hygiene during incontinent care and wear PPE appropriately. The Regional Corporate Compliance Nurse said random checks with the CNAs to ensure they were performing proper hand hygiene and incontinent care and the proper use of wearing PPE should be done. The Regional Corporate Compliance Nurse said she had not completed any random checks. The Regional Corporate Compliance Nurse said it was important to perform hand hygiene and wear PPE properly and appropriately during incontinent care because the residents could get a urinary tract infection and sepsis (infection in the bloodstream) and spread other infections. During an interview on 07/29/2024 at 04:15 PM, the Administrator said he expected all the staff to follow the policy on hand washing, changing gloves, and wearing the PPE when instructed by the signs placed at the resident's door. The Administrator said the charge nurses and clinical management were responsible for ensuring the CNAs were performing hand hygiene and wearing appropriate PPE. The Administrator said not performing hand hygiene adequately during incontinent care and not wearing the appropriate PPE could lead to the spread of disease, bacteria, and infections. 47708 12) During observation on 7/27/24 at 12:26 p.m., revealed CNA B did not sanitize hand in between residents when passing lunch trays on hall 800 and hall 900. CNA B touched and helped the residents sit up to eat lunch on hall 800 and hall 900. During an interview on 7/29/24 at 12:50 p.m., CNA B stated had been employed at the facility for a few months. Stated she had forgot to sanitize her hands between each resident when passing out meal trays on hall 900 and hall 800. During observation and interview on 7/29/24 at 12:50 p.m., of CNA B passing trays on hall 900 and hall 800, the Dietary Manager stated, I had noticed that [CNA B] did not sanitize her hands between passing meal trays but did not want to say anything. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/30/24 at 10:59 a.m., the Administrator stated he had been employed since May of 2024.The Administrator stated he was made of CNA B that she did not sanitize her hands between passing meals on 7/29/24. The Administrator stated CNA B had informed him on 7/29/24 that she did not sanitize her hands when passing lunch trays on 7/29/24. The Administrator stated hand washing in-services had been completed recently. The Administrator stated hand sanitation in-services was completed on Sunday 7/28/24 and on Monday 7/29/24. The Administrator stated he did expect staff to wash and sanitize hand between meal passing. The Administrator stated it was important for the staff to sanitize hands in between passing the resident meals trays for infection control. During an interview on 7/30/24 11:51 a.m., CNA B stated she had completed hand washing in-services a few weeks ago. CNA B stated when she was passing tray that she was supposed to sanitize hands between each tray she had passed. CNA B stated the ADON oversaw her. CNA B stated it was important to sanitize hands for possible contamination and infection control. During an interview on 7/30/24 at 2:33 p.m., the ADON stated she had been the ADON and Administrator in training for 20 days. The ADON stated she was paid salary and worked all the time at the facility. The ADON stated she was not made aware CNA B not using hand sanitation between passing meals to the residents. The ADON stated CNA B was a newly employed CNA. The ADON stated she was second in command to the CNAs at the facility. The ADON stated hand hygiene in-services was last completed on 7/28/24 and 7/29/24. The ADON stated the CNAs were to first report their charge nurse and then report to her last. The ADON stated the Administrator oversaw her. The ADON stated Hand hygiene was important for infection control and because anything you touch has germs on it, Record review of the undated Hand Hygiene policy indicated you may use alcohol-based hand cleaner or soap/water for the following: When coming on duty Before and after performing any invasive procedure. Before and after entering isolation precautions settings. Before and after assisting a resident with personal care Before and after changing a dressing. After contact with a resident's mucous membranes and body fluids or excretions . After removing gloves. You must use soap/water for the following: (alcohol base cleaner is not recommended) When hands are visibly soiled After personal us of the toilet Before and After assisting a resident with toileting (hand washing with soap and water) . (continued on next page)

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