STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675124	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Texan Nursing & Rehab of Gonzales	3428 Moulton Rd Gonzales, TX 78629

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 36232 Based on interview and record review, the facility failed to promote the residents' right to receive mail, for 1 of 1 facility review for residents' right to receive mail, in that: Facility staff did not distribute mail received on Saturdays to the residents. This deficient practice could result in residents not receiving mail in a timely manner and a diminished quality of life. The findings were: During a confidential group meeting on 06/05/2024 at 11:00 AM, members of the resident group stated they did not receive mail on Saturdays, they did not understand why it was not distributed on Saturdays, and stated they felt this practice was disrespectful. During an interview on 06/07/2024 at 11:22 AM with the BOM she stated she was the only one who distributed mail to the residents and did so Monday through Friday. Mail that came in on Saturdays remained in the mailbox until Monday. This had been the practice at the facility since she was hired in 2018. Department heads rotated serving as the manager on duty every weekend, but did not distribute the mail even though they had access to the mailbox as it was unlocked. Even when she worked as the manager on duty, approximately every two months, she did not distribute mail to the residents on Saturdays. During an interview on 06/07/2024 at 11:30 AM the Administrator stated residents did not receive mail on Saturdays, and this practice should change. Record review of facility policy Resident Rights, 2001, revealed, Employees shall treat all residents with kindness, respect and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: h. Privacy in sending and receiving mail. 2. Residents are entitled to exercise their rights and privileges to the fullest extent possible. 3. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness and dignity.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232 Based on interview and record review, the facility failed to ensure the residents' right to request, refuse, and/or discontinue treatment and to formulate an advance directive for 1 (Resident #9) of 14 residents reviewed for advance directives, in that: Resident #9 was unable to make her wishes of being full code known and, her OOH-DNR was executed by her family member without her consent or knowledge. This deficient practice put residents at risk of not having their rights honored when they stop breathing and there is no pulse. The findings were: Record review of Resident #9's face sheet, dated 06/06/2024, revealed an admitted [DATE] and readmission on 05/21/2023 with diagnoses including: Senile degeneration of brain (loss of intellectual ability associated with old age), chronic venous hypertension (abnormalities in the capillaries within the leg tissues allowing fluid, proteins and blood cells to leak into the tissues) and muscle wasting and atrophy (a decrease in muscle size and loss of muscle tissue). Record review of Resident #9's quarterly MDS assessment, dated 04/24/24, revealed a BIMS of 14 which indicated intact cognition. Record review of Resident #9's care plan, updated 01/24/2024, revealed, Resident and/or RP/family have advance directive of choice to be DNR status. Out of hospital DNR. Record review of Resident #9's physician orders as of 10/27/2023, revealed an order dated 02/06/2023, DNR. Record review of Resident #9's OOH-DNR form, dated 04/21/2023, revealed it was executed by the resident's family member. The OOH-DNR form was not signed by Resident #9. During an interview on 06/07/2024 at 12:15 PM with the DON she stated Resident #9's family member informed her the DNR was signed after the resident was hospitalized for surgery and was near death in April 2023. The family member was advised by Resident #9's physician to complete an OOH-DNR on her behalf. Resident #9's BIMS was assessed at that time to be 12, which indicated moderate cognitive impairment. The facility did not re-assess the resident's upon her return to the facility with regard to desired code status. Resident #9 should have been given the opportunity to execute the document for herself. During an interview on 06/07/2024 at 12:05 PM in the resident's room with the administrator and DON present, Resident #9 stated no one explained to her what DNR meant and this was not what she wanted. Resident #9 emphatically stated no one should be signing anything on her behalf except for her. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/07/2024 at 4:15 PM with Resident #9's family member in the resident's room with the resident present, she stated the resident was admitted to the hospital for surgery for a pressure ulcer on her coccyx. Resident #9 became septic and the family member signed an in-hospital and OOH-DNR on her behalf based on the physician's recommendation. The family member wished to respect Resident #9's wishes and have the OOH-DNR removed, effectively restoring the resident's advance directive status to full-code (The Resident wants resuscitation and all life saving measures during a medical emergency). Record review of the Texas Health and Human Services webpage titled, Out of Hospital Do Not Resuscitate Program, updated 03/25/2019, revealed, Frequently Asked Questions for DNR: --What happens if the form is not filled out correctly or EMS has doubts about any of the information? Health professionals can refuse to honor a DNR if they think: The form is not signed twice by all who need to sign it or is filled out incorrectly. Further review of the Texas Health and Human Services webpage titled, Out of Hospital Do Not Resuscitate Program, updated 03/25/2019, revealed, Filling out the Out-of-Hospital Do-Not-Resuscitate Form: Declaration A. This box is for patients who are competent . B. This box is used when the order is being completed by a legal guardian, the person with medical power of attorney for the patient or a proxy in a directive to physician for a person who is incompetent or otherwise mentally or physically incapable of communication. Record review of the facility policy Do Not Resuscitate Order revised April 2013 revealed, 5. The Interdisciplinary Care Planning Team will review advance directives with the resident during quarterly care planning sessions to determine if the resident wishes to make changes in such directives. 6. The resident's attending physician will clarify and present any relevant medical issues to the resident or legal representative as the resident's condition changes in an effort to clarify and adhere to the resident's wishes.

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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** 34788 Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy for 2 of 6 resident (Residents #10 and #25) reviewed for privacy, in that: 1. CNA A and CNA B did not close completely Resident #10's privacy curtain while providing incontinent care. 2. LVN C left her computer screen open showing Resident #25's protected information while administering medications. This deficient practice could place residents at-risk of loss of dignity due to lack of privacy. The findings include: 1. Record review of Resident #10's face sheet, dated 06/06/2024, revealed an admitted [DATE] and, a readmitted [DATE], with diagnoses which included: Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills), Hypothyroidism (under active thyroid), Type 2 diabetes mellitus (high level of sugar in the blood), Hemiplegia (Paralysis of one side of the body), Hyperlipidemia(Elevated level of any or all lipids(fat) in the blood), Hypertension (High blood pressure). Record review of Resident #10's Quarterly MDS assessment, dated 05/27/2024, revealed the resident had a BIMS score of 00, indicating she was severely cognitively impaired. Resident #10 was always incontinent of bladder and frequently incontinent of bowel and, required extensive assistance to total care with her ADLs. Record review of Resident #10's care plan, dated 12/08/2023, revealed a problem of Self-care deficit: Requires extensive assist X1 (1 person assist) with bathing. extensive X1 with bed mobility, transfers, ambulation, locomotion, dressing, eating, toilet use, and personal hygiene, with an intervention of Explain plan of care. Promote dignity by ensuring privacy, conversing with resident while providing care. Observation on 06/06/24 at 01:30 p.m. revealed CNA A and CNA B did not completely close the privacy curtains while they provided incontinent care for Resident #10, exposing the resident who could be seen from the room's door. Further observation revealed the two curtains could not be completely closed because the ceiling curtain rods were too far apart. During an interview with CNA A and CNA B on 06/06/2024 at 2:30 p.m., CNA A and CNA B confirmed the privacy curtains was not completely closed while they provided care for Resident #10 but it should have been. They confirmed they received resident rights training within the year. They revealed they had not report the malfunctioning curtain rods. During an interview with the DON on 06/07/2024 at 10:30 a.m., the DON confirmed privacy must be provided during nursing care and Resident #10's privacy curtains should have been closed completely. She confirmed the staff had received training on resident rights within the year and the training was provided by the ADON. They also check the staff skills annually and as needed. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Resident Rights Guidelines for All Nursing Procedures, undated, revealed, For any procedure that involves direct resident care, follow these steps [.] Close the room entrance door and provide for the resident's privacy. 2. Record review of Resident #25's face sheet, dated 06/06/2024, revealed an admitted [DATE] and, a readmitted [DATE], with diagnoses which included: Osteoarthritis (Type of degenerative joint disease), Hemiplegia (Paralysis of one side of the body), Dysphagia (Difficulty in swallowing), Dysphasia (Impairment in the production of speech), Major depressive disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure), Hypertension (High Blood pressure). Record review of Resident #25's Quarterly MDS assessment, dated 05/01/2024, revealed the resident had a BIMS score of 10, indicating he was moderately cognitively impaired. Resident #25 required limited assistance with his ADLs. Record review of Resident #25's care plan, dated 02/02/2024, revealed a problem of has potential for complications related to diabetes mellitus., with a goal of will have absence of signs of hypoglycemia (low blood sugar) or hyperglycemia daily (High blood sugar) and over next review. Observation on 06/06/24 at 11:16 a.m., revealed while providing an accu check (blood sugar level check) for Resident # 25, LVN C left the screen of her electronic medical record tablet open. The table was showing the medication administration record with the name of Resident #25 and his insulin order. The tablet was on the medication cart, which was in the hall in view of residents and other staff members. During an interview with LVN C, on 06/06/2024 at 11:18 a.m., LVN C confirmed the screen was left open to be seen by other staff and resident and she should have locked it to hide the information. She confirmed receiving training for resident rights within the year. During an interview with the DON on 06/07/2024 at 10:30 a.m., The DON confirmed the medication administration record was a protected information and the nurse should have locked her tablet to hide the information from other staff and residents. She confirmed the staff was receiving resident rights training at least annually and the training was provided by her or the ADON. Review of the facility's policy titled Resident Rights Guidelines for All Nursing Procedures, undated, revealed, Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on resident rights, including:[.] Confidentiality of protected health information.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident for 1 of 14 residents (Resident #39) whose assessments were reviewed, in that: The facility failed to ensure that Resident #39's care plan correctly noted the resident's exit seeking behavior in his care plan. This deficient practice could lead to improper identification of residents with elopement tendencies resulting in potential harm. The findings were: Record review of Resident #39's face sheet, dated 04/21/2023, revealed the resident was admitted to the facility on [DATE] and again on 05/20/2023 with diagnoses including diabetes mellitus (a group of diseases that affect how the body uses blood sugar), cognitive communication deficit (a problem with one or more cognitive skills involved in communication, such as attention, memory, or reasoning), dementia with psychotic disturbance (a decline in cognitive functioning, which includes thinking, remembering, and problem-solving, when the individual is not sure what is real) and heart failure (a serious condition in which the heart can't pump enough blood to meet the body's needs). Record review of Resident #39's quarterly MDS assessment, dated 04/22/2023, revealed a BIMS score of 5 which indicated severe cognitive impairment. Further review of this MDS revealed the resident used a wheelchair and was not ambulatory. Record review of Resident #39's physician orders revealed an order dated 03/29/2024 to, Check wander guard placement: RT side W/C. Special Instructions: Licensed staff to check for proper functioning and placement q shift, twice a day. 06:00 AM - 06:00 PM, 06:00 PM - 06:00 AM. Review of Resident #39's care plan, dated 04/24/2024, revealed there was no care plan addressing Resident #39's exit seeking behavior, wandering or his wander guard. Observation on 06/04/2024 at 11:15 AM in Resident #39's room revealed there was a wander guard taped securely to the resident's wheelchair. During an interview on 06/05/2024 at 1:30 PM with the DON she stated Resident #39's care plan was inaccurate. She said the resident had a tendency to wander, and this should have been reflected in his comprehensive care plan. The MDS coordinator was responsible for updating resident care plans. During an interview on 06/06/2024 at 1:50 PM with the MDS coordinator, she stated she was responsible for updating care plans. She further stated Resident #39's wandering should have been a focus area in his care plan and was overlooked. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN E on 06/06/2024 at 11:30 AM she stated she was usually the charge nurse on Resident #39's hall. He was not ambulatory and must be transferred to his wheelchair. The resident occasionally verbalized a desire to leave the facility and was easily redirected. Record review of the facility policy, Comprehensive Person-Centered Care Planning, revised 08/2017, revealed, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232 Based on observation, interview, and record review, the facility failed to ensure residents received proper treatment and care to maintain mobility and good foot health for 1 of 1 resident (Resident #9) reviewed for foot care. The facility failed to provide Resident #9 with access to podiatry care. This deficient practice placed residents at risk of discomfort, poor foot hygiene, and a decline in residents' physical condition. The findings were: Record review of Resident #9's face sheet, dated 06/06/2024, revealed an admitted [DATE] and readmission on 05/21/2023 with diagnoses including: Senile degeneration of brain (loss of intellectual ability associated with old age), chronic venous hypertension (abnormalities in the capillaries within the leg tissues allowing fluid, proteins and blood cells to leak into the tissues), coagulation deficit (problems with the ability to form clots) and muscle wasting and atrophy (a decrease in muscle size and loss of muscle tissue). Record review of Resident #9's quarterly MDS assessment, dated 04/24/24, revealed a BIMS of 14 which indicated intact cognition. Further review of this MDS revealed the resident was not ambulatory and was completely dependent on facility staff for all transfers. Record review of Resident #9's comprehensive care plan, dated 05/01/2024, revealed Resident #9 had ADL function deficits and should receive weekly skin assessments per facility schedule and preventive skin care per physician's orders. Further review of this care plan revealed there was no documentation of any refusal of care. Record review of Resident #9's physician orders revealed an order dated 02/06/2023, May see podiatrist as indicated/needed. Record review of Resident #9's EHR revealed there was no documentation that Resident #9 had ever received care from a podiatrist since her initial admission. Observation on 06/04/2024 at 1:05 PM revealed Resident #9 was in bed. She was not wearing any socks. The toenail plates (the visible part of the nail) on both her feet were longer than the nail bed (the skin beneath the nail plate). The toenail plates on both feet were overgrown, thick, curved, ragged, chipped, uneven, cracked, and had a yellowish color. The big toenail plate on the left foot was cracked in the middle of the toenail bed, and there was a thick growth present underneath the big toenail and third toenail plates. During an interview on 06/04/2024 at 1:06 PM with Resident #9 she stated she had never received care from a podiatrist at the facility or outside the facility. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/04/2024 at 1:08 PM with CNA F, who was in Resident #9's room during the observation of Resident #9's feet, she stated CNAs are responsible for clipping residents' toenails unless they were diagnosed with diabetes, then it was the responsibility of the podiatrist. CNA F stated, The foot doctor did Resident #9's feet. During an interview on 06/04/2024 at 3:00 PM with the Ombudsman, she stated Resident #9's toenails had been excessively long since February 2024 and she had brought the matter to the attention of the administrator at that time. During an interview on 06/07/2024 at 11:36 AM with the DON, she stated the facility had a contract with a podiatrist service; however, when she contacted them she was told they did not have a provider who would visit that area. She was aware that Resident #9 required podiatry care and was working with the regional consultant for the podiatry service to accommodate the resident and other residents. The facility did not have a podiatrist who visited the facility on a regular basis. During an interview on 06/07/2024 at 3:45 PM with the regional nurse consultant, she stated Resident #9 required podiatry care and it would be difficult to transport the resident to a provider outside the facility. Record review of facility policy Care of Fingernails/Toenails revised October 2010 revealed, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. 1. Nail care includes daily cleaning and regular trimming. 3. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments.5. Watch for and report any changes in the color of the skin around the nail bed, blueness of the nails, any signs of poor circulation, cracking of the skin between the toes, any swelling, bleeding, etc. 6. Stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease.

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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. 34788 Based on observation, interview, and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible for 1 of 3 halls (Hall 300) observed for accidents and hazards, in that: The facility failed to ensure potential hazards were locked up in Hall 300 This deficient practice could place residents at risk of a diminished quality of life due to an unsafe environment. The findings were: Observation on 06/06/2024 at 12:25 p.m. on Hall 300 revealed a container of Sani-Cloth, purple top (a germicidal wipe) on the 300 hall medication cart, on the left side of the cart. The container had physical and chemical hazard and precautionary statements., such as causes substantial but temporary eye damage. Call poison center or doctor for treatment advice. Further observation revealed several unnamed residents were seen in the hall. During an interview on 06/06/2024 at 12:30 p.m. with LVN E, she confirmed the container of Sani-Cloth was in the open and it contained wipes. She also confirmed there were multiple residents with dementia able to transfer, ambulate or propel themselves on hall 300. She confirmed the wipes could be a hazard if handled improperly. LVN E confirmed the wipes should have been kept inside the locked medication cart. During an interview on 06/07/2024 at 10:30 a.m. with the DON, she revealed the Sani-Cloth constrainers are supposed to be kept out of reach of the residents. She confirmed that for a resident with dementia they could constitute a hazard and place them at risk for injury. She confirmed the staff was trained in the handling of hazardous products. Review of facility policy, titled Safety and Supervision of Residents, undated, revealed Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.[.] 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QA&A reviews of safety and incident/accident reports; and a facility-wide commitment to safety at all levels of the organization .

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 34788 Based on interview and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 1 of 1 facility reviewed for nursing services. The facility failed to use the services of an RN as required, for 10 days, during the period between 3/1/2024 through 5/31/2024. This could result in resident's not receiving the needed care and services to meet their needs and could result in illness, a decline in health, and in quality of care. The findings were: Review of the facility's RN hours record revealed there were no RN coverage hours on 3/9/2024, 3/10/2024, 3/31/2024, 4/6/2024, 4/7/2024, 4/20/2024, 5/4/2024, 5/5/2024, 5/18/2024 and, 5/19/2024. All of these dates are on weekends. During an interview with the DON, on 6/6/2024 at 3:27 p.m., the DON stated the facility had two RN's, one full-time and one part-time, who worked different shifts, and confirmed there was no RN coverage on 3/9/2024, 3/10/2024, 3/31/2024, 4/6/2024, 4/7/2024, 4/20/2024, 5/4/2024, 5/5/2024, 5/18/2024 and, 5/19/2024. During an interview with the Regional Nursing Consultant, on 6/6/2024 at 4:50 p.m., the Regional Nursing Consultant confirmed they did not have any agency RN's working on 3/9/2024, 3/10/2024, 3/31/2024, 4/6/2024, 4/7/2024, 4/20/2024, 5/4/2024, 5/5/2024, 5/18/2024 and, 5/19/2024. During an Interview with the Regional Nursing Consultant on 6/7/2024 at 10:55 a.m., The Regional Nursing Consultant revealed they did not have a Nursing policy which addressed RN coverage for 8 hours per day as that was a CMS standard.

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Texan Nursing & Rehab of Gonzales	3428 Moulton Rd Gonzales, TX 78629

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788 Based on observation, interview and record review the facility failed to ensure the medication error rate was not five percent or greater. The facility had a medication error rate of 10% based on 3 errors out of 30 opportunities, which involved 3 of 4 residents (Resident #3, Resident #22 and Resident #9) reviewed for medication errors. 1. Medication Aide D failed to administer medications as ordered to Resident #3 by administering hydrocodone (a treatment for Pain))1 hour and 20 minutes after the scheduled time. 2. Medication Aide D failed to administer medications as ordered to Resident #22 by administering Duloxetine (a treatment for Depression and Nerve Pain) 1 hour and 42 minutes after the scheduled time. 3. Medication Aide D failed to administer medications as ordered to Resident #9 by administering Metoprolol (a treatment for High blood pressure and Heart failure) 1 hour and 55 minutes after the scheduled time. These failures could place residents at risk of not receiving the desired therapeutic effect of their medications. Findings include: 1. Record review of Resident #3's face sheet, dated 06/05/2024, revealed the resident admitted to the facility on [DATE]. Resident #3 had diagnoses which included: Myopathy (Muscle disease), Atrial Fibrillation (Abnormal heart rhythm), Depression (Mental state of low mood and aversion to activity), Rheumatoid arthritis (long term autoimmune disorder affecting the joint and causing pain) and Hypertension (high blood pressure). Record review of Resident #3's physician orders and medication administration record for the month of June 2024, revealed: hydrocodone-acetaminophen - Schedule tablet; 10-325 mg; Amount to Administer: 1; oral to be administered 4 times a day at 2 a.m., 8 a.m., 2 p.m. and, 8 p.m. Observation on 06/06/24 at 9:20 a.m. revealed, Medication Aide D administered 1 tab of hydrocodone 10-325 mg to Resident #3. Further observation reveled the medication order was showing red in the electronic medication administration record. 2. Record review of Resident #22's face sheet, dated 06/06/2024, revealed the resident admitted to the facility on [DATE]. Resident #22 had diagnoses which included: Chronic obstructive pulmonary disease (progressive lung disease characterized by airflow limitation), Hypertension (High blood pressure), Anxiety disorder (A group of mental illnesses that cause constant fear and worry), Type 2 diabetes mellitus (high level of sugar in the blood), Major depressive disorder(mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure) , Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #22's physician orders and medication administration record for the month of June 2024, revealed: Duloxetine capsule,delayed release; 60 mg; Amount to Administer: 1; oral with administration times of 8 a.m. and 8 p.m Observation on 06/06/24 at 9:42 a.m. revealed, Medication Aide D administered 1 tab of Duloxetine 60 mg to Resident #22. Further observation revealed the medication order was showing red in the electronic medication administration record. 3. Record review of Resident #9's face sheet, dated 06/06/2024, revealed the resident admitted to the facility on [DATE] and, readmitted [DATE]. Resident #9 had diagnoses which included: Hypertension (High blood pressure), Hypokalemia (Low level of potassium in the blood), Dementia (decline in cognitive abilities), Osteoarthritis (Type of degenerative joint disease), Chronic venous hypertension (The blood pressure in the veins of the legs is too high). Record review of Resident #9's physician orders and medication administration record for the month of June 2024, revealed: Metoprolol tartrate tablet; 25 mg; Amount to Administer: 1; oral with administration time of 8 a.m. and 8 p.m Observation on 06/06/24 at 9:55 a.m. revealed, Medication Aide D administered 1 tab of Metoprolol tartrate 25 mg to Resident #9. Further observation reveled the medication order was showing red in the electronic medication administration record. During interview with Medication Aide D on 06/06/2024 at 10:00 a.m., Medication aide D confirmed the administration time for the 3 medications was 8 a.m. and should have been administered within one hour of the administration time. She confirmed all 3 medications were administered late. She confirmed the medications were showing in red in the electronic record because it was past the latest possible administration time. She revealed the 3 medications should have been administered at 9 a.m. at the latest. During an interview with the DON on 06/07/2024 at 10:30 a.m., The DON said medications should be administered within one hour of the scheduled time, one hour before or one hour after. Medications ordered to be administered at 8 a.m. should be administered at the latest at 9 a.m. and not earlier than 7 a.m. Record review of the facility's policy titled, Administering Medications, undated, revealed Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34788 Based on observation, interview, and record review, the facility failed to ensure all drugs and biological were stored in locked compartments for 1 of 3 medication carts (Hall 300 Medication Cart) reviewed for storage, in that: During medications administration, LVN C left Hall 300 Medication cart unlocked on 1 occasion. This deficient practice could place residents at risk of misappropriation of medications or harm due to accidental ingestion of unprescribed mediations. The findings were: Observation on 06/06/2024 at 11:16 a.m revealed LVN C was administering medications to residents. LVN C was checking Resident #5's blood sugar and going in his rooms. On one occasion the medication cart was left unlocked and out of sight of LVN C. Inside the unlocked cart were blister packs, bottles, and vials of medications for the residents. During an interview with LVN C on 06/06/2024 at 11:18 a.m., LVN C confirmed the medication cart was left unlocked while she was doing a blood sugar check in the resident's room. LVN C confirmed she knew she had to keep the cart locked and had forgotten. During an interview with the DON on 06/07/2024 at 10:30 a.m., the DON confirmed the medication cart should have been kept locked. The DON confirmed the nursing staff received training about drug diversion including keeping their cart locked at all times when not in use to prevent drug diversion. The DON revealed one possible outcome of drug diversion was the residents missing doses of medications. Review of Nurse proficiency checklist for LVN C, dated 05/01/2024 revealed LVN C passed proficiency for Medication Administration. Record review of the facility's policy titled, Security of Medication Cart,, undated, revealed, Medication carts must be securely locked at all times when out of the nurse's view.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36232 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 for 1 of 1 kitchen, in that: 1. There was a bag of shredded cheese past its use-by date in the reach-in cooler. 2. There were cleaning supplies in the dry storage room. 3. There was a bag of breadcrumbs that was opened, unsealed, without a label and use-by date in the dry storage room. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: 1. Observation on 06/04/2024 at 10:10 AM revealed there was a 5-lb. bag of shredded Cheddar cheese on a shelf in the reach-in cooler. The cheese was in its original package and placed in a clear, gallon-sized, zipper-sealed bag. There was approximately 3/4 lb. of cheese remaining in the bag. A small white sticker on the bag read, 5-7. During an interview on on 06/04/2024 at 10:12 AM with the DM she stated the numbers on the sticker meant the bag of cheese had been opened on 05/07/2024, and based on the facility's food storage policy, the cheese was well past its use-by date and should have been discarded. The DM further stated any staff member who stored food in the cooler was responsible for properly labeling and dating food and discarding food that was past its use-by date to prevent the food from potentially causing foodborne illness. 2. Observation on 06/04/2024 at 10:14 AM in the dry storage area revealed several cleaning and maintenance tools were stored in close proximity to racks holding food staples. They included a broom, plunger, and dust pan with a long handle. There was a bag containing mop heads tied onto a food rack. During an interview on 06/04/2024 at 10:14 AM with the DM she stated the cleaning tools should not have been stored in the same area as dry food; however, the facility had very little space designated for storage. The DM further stated, the mop heads stored next to the food were the clean ones. 3. Observation on 06/04/2024 at 10:15 AM in the dry storage room revealed a 25-lb. sack of Japanese-style breadcrumbs that was open and partially folded down. There was a piece of tape on the sack that read, Opened 4-16. The sack was not secured in a sealed bag or carton to prevent contamination from rodents, pests or other potential contaminants. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/04/2024 at 10:16 AM with the DM she stated the sack of breadcrumbs should have been properly sealed to prevent contamination from pests and to preserve freshness. Any dietary employee storing food in the dry storage area was responsible for properly sealing, labeling and dating food products. She trained all dietary employees upon hire and periodically throughout the year. When asked on 06/04/2024 at 10:30 AM for the facility dietary policies, the DM stated the facility used the Texas Food Establishment Rules (TFER), 2015 edition, as their policy manual. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 6-501.113 Storing Maintenance Tools. Maintenance tools such as brooms, mops, vacuum cleaners, and similar items shall be: (A) Stored so they do not contaminate food, equipment, utensils, linens and single-service and single-use articles, and (B) Stored in an orderly manner that facilitates cleaning the area used for storing the maintenance tools. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 3-305.11, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination.

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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** 36232 Based on interview, and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 2 residents (Resident #42) reviewed for hospice services, in that: The facility did not have Resident #42's most recent Physician Certification of Terminal Illness. 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. The findings were: Record review of Resident #42's face sheet, undated, revealed the resident was admitted to the facility on [DATE] and again on 10/11/2023 with diagnoses including: unspecified injury of right vertebral artery (can lead to the formation of a blood clot resulting in stroke), restless agitation (a feeling of severe restlessness, crankiness, or uneasiness), cognitive communication deficit (trouble participating in conversations) and chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #42's quarterly MDS assessment, dated 04/29/2024, revealed a BIMS of 6, indicating severe cognitive impairment. Further review of this MDS revealed in Section J, Health Conditions, under Prognosis the box next to condition or chronic disease that may result in a life expectancy of less than 6 months (Requires physician documentation) Yes was checked. In Section O, Special Treatments, Procedures, and Programs, the box was checked indicating the resident was on hospice care while at the facility. Record review of Resident #42's care plan, revised 05/02/2024, revealed a focus, Resident is on Hospice due to COPD. Record review of Resident #42's physician's orders revealed an order dated 11/30/2023 admitting the resident to hospice services. Record review of Resident #42's facility clinical record and hospice binder from the time of admission to 06/07/2024 revealed the record did not include the resident's Physician Certification of Terminal Illness. (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 with the Administrator and nurse consultant on 06/07/24 at 02:07 PM, the nurse consultant stated the facility did not have the physician's certification of terminal illness, Form 3074, for Resident #42 in the hospice binder or the electronic health record. She further stated this document should have been found in the resident's hospice binder along with the other hospice documents and it was necessary to facilitate communication and coordination of care between the facility care team and the hospice care team. Record review of the facility policy, Hospice Program, revised July 2017, revealed, .to coordinate care provided to the resident by our facility staff and the hospice staff .d. Obtaining the following information from the hospice: (1) The most recent hospice plan of care specific to each resident; (2) Hospice election forms; (3) Physician certification and recertification of the terminal illness specific to each resident .

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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** 34788 Based on observations, interviews, and record reviews, 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 disease and infection for 4 of 6 residents (Residents #5, #9, #10 and, #32) reviewed for infection control, in that: 1. Medication Aide D did not sanitize the Blood pressure cuff between Residents. 2. CNA B did not use the proper technique to sanitize her hands while providing incontinent care for Resident #10. 3. LVN E touched Resident #32's bed table and did not sanitize her hands prior to providing care. These deficient practices could place residents at-risk for infection due to improper care practices. The findings included: 1. Record review of Resident #5's face sheet, dated 06/06/2024, revealed an admitted [DATE] and, a readmitted [DATE] with diagnoses which included: Type 2 diabetes mellitus (high level of sugar in the blood), History of urinary tract infection(an infection in any part of the urinary system) , Dysuria (Painful or uncomfortable urination), Bipolar disorder (Mental disorder characterized by periods of depression and periods of abnormally elevated mood), Hypertension (High blood pressure) Record review of Resident #5's Annual MDS assessment, dated 05/29/2024, revealed Resident #5 had a BIMS score of 10, which indicated moderate cognitive impairment. Resident #5 was indicated to always be incontinent of bowel and bladder. She required limited to extensive assistance with her ADLs. Review of Resident #5's Physician orders and Medication administration record for June 2024 revealed Lisinopril tablet; 20 mg; Amount to Administer: 1; oral with a requirement of taking the resident's blood pressure prior to administration. Record review of Resident #9's face sheet, dated 06/06/2024, revealed the resident admitted to the facility on [DATE] and, readmitted [DATE]. Resident #9 had diagnoses which included: Hypertension (High blood pressure), Hypokalemia (Low level of potassium in the blood), Dementia (decline in cognitive abilities), Osteoarthritis (Type of degenerative joint disease), Chronic venous hypertension (The blood pressure in the veins of the legs is too high). Record review of Resident #9's Quarterly MDS assessment, dated 04/24/2024, revealed Resident #9 had a BIMS score of 14, which indicated mild cognitive impairment. Resident #9 was indicated to always be incontinent of bladder and a colostomy. She required extensive assistance to total care with her ADLs. Record review of Resident #9's physician orders and medication administration record for the month of June 2024, revealed: Metoprolol tartrate tablet; 25 mg; Amount to Administer: 1; oral (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/06/24 at 9:55 a.m. revealed while administering medications, Medication aide D, used the same Blood Pressure cuff on Resident #5 and Resident # 9 without using a sanitizing wipe to clean the Blood Pressure cuff between the residents. During an interview on 06/06/2024 at 9:57 a.m., Medication aide D confirmed not cleaning the Blood Pressure cuff in between residents but she should have sanitized the cuff to prevent cross contamination. She revealed she had no wipe container in her cart but would ask for one. She confirmed receiving infection control training within the year. During an interview on 06/07/2024 at 10:30 a.m. with the DON, she confirmed medical equipment should be sanitized in between resident to prevent cross contamination. She confirmed the staff was trained at least yearly by either herself or the ADON. The facility did not have a policy in reference to cleaning the blood pressure cuff in between resident. 2. Record review of Resident #10's face sheet, dated 06/06/2024, revealed an admitted [DATE] and, a readmitted [DATE], with diagnoses which included: Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills), Hypothyroidism (under active thyroid), Type 2 diabetes mellitus (high level of sugar in the blood), Hemiplegia (Paralysis of one side of the body), Hyperlipidemia(Elevated level of any or all lipids(fat) in the blood), Hypertension (High blood pressure). Record review of Resident #10's Quarterly MDS assessment, dated 05/27/2024, revealed the resident had a BIMS score of 00, indicating she was severely cognitively impaired. Resident #10 was always incontinent of bladder and frequently incontinent of bowel and, required extensive assistance to total care with her ADLs. Record review of Resident #10's care plan, dated 12/08/2023, revealed a problem of Self-care deficit: Requires extensive assist X1 (assistance of one person) with bathing. extensive X1 with bed mobility, transfers, ambulation, locomotion, dressing, eating, toilet use, and personal hygiene, with an intervention of Explain plan of care. Promote dignity by ensuring privacy, conversing with resident while providing care. Observation on 06/06/2024 at 01:30 p.m. revealed while providing incontinent care for Resident #10 CNA B changed her gloves and used sanitizer but did not rub the sanitizer between her fingers. During an interview on 06/06/2024 at 2:30 p.m. CNA B confirmed she should have rub the sanitizer between her fingers to sanitize the entire surface of her hands. She forgot. She confirmed receiving infection control and hand washing training within the year During an interview with the DON on 06/07/2024 at 10:20 a.m., the DON confirmed that the correct technique to use sanitizer was to sanitize the whole hand, including between the fingers. The facility was doing annual infection control and incontinent care training and annual skills checks. Review of facility policy, titled Handwashing/Hand Hygiene, undated, revealed Using Alcohol-Based Hand Rubs [.] Cover all surfaces of hands and fingers until hands are dry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #32's face sheet, dated 06/06/2024, revealed an admitted [DATE] and, a readmitted [DATE], with diagnoses which included: Malignant neoplasm of brain (Brain Cancer), Hodgkin lymphoma (Type of blood cancer), Gastrostomy status (artificial opening in the stomach), Dysphagia (Difficulty swallowing) and Anxiety (A group of mental illnesses that cause constant fear and worry). Record review of Resident #32's Quarterly MDS assessment, dated 05/08/2024, revealed the resident had a BIMS score of 10, indicating she was moderately cognitively impaired. Resident #32 was always incontinent of bladder and bowel and, required total care with her ADL. She was coded as having a feeding tube while being a resident. Record review of Resident #32's care plan, dated 11/28/2023, revealed a problem of Dependent on tube feeding for nutrition and hydration, with potential for complications, side effects., with an intervention of Provide local care to G-tube site as ordered and monitor for sign and symptoms of infection. Observation on 06/06/24 at 12:14 p.m., revealed while providing enteral feeding for Resident # 32, LVN E, after washing her hands, touched the side table to move it closer to the bed with her bare hand. She did not sanitize the table prior to the care. LVN E, then, put her gloves on and started providing the bolus feeding without sanitizing or washing her hands. During an interview on 06/06/2024 at 12:33 p.m., LVN E confirmed touching the bed table and confirmed not sanitizing the table prior to using it. LVN E confirmed the table was considered dirty as part of the resident's environment and that she should have washed her hands prior to putting her gloves on. She confirmed receiving infection control training within the year During an interview with the DON on 06/07/2024 at 10:30 a.m., The DON confirmed the objects and environment around a resident were considered contaminated and the LVN should have sanitized or washed her hands prior to putting her gloves on and starting the care. Review of facility policy, titled Handwashing/Hand Hygiene, undated, revealed 7. Use an alcohol-based hand rub containing at least 62% alcohol [.] After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident.