STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675133	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Nursing Home	1100 N 4th St Longview, TX 75601

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929 Based on interviews and record review the facility failed to ensure each resident was informed before or at the time of admission, and periodically during the residents stay, of services available in the facility and of charges for those services, which included charges for services not covered under Medicare/Medicaid or by the facility's per diem rate for 2 of 3 residents (Resident #274, and Resident #275) reviewed for Medicare/Medicaid coverage. The facility failed to ensure Resident #274, and Resident #275 were given a SNF ABN (a document that informs a Medicare beneficiary that Medicare will no longer pay for skilled services) when discharged from skilled services at the facility prior to covered days being exhausted. These failures could place residents at risk for not being aware of changes to provided services. Findings included: 1. Record review of Resident #274's face sheet, dated 10/15/24, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included embolism and thrombosis of arteries of the upper extremities (a condition where blood clots form in the arms), and type 2 diabetes (a chronic condition where the levels of sugar, or glucose, build up in the body). Record review of Resident #274's quarterly MDS assessment, dated 09/26/24, indicated she was able to make herself understood, and able to understand others. She had a BIMS score of 14, which indicated she had intact cognition. Record review of the SNF Beneficiary Notification Review indicated Resident #274 received Medicare Part A skilled services on 11/22/23 and the last covered day of Part A was 07/01/24. The SNF Beneficiary Notification Review indicated the facility/provider notified the Resident of discharge from Medicare Part A services with a NOMNC form on 06/28/24. The review further did not contain a SNF ABN for Resident #274. 2. Record review of Resident #275's face sheet, dated 10/15/24, indicated she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included metabolic encephalopathy (a brain disorder caused by a chemical imbalance in the blood that affects brain function), and chronic obstructive pulmonary disease (a common lung disease that makes it difficult to breathe). (continued on next page)

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #275's admission MDS assessment, dated 03/14/24, indicated she was able to make herself understood, and was able to understand others. She had a BIMS score of 15, which indicated intact cognition. Record review of the SNF Beneficiary Notification Review indicated Resident #275 received Medicare Part A skilled services on 03/12/24 and the last covered day of Part A was 05/13/24. The SNF Beneficiary Notification Review indicated the facility / provider notified the Resident of discharge from Medicare Part A services with a NOMNC form on 05/08/24. The review further did not contain a SNF ABN for Resident #275. During an interview on 10/15/24 at 11:50 AM, SW E said that an ABN form was not provided to Resident #275. She did not realize the form was required to be given to the resident and stated it should have been provided. During an interview on 10/15/24 at 12:20 PM, SW E said an ABN form was not provided to Resident #274. She said it was not provided for the same reason as Resident #275. During an interview on 10/16/24 at 02:28 PM, SW E said Resident #275 and Resident #274 should have been provided an ABN form. She said it was important for them to receive the form because it was required by regulation. She said the ABN form should have been issued at the same time as the NOMNC. She said the risk was that the resident may not be aware of out-of-pocket costs after being discharged from Part A services. During an interview on 10/16/24 at 02:34 PM, the Interim Administrator said Residents #274 and #275 should have received the ABN form. She said it was important for the residents to receive the form because it would have helped the residents understand the cost of their services if they stayed in the facility after they ran out of Part A days. She said the risk was they could be charged and not know the cost of their stay. She said it could also cause the resident to have increased anxiety. Record review of the facility's policy, Beneficiary Notice Policy, effective 04/20/23, stated: .A SNF ABN is evidence of beneficiary knowledge about the likelihood of a Medicare denial, for the purpose of determining financial liability for expenses incurred for extended care items or services furnished to a beneficiary and for which Medicare does not pay . .Deadline for providing ANB/NOMNC to resident or guardian: 48 hours before services are set to expire . .The Social Service department is responsible for completing and issuing these forms to the resident and/or family to be signed .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interviews and record review, the facility failed to ensure residents were free from abuse for 3 of 6 residents (Resident #21, Resident #50, and Resident #74) reviewed for abuse. The facility failed to ensure Resident #21 did not feel abused during bathing by CNA P in September and October 2024. The facility failed to ensure Resident #50 did not experience abuse by Resident #70 on 10/06/24. The facility failed to ensure Resident # 74 (victim) was free from undesired touching by Resident #77 (alleged perpetrator) on 10/5/2024. These failures could place resident at risk for emotional distress and further abuse. Findings included: 1. Record review of Resident #21's face sheet dated 10/14/24 indicated Resident #21 was a 69-years-old female admitted on [DATE] with diagnoses including need for assistance with personal care, chronic kidney disease (is a long-term condition that occurs when the kidneys are damaged and can't filter blood properly), weakness, pain in right and left shoulder, diabetes mellitus (a group of diseases that affect how the body uses blood sugar (glucose)), and hidradenitis suppurativa (is a painful, long-term skin condition that causes skin abscesses and scarring on the skin). Record review of Resident #21's quarterly MDS assessment dated [DATE] indicated Resident #21 was understood and understood others. Resident #21 had clear speech, adequate hearing, and adequate vision. Resident #21 had a BIMS score of 12 which indicated moderate cognitive impairment. Resident #21 was dependent for shower/bathe self and personal hygiene. Record review of Resident #21's undated care plan indicated Resident #21 had an ADL self-care performance deficit. Interventions included bathing: shower at least once a week and as needed per CNA. Resident #21 was dependent for bathing. Bed mobility: assist resident to turn and reposition at least once every 2 hours. Roll left and right, sit to lying, and lying to sitting substantial/maximal assist. Record review of Resident #21's shower sheets, provided by the ADM on 10/16/24, indicated: *09/19/24 Received bed bath by CNA P *09/24/24 Received bed bath by CNA P *09/28/24 Received bed bath by CNA P (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #35's face sheet dated 10/14/24 indicated Resident #35 was a 65-years-old female admitted on [DATE] and 09/11/23 with diagnoses including Type 2 diabetes (is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel) and need for assistance with personal care. Record review of Resident #35's quarterly MDS assessment dated [DATE] indicated Resident #35 was understood and understood others. Resident #35 had adequate hearing, clear speech, and adequate vision. Resident #35 had a BIMS score of 15 which indicated intact cognition. During an interview on 10/14/24 at 10:05 a.m., Resident #21 said she was supposed to get a bed bath every night because her sores oozed and smelled. She said CNA P was really rough during care. She said it always seemed like CNA P did not want to assist her. During an interview on 10/14/24 at 10:07 a.m., Resident #35, roommate of Resident #21, said CNA P did not abuse her because she knew better. She said CNA P did not answer call lights or brought things you asked for during her shift. She said it always seemed like CNA P had a bad attitude about doing care like bathing. During an interview on 10/15/24 at 11:10 a.m., Resident #21 said CNA P was rough when turning and cleaning her during bed baths. She said CNA P was rough with her every time she gave her a bath except for the last bath she got. She said it had been happening for a while but, definitely the last two months. She said CNA P did not like giving her bed baths, but the nurses would make her. She said then CNA P would be mad at her and take it out on her during the baths. She said when CNA P was rough with her, it made her feel bad and in more pain. She said she told a night shift nurse about CNA P not wanting to give her a bath and being mad about it. She said she could not remember the nurse's real name because she went by a different name. She said the nurse did not work at the facility anymore. She said she felt like she was being abuse by CNA P during care. During an interview on 10/15/24 at 11:12 a.m., Resident #35 said when CNA P was giving Resident #21 a bed bath, she would hear Resident #21 tell CNA P she was hurting her. On 10/15/24 at 1:21 p.m., call CNA P and left a voice mail. On 10/15/24 at 3:04 p.m., call CNA P and left a voice mail. On 10/17/24 at 11:47 a.m., called CNA P and left a voice mail. CNA P did not return phone call before or after exit. 2. Record review of Resident #50's face sheet dated 10/14/24 indicated Resident #50 was a 68-years-old male admitted on [DATE], 01/08/22, and 03/14/23 with diagnoses including type 2 diabetes mellitus (is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), vascular dementia (is a type of dementia that occurs when blood flow to the brain is interrupted, damaging brain cells and impairing thinking, memory, and behavior), generalized anxiety disorder (is a mental health condition that causes people to experience excessive and persistent worry about everyday things), depression (is a serious mood disorder that affects a person's thoughts, feelings, behavior, and sense of well-being), and acquired absence of left and right leg below knee. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #50's annual MDS assessment dated [DATE] indicated Resident #50 was understood and understood others. Resident #50 had a BIMS score of 08 which indicated moderate cognitive impairment. Record review of Resident #50's undated care plan indicated Resident #50 had potential to demonstrate physical behaviors related to when he gets upset. 10/06/24: Resident #50 hit/curse at CNA staff. Intervention included intervene before agitation escalates. Record review of Resident #50's physical aggression received incident report dated 10/06/24 indicated . Resident #50 .Incident location: Resident's room .Nursing description: Resident #50 was in the hallway by his room when another resident [Resident #70] came in down the hallway and hit .had hit a staff member . Resident description: was sitting in wheelchair when the other resident rolled down the hallway and hit me . mental status: oriented to person and impulsiveness .predisposing physiological factors: confused, incontinent, and impaired memory . Record review of Resident #70's face sheet dated 10/14/24 indicated Resident #70 was a 64-years-old, male admitted on [DATE] with diagnoses including Alzheimer's disease (is a brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out the simplest tasks), Parkinson's disease (is a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), and personal history of transient ischemic attack (is a brief episode of stroke-like symptoms caused by a temporary lack of blood flow to the brain) and cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). Record review of Resident #70's quarterly MDS assessment dated [DATE] indicated Resident #70 was understood and understood others. Resident #70 had a BIMS score of 11 which indicated moderate cognitive impairment. Record review of Resident #70's undated care plan indicated Resident #70 had the potential to demonstrate physical/verbal behaviors related to anger. Resident #70 would slam against the nurses' cart and yell at staff when something set him off. On 10/4/24, aggression episode towards staff. On 10/06/24, aggression episode towards resident (slap resident on face) and staff (threatened/hit/verbally abuse). Intervention included monitor/document observed behaviors and attempted interventions in behavior log. Record review of Resident #70's physical aggression initiated, dated 10/06/24 indicated .Resident #70 . Incident location: hallway .Nursing description: Resident [Resident #70] rolled down the hallway where another resident was sitting in her wheelchair .the other resident exchange an altercation with a staff member .This resident [Resident #70] rolled up the other resident unprovoked .Resident [Resident #70] stated I got tired of his mouth, and he put his hands on the nurses .mental status: oriented to person, oriented to place, oriented to time, oriented to situation, and impulsiveness . Record review of the facility's incident self-report dated 10/06/24 indicated .10/06/24 at 3:30 p.m .Resident #50 was heard calling out for help in the dining room .when the weekend RN supervisor [RN F] responded, she witnessed Resident #70 standing in front of Resident #50 and Resident #70 was slapping Resident #50 in the face .Resident #70 was aggressive towards the weekend supervisor [RN F] during the separation of the two residents . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the provider investigation report dated 10/11/24 indicated .10/06/24 at 3:20 p.m .location of incident: dining room .alleged perpetrator: Resident #70 .Resident #50 was being belligerent to aides and nurses in the dining room .Resident #70 told him [Resident #50] to stop being mean to the staff and go get cleaned up .Resident #50 allegedly said no and Resident #70 slapped him across the face .Resident #70 was determined to be taking up for the facility staff due to his perception that Resident #50 was constantly being mean and nasty towards them .Resident #70 stated he told Resident #50 to stop being mean and then just slapped him to make his point .Facility Investigation Findings: Confirmed . Record review of an undated witness statement by RN F indicated .I [RN F] was getting off of elevator and I could hear someone screaming 'help me' .I [RN F] walked into the dining room and I observed both residents sitting in their wheelchairs at dining room table .Resident #70 was holding Resident #50's right hand down on the table as he was slapping Resident #50's face on the right side .I [RN F] then asked Resident #70 to stop as I was approaching the table to separate the two residents .I [RN F] then made it to the table to redirect and separate the two at that time Resident #70 became more aggressive and was trying to strike Resident #50 again .[LVN L] then was trying to assist me calming the resident [Resident #70] down .Resident #70 then began to rise out of his wheelchair at this nurse .I [RN F] had to physically put my hands up in front of the charge nurse [LVN L] and resident [Resident #70] to prevent him from striking her .Resident #70 had calmed down as I [RN F] propelled his wheelchair to his room .I then asked Resident #70 what happened to cause him to strike Resident #50 .Resident #70 said that Resident #50 is always talking 'ugly' to the staff and he was tired of it and he was going to 'teach him a lesson' . Record review of Resident #42's face sheet dated 10/17/24 indicated Resident #42 was a 48-years-old female admitted on [DATE] with diagnosis including multiple sclerosis (is a chronic autoimmune disease that affects the central nervous system (CNS)). Record review of Resident #42's quarterly MDS assessment dated [DATE] indicated Resident #42 was understood and understood others. Resident #42 had clear speech, adequate hearing, and adequate vision. Resident #42 had a BIMS score of 15 which indicated intact cognition. During an interview on 10/14/24 at 11:08 a.m., Resident #59 said Resident #70 never hit him. He said the staff at the facility was lying. During an interview on 10/14/24 at 12:07 p.m., Resident #42 said Resident #50 hit CNA Q in the hallway over being out of something. She said Resident #70 heard Resident #50 cussing at CNA Q. She said Resident #70 and Resident #50 got into it in the hallway. She said she was not in the dining room when the other incident happened. She said she heard Resident #70 hit Resident #50 because he hits the CNAs. She said Resident #70 was normally not aggressive but Resident #50 was. She said she did not think it was fair Resident #70 got in trouble for hitting Resident #50 because he was sticking up for the CNAs. During an interview on 10/14/24 at 2:38 p.m., Resident #70 said he never hit anybody. He said he did not remember hitting Resident #50. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/15/24 at 2:32 p.m., RN F said she was coming off the elevator near the dining room when she heard Resident #50 screaming out for help. She said she arrived in the dining room and saw Resident #70 open hand slapping Resident #50 in the face and holding Resident #50's hand down on the table. She said she immediately separated the residents. She said Resident #70 was so angry, he was trying to stand up out of his wheelchair to reach Resident #50. She said Resident #70 said Resident #50 was saying bad things and he was tired of it. She said Resident #50 was sitting in his wheelchair with a shocked look on his face. She said that she was aware of, this was the first altercation between Resident #50 and Resident #70. She said this incident was the first time Resident #70 had been aggressive towards a resident. She said LVN L tried to help during the altercation and Resident #70 tried to hit her too. She said Resident #70 was placed on 1:1 monitoring, and the ADM and the DON were notified. She said the facility called an ambulance but Resident #70 refused to leave for the evaluation. She said Resident #70 also refused an inpatient behavioral referral. She said after the incident, Resident #50 seemed fine the rest of the day. She said Resident #70 eventually calmed down. She said Resident #70 was cognitive enough to know what he was doing. She said she would consider Resident #70 slapping Resident #50 abuse. During an interview on 10/15/24 at 3:18 p.m., LVN L said Resident #50 was upset and hit CNA Q on her arm. She said Resident #70 saw Resident #50 hit CNA Q. She said Resident #70 wheeled himself to Resident #50's room and grabbed him by the arm. She said when she went to separate Resident #50 and Resident #70, Resident #70 tried to hit her too. She said after the hallway incident, Resident #70 went into his room and Resident #50 went to the dining room. She said she notified RN F about the hallway incident between Resident #50 and Resident #70. She said she thought everything was okay between the residents. She said she went to smoke and walked back into RN F trying the separate Resident #50 and Resident #70. She said the residents were separated and Resident #70 placed on 1:1. She said Resident #70 refused to go with emergency medical service. She said the police were also called and they spoke with Resident #70. She said Resident #70 was placed on 1:1 for 3 days until he was released by the NP. She said Resident #70 could sometimes get violent if he did not get his way. During an interview on 10/16/24 at 2:45 p.m., CNA Q said Resident #50 came out of his room for a towel and got upset there were none available. She said Resident #50 was already agitated from a visit with his. She said Resident #50 swung and hit her on the arm. She said Resident #70 was in his doorway and saw it happen. She said Resident #70 came out of his room and approached Resident #50. She said Resident #70 started swinging at Resident #50 and hit him. She said she and LVN L separated the residents. She said they wheeled Resident #50 to the dining room and Resident #70 to his room. She said Resident #70 tried to stand out of his wheelchair during the argument and tried to hit LVN L. She said that was the first time she had seen Resident #70 and Resident #50 interact. During an interview on 10/17/24 at 2:05 p.m., Regional RN FF, acting DON, said staff being rough during care was not appropriate. She said if a staff member abused a resident, then the resident would not want to receive care from the abuser. She said the resident needed to voice their concerns to the nursing staff and the abuse coordinator. She said residents should be educated on reporting mistreatment or abuse in resident council meetings and a letter sent out to the residents and resident's family about reporting abuse and who the abuse coordinator was. She said the Interim ADM was the abuse coordinator. She said she was not too familiar with the incident between Resident #70 and Resident #50. She said she would consider the incident between the resident abuse because they touched. She said the residents should have been separated, monitored, and psychological evaluation ordered. She said Resident #70 refused to go to a behavioral hospital. She said she did not think upper management knew about the hallway incident that happened before the dining room altercation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/24 at 2:58 p.m., the Interim ADM said she had not interviewed Resident #35 yet. She said she was working on the investigation since the abuse allegations were made 10/15/24. She said CNA P did not return the phone calls made to her by the facility but texted the facility asking what was going on. She said CNA P denied the allegation and claimed Resident #35 refused bed baths. She said CNA P said she did not know Resident #35 had issues with her. She said CNA P was suspended pending investigation. She said she expected staff to treat residents with respect. She said she expected staff to introduce themselves to residents, explain what they were going to do, and provide the assistance the resident needed. She said residents should be informed of who the abuse coordinator was and how to report abuse by the abuse coordinator during visits with the residents. She said she had only been at the facility for a few days. She said the social worker should also have conversations with the residents on abuse and reporting. She said during activities, the Activity Director should also be educating resident on how to file a complaint and who the abuse coordinator was. She said if a staff member was being rough during care including bathing, it would be considered abuse. She said if a resident was abused, they could feel neglected, frightened, depressed, and treated unfairly. She said the residents could also feel like staff did not like them and were being treated bad as a form of retaliation. She said she would consider Resident #70 slapping Resident #50 as abuse. She said anyone getting slapped would be upset about it. She said it depended on the resident's BIMS score on their reaction and lasting effect on being slapped. She said when resident to resident altercations happened, they should be separated and monitored 1:1 to help prevent it from happening again 3. Record review of Resident #74's face sheet, dated 10/14/2024, indicated she was a [AGE] year-old female, who was readmitted to the facility on [DATE] with the diagnoses which included Guillain-Barre syndrome (a condition in which the body's immune system attacks the nerves), muscle wasting and atrophy (wasting or thinning of muscle mass), difficulty walking, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) Record review of Resident #74's quarterly MDS, dated [DATE], indicated she had a BIMS score of 15, which indicated she was cognitively intact. Resident #74's MDS indicated she was understood and understands others. Resident #74 was dependent for most ADL's such as toileting hygiene, showering, dressing upper and lower body, putting on and taking off footwear, and she required substantial assistance with personal hygiene. Record review of Resident #74's undated care plan, indicated a focus on Resident #74 required antidepressant medication for a diagnosis of depression with interventions for following: o Educated the resident and family about risks, benefits, and the side effects and or toxic symptoms of anti-depressant drugs given. o Give antidepressant medications as ordered by the physician. Monitor and document side effects and effectiveness. Side effects: dry mouth, dry eyes, constipation, urinary retention, and suicidal ideations. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Monitor, document, and report to physician as needed ongoing signs or symptoms of depression unaltered by antidepressant medications such as: sadness, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideation, negative mood or comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight and appetite, fear or being alone or with others, unrealistic fears, attention seeking, concern with body function, anxiety and constant reassurance. Record review of Resident #77 s face sheet, dated 10/14/2024, revealed he was a [AGE] year-old female, who was admitted to the facility on [DATE], with the diagnoses which included Parkinson's disease (a movement disorder of the nervous system that worsens over time), schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania, and a milder form of mania called hypomania), mild cognitive impairment (the stage between the expected decline in memory and thinking that happens with age and the more serious decline of dementia), and cerebrovascular disease (a term for conditions that affect blood flow to your brain). Record review of Resident #77's quarterly MDS, dated [DATE], indicated she had a BIMS score of 12, which indicated she was moderately cognitively impaired. Resident #77's MDS did not indicate resident hallucinated or delusions during the look back period. Record review of Resident #77's undated care plan indicated, Resident #77 was sexually inappropriate as evidenced by Resident #77 taking her clothes off and began to rub on her roommate leg and made statement that she needed some loving and was making in appropriate remarks. Interventions included: o Evaluate the resident's ability to understand behavior and the consequences of that behavior. o Psychiatric services consult as needed. o Reinforce with staff that clear, firm limits are healthy, and required when resident makes inappropriate gestures and statements. o Report incidents of target behavior to charge nurse. o Resident was placed on one-on-one until sent out to psychiatric hospital. During an interview on 10/15/2024 at 11:06 AM, Resident # 74 said on 10/5/2024 that Resident #77 (perpetrator) was naked in her wheelchair and wheeled herself to her bedside and started rubbing all over me and touched my leg. Resident #74 said her roommate attempted to ease up on her bed and she pushed her back. Resident #74 said her roommate Resident #77 attempted to grab her hand to prevent her from grabbing her call light. Resident #74 said a CNA came in and saw Resident #77 (perpetrator) next to her bed naked and placed the resident back in her bed. Resident #74 said she felt nervous but fell back asleep and Resident #77 (perpetrator) did not bother her again throughout the night. She said she reported it and was interviewed by the weekend supervisor. The police were called, and a statement was given. Resident #74 said no administrative staff interviewed her. (continued on next page)

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	675133	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Nursing Home	1100 N 4th St Longview, TX 75601

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/15/2024 at 12:53 PM CNA LL said she worked the 6 PM to 6 AM shift on 10/5/2024. CNA LL said she went in Resident # 74's room because her call light was on. She said Resident #74 was sitting up in her bed and Resident #77 (perpetrator) was naked in her wheelchair next to Resident #74's bed. CNA LL said Resident #77 (perpetrator) was not touching Resident #74 when she turned on the light. CNA LL said she assisted Resident #77 (perpetrator) back to her side of the room, dressed her, and placed her back in her bed. CNA LL said she immediately reported to the incident to ADON N who was working the unit. CNA LL said she left the door to Resident # 74's room open and made rounds. CNA said the next day when she returned to the unit, Resident #77 (perpetrator) was on 1 on 1 care. She said Resident #74 was not harmed. CNA LL said she did not know if the abuse coordinator was notified. CNA LL said she was not aware the resident had been touched or hurt. She just observed Resident #77 (perpetrator) naked, so she continued to check on them. During an interview on 10/15/2024 at 2:15 PM, RN F said she came in that morning about 9 AM and said the charge nurse was ADON N. RN F said LVN L said she needed to talk to me and reported Resident #74's roommate Resident #77 (perpetrator) was inappropriate with her. RN F said ADON N did not know anything about the incident and Resident #74 had told LVN L what happened. RN F said ADON N said she was only aware that the roommate was naked. RN F said Resident #74 did not voice to the CNA what had occurred. RN F said Resident #77 (perpetrator) had never been inappropriate prior to the allegation and was not sure how long they had been roommates. RN F said she did not feel the CNA was aware of the allegations and did appropriate care for both residents. During an interview on 10/16/2024 at 3:06 PM, CNA Q said Resident #74 had told her that Resident #77 (perpetrator) was touching on her and saying sexual things toward her. CNA Q said she was told the incident happened on a night shift and Resident #74 told her she reported it to the CNA. CNA Q said CNA LL did not report because she knew Resident #77 (perpetrator). CNA Q said Resident #77 (perpetrator) did have episodes of behaviors where she would lay down in her bed and not move and reported Resident #77 (perpetrator) did not like help. CNA Q said Resident #77 (perpetrator) would have episodes where she would not sleep for days. CNA Q said Resident #74 did not verbalize feeling scared or afraid. CNA Q said she would report immediately to the nurse if allegations were reported to her and said the abuse coordinator was the ADM. CNA Q said unwanted touching was considered abuse. During an interview on 10/17/2024 at 9:11 AM, Social worker E said the perpetrator never had any previous behaviors. Social worker E said the perpetrator transferred to the hospital and was currently receiving psychiatric care. Social worker E said Resident #77 (perpetrator) was having manic behaviors which included restless, not sleeping at night, and wheeling herself all over the facility. Social worker E said Resident #77 (perpetrator) was on medication and she started attending out-patient behavioral therapy approximately 1 week prior to incident. Social worker E said Resident #74 was not fearful or scared and was understanding of the situation. Social worker E said she had completed a trauma screen assessment on Resident #74 for 3 days in a row. She said the facility was not planning on returning Resident #77 (perpetrator) to the room. Social worker E said Resident #74 was receiving in-house psychiatric services and no concerns had been reported to facility since incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/2024 at 9:45 AM, ADON N said she had only been at the facility for 2 weeks. ADON N said Resident #74 had intermittent confusion. She said Resident #74 had never made any previous allegations. ADON N said she was not made aware of the allegations that night and made aware the next morning during report. ADON N said she was on call the night of the allegation and did not receive any calls. ADON N said Resident #77 (perpetrator) was removed from Resident #74's room and was in the dining area most of the day. ADON N said Resident #77 (perpetrator) had some behaviors which included yelling, wandering, demanding, and cussing. ADON N said Resident #77 (perpetrator) had to be redirected often. ADON N said Resident #77 (perpetrator) was removed from room and placed on 1:1 care on a different unit. During an interview on 10/17/2024 at 11:31 AM, the Regional Nurse FF said the DON reported the incident. She said she expected the nurses and staff to report any abuse concerns to the ADM even on the weekends. The Regional nurse said the on-call nurse would be available if the ADM was not available. She said she expected an intervention to be in place to keep residents safe. The Regional Nurse FF said the abuse coordinator, the DON, and the Social worker were responsible for conducting a thorough investigation. The Regional Nurse FF said if Resident #77 (perpetrator) was not removed from the victim, the victim could continue to be harmed. During record review of police report dated 10/6/2024 indicated an indecent exposure occurred during unknown hours of 11 PM and 2 AM on 10/5/2024. The police report indicated Resident #77 (perpetrator) was in the lobby in a counseling room to discuss events. The report indicated Resident #77 (perpetrator) was masturbating in her bed and got up to Resident #74's bedside to see if she wanted to join her. Resident #77 (perpetrator) reported to police she was masturbating next to Resident #74's bed and touching her leg and she wanted to touch her vagina. Resident #77 (perpetrator) reported to the police she did not touch Resident #74's vagina and only rubbed her legs. The perpetrator told police a nurse came into the room and told her to leave Resident #74 alone and she was taken to another room for some pills and went to sleep. Record review of police report dated 10/6/2024 indicated interview with Resident #74 said she woke up because she heard a lot of stuff fall. Resident #74 said Resident #77 (perpetrator) had pushed her tray over and was beside her bed naked and rubbing on her leg asking if she wanted to make love with her. Resident #74 told Resident #77 (perpetrator) no and to get back to bed. Resident #74 said Resident #77 (perpetrator) told her she wanted to touch her vagina. Resident #74 pushed the nursing help button, and Resident #77 (perpetrator) grabbed her hand and started rubbing it. Resident #74 said the nurse came into the room and removed Resident #77 (perpetrator). Resident #74 told police Resident #77 (perpetrator) only rubbed her leg that was protected by the cover and rubbed her hand when she pushed the button. The police were informed Resident #77 (perpetrator) would not be returning to the facility and was getting transported to an in-patient psychiatric hospital. Record review of a facility's, Violence Between Residents policy revised date 08/2020 indicated .the facility acts promptly and conscientiously to prevent and address between residents .facility staff monitors resident for aggressive or inappropriate behaviors toward other residents . Record review of a facility's Abuse Prevention and Prohibition Program policy revised date 10/24/22 indicated .each resident has the right to be free from mistreatment, neglect, abuse .staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment .the facility is committed to protecting residents from abuse by anyone, including but not limited to facility staff, other residents . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49019

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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** 48958 Based on interviews and record review, the facility failed to report the results of all investigations to the Administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation was verified appropriate corrective action must be taken for 1 of 7 residents (Resident #1) reviewed for abuse and neglect. The facility failed to ensure the provider investigation report regarding Resident#1's incident with Resident #26, dated 09/12/24 was turned into the state survey agency (HHSC) within 5 working days of the reported incident for Resident #1. This failure could place residents at risk for abuse and neglect. Findings included: 1. Record review of Resident #1's face sheet, dated 10/14/24, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included unspecified dementia (a group of symptoms that affect a person's memory, thinking, and social abilities), generalized anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry about various aspects of daily life), and chronic obstructive pulmonary disease (a group of progressive lung diseases that cause obstructed airflow from the lungs and make breathing difficult). Record review of Resident #1's quarterly MDS assessment, dated 08/30/24, indicated she was able to make herself understood and understand others. She had a BIMS score of 9, indicating moderate cognitive impairment. Record review of the facility's provider investigation report for the reported incident for Resident #1, dated 9/12/24 (date facility made aware of incident), indicated that Resident #1 alleged that Resident #26 hit her on the back after an argument over the television and other belongings in the room. Resident #1 cannot recall when the incident occurred but thinks it may have happened on 09/11/24 at an unknown time, but she was not sure. Head-to-toe skin assessment performed, and no injury noted to Resident #1's back. The residents were immediately separated. Resident #26 was moved to a different room on the 200 hall and both residents were interviewed. Staff increased supervision of both residents to ensure no emotional distress for either. Neither resident could remember the details of the events or dates they occurred. Both were extremely confused and poor historians. No injuries to either resident was noted during head-to-toe assessments. Resident #26 had bruising from falls that were in the healing process at the time of the head-to -toe assessment. Ultimately, the facility's investigation concluded that the allegation of abuse was inconclusive. In-services were conducted with facility staff on the prevention of abuse and neglect and in-service on de-escalation. The allegation was reported to the state survey agency on 09/12/24 . During an interview on 10/15/24 at 12:41 PM, the Administrator she said the provider investigation report for incident 531976 was not turned into the state. She said it should have been turned into the state within 5 days of the 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 10/15/24 at 12:43 PM, the Administrator provided an email dated 10/01/24 indicating the PIR was submitted on 10/01/24. She said it was submitted in 6 days and it should have been submitted in 5 days or less. During an interview on 10/15/24 at 12:54 PM, the Administrator said the facility did not have a policy other than the abuse policy for turning in a PIR in 5 days. During an interview on 10/17/24 at 12:20 PM, the Administrator said, I cannot tell you why the provider investigation report was not turned in to HHSC for Resident #1, because that was before I got here. The Administrator said the provider investigation report should have been turned in to HHSC within 5 working days of the investigation. She said she was the Administrator and her first day was 10/14/24 . Record review of the facility's undated policy, Abuse/Neglect, stated: .IX. Reporting/Response . .D iv. The administrator will provide the state survey agency, law enforcement and the Ombudsman with a copy of the investigative report within 5 days of the incident .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interviews and record review, the facility failed to ensure assessments accurately reflected the resident's status for 2 of 24 resident reviewed for assessments. (Resident #49 and Resident #88) The facility failed to ensure Resident #49's MDS dated [DATE], was not inaccurately coded for being on an antipsychotic medication (are a class of psychotropic medication primarily used to manage psychosis). The facility failed to ensure Resident #49's MDS dated [DATE], was not inaccurately coded as having a diagnosis of bipolar (is a mental illness that causes extreme shifts in mood, energy, and activity levels) instead of mood disorder. The facility failed to ensure Resident #88's MDS dated [DATE] was coded for being PASRR (is a federally mandated review process, requiring all people seeking Medicaid-certified nursing facilities admissions to be screened for mental illness or intellectual and developmental disability regardless of funding source or age) positive for development disability/intellectual disability. These failures could place residents at risk of not having individual needs met. Findings included: 1. Record review of Resident #49's face sheet dated 10/14/24 indicated Resident #49 was a 54-years-old male admitted on [DATE] and 09/18/23 with diagnoses including mood disorder (is a mental health condition that primarily affects your emotional state) and vascular dementia (is a type of dementia that occurs when blood flow to the brain is interrupted, damaging brain cells and impairing thinking, memory, and behavior), severe, with mood disturbance (is a general term for a range of psychiatric conditions that affect a person's emotional state). Record review of Resident #49's quarterly MDS assessment dated [DATE] indicated Resident #49 was understood and understood others. Resident #49 had a BIMS score of 05 which indicated severe cognitive impairment. The MDS indicated Resident #49 had diagnoses including depression and bipolar disorder. The MDS indicated Resident #49 had received an antipsychotic during the last 7 days of the assessment period. Record review of Resident #49's consolidated physician orders active as of 10/15/24 indicated Depakote Oral Tablets Delayed Release (Divalproex Sodium) (is an anticonvulsant), give 125 mg by mouth in the morning for [sic]. Start date 01/11/24. Resident #49's consolidated physician orders did not reflect an antipsychotic medication. Record review of Resident #49's undated care plan indicated: *Resident #49 had history of behavioral problems. On 09/18/23, Resident #49 returned from an inpatient stay at a behavioral unit with a new diagnosis of mood disorder due to known physiological condition with manic features. Intervention administer medication as ordered. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Resident #49 required antidepressant medication for diagnosis of depression and mood disorder. Intervention included give antidepressant medications ordered by physician. Record review of Resident #49's psychiatric subsequent assessment dated [DATE] indicated . Resident #49 had primary treating diagnosis: other specified depressive episodes, secondary treating diagnosis: other psychoactive substance dependence with psychoactive substance-induce mood disorder, tertiary treating diagnosis: vascular dementia, severe, with mood disturbance, diagnosis treating: other seizures (is a temporary, abnormal burst of electrical activity in the brain) .history of presenting illness .depression . Resident #49 psychiatric subsequent assessment did not reflect a diagnosis of bipolar disorder. During an interview on 10/15/24 at 10:18 a.m., MDS Coordinator W said she completed Resident #49's MDS assessment. She said Resident #49 was on Depakote, an anticonvulsant, but it was prescribed for his mood disorder. She said she classified the Depakote as an antipsychotic because until October 1, 2024, an anticonvulsant option was not available. She said Resident #49 had a mood disorder, so she coded it as bipolar disorder. She said there was no documentation stating Resident #49's mood disorder was bipolar. During an interview on 10/15/24 at 10:30 a.m., MDS Coordinator W said she was new to the facility and stated she was still learning. She said the Regional MDS Coordinator had educated her on how to correctly code anticonvulsants and mood disorders. 2. Record review of Resident #88's face sheet dated 10/16/24 indicated Resident #88 was a 59-years-old male admitted on [DATE] and 09/09/24 for diagnoses including Asperger's syndrome (is a neurodevelopmental disorder that is part of the autism spectrum and is characterized by difficulties with social interaction and communication, as well as repetitive behaviors and interests), limitation of activities due to disability, need for assistance with personal care, obstructive and reflux uropathy (is a general term for a urinary tract disorder that occurs when urine flow is obstructed, either structurally or functionally), and retention of urine (is the inability to empty the bladder). Record review of Resident #88's annual MDS assessment dated [DATE] indicated Resident #88 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Resident #88 had unclear speech, adequate hearing, and impaired vision. Resident #88 was sometimes understood and sometimes understood others. Resident #88 had a BIMS score of 03 which indicated severe cognitive impairment. Resident #88 admission performance was substantial/maximal assistance for oral hygiene and dependent for chair/bed-to-chair transfer. Resident #88 had an indwelling catheter and always incontinent for bowel. Record review of Resident #88's undated care plan indicated Resident #88 was PASRR positive and receiving specialized services. Intervention included will continue to monitor PASRR services were ordered. Record review of Resident #88's PASRR Evaluation (Level II) dated 05/21/24 indicated Resident #88 had a developmental disability other than an intellectual disability that manifested before the age of 22. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 10:05 a.m., MDS Coordinator W said if Resident #88 was PASRR positive, it should have been coded on his annual MDS. She said she had not completed Resident #88's MDS. She said MDS Coordinator V had done Resident #88's annual MDS assessment. During an interview on 10/17/24 at 10:45 a.m., MDS Coordinator V said she completed Resident #88's annual MDS assessment. She said Resident #88 was PASRR positive for development disability and received services. She said Resident #88's PASRR status should have been coded on his MDS assessment. She said it was a data entry error on her part. She said the Corporate MDS Coordinator spot checked the facilities submitted MDS assessments. She said it was important for Resident #88's PASRR status to be on his MDS to make sure he was getting services and it was part of his clinical record. She said a resident's MDS assessment should be accurate to know the resident's status and what the facility was doing for them. During an interview on 10/17/24 at 11:00 a.m., the Regional MDS Coordinator X said a resident's PASRR positive status should be reflected on their annual MDS. She said Depakote was an anticonvulsant not an antipsychotic. She said after October 1, 2024, the MDSs had an anticonvulsant coding option. She said medications should be coded as their drug classification not how they were being used. She said Resident #49's mood disorder should have been added on additional diagnoses not coded as bipolar. She said it was important for a MDS assessment to be accurate because it reflected the resident's care during the assessment period and identified needs. She said the MDS assessments should always be coded correctly per the RAI. She said she audited the facility's MDS assessments last month and tried to do them quarterly. During an interview on 10/17/24 at 2:05 p.m., the Regional RN FF said the MDS Coordinator was responsible for accurate MDS assessments. She said she expected resident's MDS assessment to be accurate. She said the DON signed the MDS assessment indicating it had been reviewed and was accurate. She said the RN who signed the resident's MDS assessment was responsible for ensuring the MDS Coordinator coded the resident's information correctly. She said Depakote was an anticonvulsant not an antipsychotic. She said a mood disorder should not automatically be coded as bipolar disorder. She said positive PASRR status should be reflected on the resident's MDS assessment. She said if the MDS was not accurate, it did not reflect the resident's plan of care accurately. During an interview on 10/17/24 at 2:58 p.m., the Interim ADM said the MDS Coordinator was responsible for accurate MDS assessments. She said when the RN signed the MDS assessment, it implied it was ready to be closed. She said the Regional MDS Coordinator or RN, who signed the MDS assessment should ensure the MDS Coordinator submitted accurate MDS assessments. She said it was important for MDS assessments to be accurate because the information was how the facility cared for the resident and showed the level of care they would be receiving. She said if the MDS assessment was not accurate, the resident was at risk for not receiving accurate care. She said a resident's PASRR positive status should be on their MDS assessment. She said only documented diagnoses should be coded on the MDS assessment. Record review of an undated facility's Minimum Data Set policy indicated .the facility will follow RAI guideline for all areas related to MDS process .to utilize the most current version of the RAI manual to guide all IDT members on the proper procedure for coding items on MDS assessment .

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on interviews and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR) Level I assessment accurately reflected the resident's status for 1 of 13 residents (Resident #97) reviewed for PASRR Level I screenings. 1. The facility failed to ensure the accuracy of the PASRR Level 1 screening for Resident #97. This failure could place residents who had a mental illness at risk of not receiving a needed assessment (PASRR Evaluation), individualized care, or specialized services to meet their needs. Findings included: Record review of Resident #97's face sheet, dated 10/14/2024, revealed he was a [AGE] year-old male, who was readmitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis following cerebral infarction (symptom that involves one-sided paralysis after blood flow to the brain is blocked or reduced), obstructive and reflux uropathy (when your urine can't flow (either partially or completely) through your ureter, bladder, or urethra due to some type of obstruction), and schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior). Record review of Resident #97's quarterly MDS, dated [DATE], indicated he had a BIMS score of 15, which indicated he was cognitively intact. Resident #97's MDS revealed an active diagnosis of Schizophrenia. Record review of Resident # 97's PASARR level L1 dated 8/2/2023 indicated Resident #97 did not have a mental illness. Record review of Resident #97's care plan, undated revealed Resident #97 required psychotropic medication for diagnosis of Schizophrenia. Resident #97's care plan did not indicate he was PASRR positive or negative. Record review of Resident #97's PASRR Level 1 Screening, dated 08/03/2023, indicated in Section C Mental Illness was marked as no, which indicated Resident #97 did not have a mental illness. During an interview on 10/17/2024 at 9:08 AM Social worker E said she does not complete any of the PASSR level one screenings or PASSR. Social worker E said she attends the meetings for care plans. Social worker E said she was not sure which residents were receiving PASSR services. She said she was aware that residents with mental illness and do not have dementia can qualify for services and those residents with intellectual disabilities. (continued on next page)

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Highland Pines Nursing Home	1100 N 4th St Longview, TX 75601

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 8:34 AM, MDS Coordinator V said all residents should have a PASSR level one. She said if a resident had a diagnosis of a mental illness or intellectual disability, they would be positive. She said there were 2 authorities depending on if the resident had mental illness or intellectual disabilities. MDS Coordinator V said she would be aware if a resident qualified if they received a negative letter. MDS Coordinator V said if the resident was positive, then the facility would schedule a meeting and the facility only care plans if a resident was positive. MDS Coordinate V said Resident # 97 had come to the facility with a diagnosis of schizophrenia and said the hospital incorrectly marked mental illness as no. MDS Coordinator said she had completed the form 1012 on 10/17/2024 and the local authority had already requested records. MDS Coordinator V said Resident #97 had already been receiving psychiatric services since 8/2/2023. During an interview on 10/17/2024 at 9:33 AM, ADON N said she was not sure about PASRR. During an interview on 10/17/2024 at 11:31 AM, Regional Nurse FF said the MDS nurse was responsible for ensuring the PASARR forms were completed. She said the resident's PASARR should have been positive with a diagnosis of schizophrenia. Regional Nurse FF said the MDS nurse should have identified the diagnosis and referred PASARR evaluation. She said she expected the nurses to complete the form 1012 when identified a resident had a mental illness. Regional Nurse FF said if the resident has proper orders in place, the care was coordinated to receive services. During an interview on 10/17/2024 at 11:55 AM, the ADM said she had been the ADM since Monday. The ADM said a resident who had a mental illness should be evaluated for a positive PASSR. She said the resident could qualify for additional services. Record review of the facility's policy, undated and titled Pre-Admission Screening Resident Review (PASRR) stated: To ensure that all Facility applicants are screened for mental illness and/or intellectual disability prior to admission and to ensure this assessment effort is coordinated with the appropriate state agencies if indicated. PASARR is a federal requirement .A. PASSR level I screening is to be completed before the individual is admitted .B. All first-time applicants to the facility, regardless of Medicaid status or payor .ii. The state is responsible for providing specialized services to residents with MD/ID residing in Medicaid certified facilities .

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on interviews and record review the facility failed to notify the State Mental Health Authority to inform them of a significant change in mental condition for 1 of 5 (Residents #93) residents reviewed for Preadmissions Screening and Annual Resident Review (PASRR). 1. The facility failed to notify the SMHA to ensure Resident #93 received a new PASRR level 1 screening following identification of his diagnosis of post-traumatic stress disorder on 01/25/24. This failure could affect residents who may have a mental disorder diagnosis by placing them at risk for not receiving the necessary services that may benefit them daily. Findings included: Record review of Resident #93's face sheet, dated 10/14/24, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included post-traumatic stress disorder (a real disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event), encephalopathy (a broad term for any brain disease that alters brain function or structure) and other specified depressive episodes (a diagnosis for a person who has symptoms of a depressive disorder but doesn't meet the full criteria for a specific depressive disorder). Record review of Resident #93's quarterly MDS assessment, dated 9/20/24. The MDS indicated a BIMS score of 12 indicating Resident #93's cognition was moderately impaired. The MDS indicated Resident #93 was independent with activities of daily living. Record review of Resident #93's admission record, dated 05/05/23, reflected his diagnoses included encephalopathy unspecified, onset date 05/05/23; and other specified depressive episodes, onset date 05/05/23. Record review of Resident #93's face dated 10/14/24, indicated she had a diagnosis that included post-traumatic stress disorder. Record review of Resident #93's PASRR Level 1 Screening, dated 05/05/23, indicated the resident did not have mental illness, intellectual disability, or developmental disability. Record review of Resident #93's PASRR Level 1 Screening, dated on 01/25/24 or after PTSD diagnosis was not indicated, the resident did not have a PASRR Level 1 Screening. Record review of Resident #'s Order Summary Report, dated 07/09/24, reflected: 1. Venlafaxine HCL 50 mg, two times daily for depression During an interview on 10/15/24 at 8:35 A.M., with Resident #93 she said the facility was treating her depression and PTSD with medications and counseling. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/15/24 at 2:37 P.M., with Regional MDS Coordinator X she said PTSD was not a diagnosis for a positive PASRR. During an interview on 10/15/24 at 2:44 P.M., with MDS Coordinator V said she had not heard PTSD was a diagnosis for a positive PASRR. She said normally the residents have another diagnosis to go with PTSD for a positive PASRR. During an interview on 10/15/24 at 3:58 P.M., Regional MDS Coordinator X notified the State Surveyor that they were going to do a 1012 Form for Resident #93 and they were going to get the doctor to sign the order tonight. She said they were going to enter the form in the portal and that will trigger PASRR to complete a PASRR level 1 evaluation. She said the facility would have an in-service for our MDS nurses for PASRR positive diagnosis. Regional MDS Coordinator X said after Resident #93 received the PTSD diagnosis she was supposed to have a PASRR Level 1 evaluation. During an interview on 10/16/24 at 9:41 A.M., with Regional MDS Coordinator notified the state surveyor that 1012 was filed for Resident #93 and the facility was waiting for PASRR for an evaluation. During an interview on 10/17/24 at 9:27 A.M., with MDS Coordinator V she said Resident #93 should have had a new PASRR eval done after she received a new diagnosis of PTSD. She said the PASRR eval was not done after the state surveyor intervention. She said the facility had filed a 1012 and called the MD. She said she had requested the PL1 and requested the records from the state. She said the negative effects of a resident not receiving PASRR services was residents with mental illness could miss out on counseling services and other services that could be offered. During an interview on 10/17/24 at 10:54 A.M., with the Administrator she said she expected for residents to have an accurate PASRR assessment. She said the negative effects on residents not having an accurate PASRR evaluation could affect the resident's health and they could be paying for services that the PASRR benefits could cover. Record review of facility's Pre-Admission Screening Resident Review (PASRR) policy indicated . the facility also conducts a Level 1 screening for current residents who experience a significant change in their condition based on MDS 3.0 guidelines . a Level 1 PASRR is completed each time a resident is hospitalized and readmitted if there has been a significant change in condition .

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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** 46929 Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment for 1 of 24 residents reviewed for care plans. (Resident #25) The facility failed to ensure that Resident #25's care plan addressed his oxygen use. These failures could place residents at risk for not receiving the necessary care or having important care needs identified. Findings included: Record review of Resident #25's face sheet, dated 10/15/24, indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included chronic respiratory failure (a long-term condition that makes it difficult to breathe because the lungs can't exchange oxygen and carbon dioxide properly), heart failure (a serious condition that occurs when the heart can't pump enough blood and oxygen to meet the body's needs), chronic obstructive pulmonary disease (a common lung disease that makes it difficult to breathe), and chronic pulmonary edema (fluid buildup in the lungs over time). Record review of Resident #25's quarterly MDS, dated [DATE], indicated he was able to make himself understood and he was able to understand others. His BIMS score was 11, which indicated moderately impaired cognition. Record review of a screenshot of Resident #25's physician's orders, taken on 10/15/24 at 2:10PM, indicated the resident did not have an order for oxygen. Record review of a printed copy of Resident #25's physician's orders, provided by ADON A on 10/15/24 at 3:44PM, and further dated for 10/15/24 at 03:06PM, indicated these orders: *Change respiratory tubing, mask, bottled water, clean filter every 7 days as needed. The start date was 08/06/24. *Change respiratory tubing, mask, bottled water, clean filter every 7 days, every night shift every Wednesday. The start date was 08/07/24. *Oxygen at 2-4 liters per minute via nasal cannula every shift. The start date was 10/15/24. Record review of Resident #25's undated care plan indicated the care plan did not address his oxygen use. During an observation on 10/14/24 at 10:19 AM, Resident #25 was lying in bed watching TV in his room. He had oxygen in place via nasal cannula. The oxygen concentrator was set at 2.5LPM. (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 observation on 10/14/24 at 2:17PM, Resident #25 was lying in bed watching TV in his room. He had oxygen in place via nasal cannula. During an observation on 10/15/24 at 08:47 AM, Resident #25 was in his room lying in bed. He had oxygen in place via nasal cannula. During an interview on 10/15/24 at 03:44 PM, ADON A said Resident #25 did not have an order for oxygen. She said she obtained the order after this state surveyor pointed out the missing order, and then entered it into the resident's orders. She said the facility did not have a standing order for continuous oxygen use. During an interview on 10/16/24 at 02:01 PM, ADON A said Resident #25 should have a care plan for oxygen. She said there was no risk to the resident because it was obvious the resident was on oxygen. During an interview on 10/16/24 at 02:20 PM, the DON said Resident #25 should have a care plan for oxygen. She said the risk was that an unfamiliar staff might miss that Resident #25 required oxygen. During an interview on 10/16/24 at 02:34 PM, the Interim Administrator said there should have been a care plan for oxygen for Resident #25. She said the risk was that staff might not be aware of the doctor orders if it was not care planned. During an interview on 10/16/24 at 03:00PM, MDS Coordinator V said she was one of the MDS coordinators in the facility. She said she expected a resident on oxygen to have a care plan for oxygen. She said there was no risk to the resident because the nurses go by the orders. Record review of the facility's policy, Care Planning, revised 10/24/22, stated: Purpose To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. Policy I. The Facility's Interdisciplinary Team (IDT) will develop a Baseline and/or Comprehensive Care Plan for each resident in accordance with OBRA and MDS guidelines. II. The Care Plan serves as a course of action where the resident (resident's family and/or guardian or other legally authorized representative), resident's Attending Physician, and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs. III. A Licensed Nurse will initiate the Care Plan, and the plan will be finalized in accordance with OBRA/[MDS] guidelines and updated as indicated for change in condition, onset of new problems, resolution of current problems, and as deemed appropriate by clinical assessment and judgment on an [as] needed [basis] .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observations, interviews, and record review, the facility failed to provide the necessary services to maintain personal hygiene for 2 of 5 residents reviewed for ADLs. (Resident #81 and Resident #88) The facility failed ensure Resident #81 was provided timely incontinent care on 10/15/24. The facility failed to ensure Resident #88 did not have yellow substance on his gum line and between his teeth on 10/14/24, 10/15/24, and 10/16/24. The facility failed to ensure Resident #88 was gotten or offered to get out of bed in October 2024. Theses failures could place residents who required assistance from staff for ADLs at risk of not receiving care and services to meet their needs which could result in poor care, feelings of poor self-esteem, lack of dignity and health. Findings included: 1. Record review of Resident #81's face sheet dated 10/17/24 indicated Resident #81 was a 75-years-old female admitted on [DATE] and 08/07/22 with diagnoses including chronic respiratory failure (occurs when the body has low levels of oxygen in the blood) and need for assistance with personal care. Record review of Resident #81's annual MDS assessment dated [DATE] indicated Resident #81 was understood and understood others. Resident #81 had a BIMS score of 13 which indicated intact cognition. Resident #81 did not reject care. Resident #81 was dependent for toilet hygiene. Resident #81 was always incontinent for urinary and bowel. Record review of Resident #81 undated care plan indicated Resident #81 had an ADL self-care performance deficit. Intervention included toilet use: Resident #81 was incontinent of bowel and bladder. Required staff assist with clothing and cleansing self. Toilet hygiene: dependent. During an interview on 10/15/24 at 8:33 a.m., Resident #81 was sitting up in her wheelchair about to eat breakfast. She said she had not been changed but would get changed after breakfast. During an interview on 10/15/24 at 4:11 p.m., Resident #81 was lying in bed with new clothes on. She said she had gotten her brief changed around 10 am and not changed again until 4pm. She said her brief had gotten so wet, it leaked through her clothes and sheets. She said CNA Q kept telling her she would get to her soon. She said CNA Q said they were short staffed which was why it took so long to get changed. She said she liked to keep pullups stored in her bed for instances like today. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #88 face sheet dated 10/16/24 indicated Resident #88 was a 59-years-old male admitted on [DATE] and 09/09/24 for diagnoses including Asperger's syndrome (is a neurodevelopmental disorder that is part of the autism spectrum and is characterized by difficulties with social interaction and communication, as well as repetitive behaviors and interests), limitation of activities due to disability, and need for assistance with personal care. Record review of Resident #88's annual MDS assessment dated [DATE] indicated Resident #88 had unclear speech, adequate hearing, and impaired vision. Resident #88 was sometimes understood and sometimes understood others. Resident #88 had a BIMS score of 03 which indicated severe cognitive impairment. Resident #88's admission performance was substantial/maximal assistance for oral hygiene and dependent for chair/bed-to-chair transfer. Record review of Resident #88's undated care plan indicated Resident #88 had an ADL self-care performance deficit. Interventions included transfers: chair to bed was dependent on using mechanical lift with 2 staff. Personal hygiene/oral hygiene: the resident required 1 staff participation with personal hygiene and oral care. Record review of Resident #88's ADL task sheet dated 10/2024, provided by ADM on 10/16/24 indicated transferring activity did not occur for any shifts on 10/01/24, 10/02/24, 10/03/24, 10/04/24, 10/06/24, 10/07/24, 10/08/24, 10/09/24, 10/10/24, 10/11/24, 10/12/24, 10/13/24, 10/14/24, and 10/15/24. Record review of Resident #88's ADL task sheet dated 10/2024, provided by ADM on 10/16/24 indicated for personal hygiene (including brushing teeth): *10/14/24: Dependent with one-person physical assist *10/15/24: Dependent with one-person physical assist During an observation on 10/14/24 at 11:17 a.m., Resident #88 was lying in bed with the television on. Resident #88 had a contracture noted to his right arm and hand. Resident #88's privacy curtain was pulled, and the room was dark. Resident #88 had a yellow substance on his gum line and teeth. During an observation on 10/14/24 at 12:36 p.m., Resident #88 was sitting partially up eating his lunch. During an observation on 10/15/24 at 8:56 a.m., Resident #88 was sitting up in bed eating his breakfast. During an observation and interview on 10/15/24 at 11:01 a.m., Resident #88 was sitting up in bed. Resident #88 had unclear speech and was hard to understand. Resident #88 said Yes when asked if he wanted to get out of the bed. Resident #88 had a contracture noted to his right arm and hand. Resident #88's privacy curtain was pulled, and the room was dark. Resident #88 had a yellow substance on his gum line and teeth. During an observation on 10/16/24 at 2:30 p.m., Resident #88 was lying in bed with the television on. Resident #88 had a contracture noted to his right arm and hand. Resident #88's privacy curtain was pulled, and the room was dark. Resident #88 had a yellow substance on his gum line and teeth. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/24 at 2:45 p.m., CNA Q said she have never gotten Resident #88 out of the bed and had not asked him if he wanted too either. She said she really did not know why Resident #88 was not gotten out of the bed. She said he has only gotten out of the bed for doctor appointments. She said when he was out of the bed for his doctor's appointments, he wanted to get back in the as soon as he returned. She said Resident #88 required a mechanical lift with 2 people and it was hard to get another staff member to help. She said there was only one CNA staffed for the hall. She said he was hard to understand but answered yes or no. She said the residents needed to get out of the bed sometimes to enjoy the atmosphere, or view, and socialization. During an interview on 10/16/24 at 2:10 p.m., LVN R said CNAs were responsible for providing resident incontinent care. She said a resident should be checked and/or changed every 2 hours and as needed. She said incontinent care needed to be provided to the resident every 2 hours to prevent skin breakdown. She said the CNAs and LVNs were responsible for providing or setting up oral care to the residents. She said oral care should be provided at least every shift. She said if oral care was not provided, the resident could have bad breath and teeth. She said the residents not receiving timely care could affect their self-confidence. She said nursing staff should be rounding on the residents to ensure incontinent and oral care were being provided. She said the residents should be encouraged or gotten up at least daily. She said CNAs were responsible for getting the residents out of bed. She said it was important to get the residents out of bed to prevent skin breakdown, keep them active, and socialization. She said the residents could become depressed being in their room all the time. She said she had Resident #88 a few times in the past. She said Resident #88 liked to get out of bed sometimes, but he did not stay up for long periods of time. During an interview on 10/17/24 at 8:15 a.m., RN H said she had been employed at the facility for 3 months and worked night shift. She said CNAs should be checked every 2 hours and as needed for incontinence. She said it was important to check the residents every 2 hours to make sure they were dry. She said when the residents were not checked and changed every 2 hours, it placed the resident at risk for skin problems. She said oral care should be provided every shift or at least daily to the residents. She said it was important to provided oral care to the residents for good hygiene, prevent cavities and gingivitis, and the loss of teeth. She said CNAs and LVNs could provide oral care to the residents but the LVNs should be ensuring the CNAs provided oral care. On 10/17/24 at 10:10 a.m., called CNA Q but unable to leave a voice mail. CNA Q did not return call before or after exit. During an interview on 10/17/24 at 10:15 a.m., CNA O said she worked the hall Resident #81 and Resident #88 resided on. She said incontinent care should be provided to the residents every 2 hours. She said Resident #81 had complained to her about being left wet for long periods of time when CNA Q worked. She said when the residents were wet too long it could cause skin breakdown. She said when the residents were left wet too long, they could wonder what they had done to get treated that way. She said if Resident #88 wanted to get out of the bed, he would let staff know. She said the residents should be asked daily if they wanted to be gotten out of the bed. She said did not think staff asked Resident #88 if he wanted to get out of the bed daily. She said Resident #88 was a 2-person mechanical lift transfer. She said CNAs were supposed to provide oral care to the residents after each meal. She said sometimes Resident #88 did not let them get in his mouth. She said Resident #88 could do oral care himself after setting up the supplies. She said if oral care was not provided, the residents could have rotten teeth and bad breath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 10:37 a.m., ADON N said any qualified staff could change a resident, but it was the CNA's responsibility. She said incontinent care should be provided every 2 hours and as needed. She said incontinent care could not be provided during meal service. She said the residents needed to be changed timely to prevent skin breakdown and infections. She said untimely incontinent care placed the residents at risk for pressure ulcers. She said LVNs needed to check with the residents during rounding, medication pass, or when answering lights to ensure CNAs were providing timely incontinent care. She said CNAs or anyone certified could provide oral care to the residents. She said oral care should be provided as needed, daily, or every shift. She said the residents should get their teeth brushed to remove plague buildup or a dental referral needed to be made to remove it. She said the residents needed to be offered to be gotten out of the bed every 2 hours by staff. She said some residents needed to be asked closed ended questions to get them out of the bed. She said getting the residents out of the bed prevented pressure ulcers. She said the residents could get depressed when not gotten out of the bed. She said it was important to get the residents out of the bed for socialization and physical health. She said LVNs should be making rounds to ensure the residents were gotten out of the bed at least daily. During an interview on 10/17/24 at 2:05 p.m., the Regional RN, acting DON, said the CNAs were responsible for providing incontinent care every 2 hours and as need. She said the charge nurses and nursing management should be ensuring it happened by rounding. She said timely incontinent care was important to prevent skin concerns or damage. She said the LVNs, and CNAs should provide oral care to the residents daily and as needed. She said LVNs should be ensuring it happened by rounding and supervision. She said oral care prevented cavities and infections. She said the residents should be encouraged and offered daily to get out of the bed, but it could be patient specific. She said the CNAs and LVNs were responsible, but the IDT should be involved also. She said some residents were [NAME] of certain staff members and will do stuff for them but not others. She said it was important for the resident's quality of life. She said getting out of the bed decreased contractures and skin issues. She said the IDT should be rounding and doing assessment to ensure the residents were being offered and gotten out of the bed. During an interview on 10/17/24 at 2:58 p.m., the Interim ADM said incontinent care should be provided as needed and every 2 hours. She said the CNAs, or any staff member could provide incontinent care. She said the charge nurses should ensure it was being done. She said incontinent care needed to be provided to prevent skin breakdown and pressure ulcers. She said CNAs during ADL care, or nurses, when needed could provide oral care. She said oral care should be provided every shift. She said LVNs should ensure it was being provided. She said the LVNs should be checking the electronic charting system for documentation of oral care being provided or rounding. She said when oral care was not provided, the mouth could get infected. She said oral care protected the residents from plaque buildup, sores, and cracked lips. She said CNAs should try to get the residents out of the bed every day. She said the more a resident laid in bed, the weaker they became. She said when a resident laid in bed too long, they could develop pneumonia. She said it was important to get a resident out of the bed to decrease the risk of pressure injuries, encouraged socialization, and helped prevent self-inflicted isolation. She said a resident could become depressed. She said LVNs needed to make rounds and ask the residents themselves about getting out of the bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility's Care and Service policy revised date 06/2020 indicated .that all residents receive the necessary care and services based on an individualized comprehensive assessment process .residents are provided with the necessary care and services to maintain the highest practicable physical, mental, and social well-being level of in an environment that enhances quality of life .care and services are provided in a manner that consistently enhances self-esteem and self-worth .the IDT receives and reviews initial assessment information to ensure that members of the IDT interact with residents in a manner that enhances self-esteem and self-worth, such as activities related to bathing, grooming .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observations, interviews, and record review the facility failed to ensure residents received care, consistent with professional standards of practice, to prevent pressure ulcers based on the comprehensive assessment for 3 of 6 Residents (Resident #21, Resident #51, and Resident #79) whose records were reviewed for skin integrity. The facility failed to ensure Resident #21, Resident #51, and Resident #79's pressure-relieving mattresses (is designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) were on the correct settings. The facility failed to ensure Resident #79 received and/or documented wound care on 10/05/24, 10/06/24, 10/07/24, 10/10/24, 10/11/24, and 10/13/24. These failures could place residents at risk for developing pressure ulcers and could contribute to developing avoidable pressure ulcers. Findings included: 1. Record review of Resident #21's face sheet dated 10/14/24 indicated Resident #21 was a 69-years-old female admitted on [DATE] with diagnoses including need for assistance with personal care, chronic kidney disease (is a long-term condition that occurs when the kidneys are damaged and can't filter blood properly), weakness, pain in right and left shoulder, diabetes mellitus (a group of diseases that affect how the body uses blood sugar (glucose)), and hidradenitis suppurativa (is a painful, long-term skin condition that causes skin abscesses and scarring on the skin). Record review of Resident #21's quarterly MDS assessment dated [DATE] indicated Resident #21 was understood and understood others. Resident #21 had clear speech, adequate hearing, and adequate vision. Resident #21 had a BIMS score of 12 which indicated moderate cognitive impairment. Resident #21 had an indwelling catheter and was always incontinent for bowel. Resident #21 weighed 241 lbs. Resident #21 was at risk of developing pressure ulcers/injuries. Resident #21 had open lesions other than ulcers, rashes, cuts. Resident #21 had a pressure reducing device for bed as a skin and ulcer/injury treatment. Record review of Resident #21's consolidated physician order active as of 10/16/24 indicated may use low air loss mattress. Check settings every shift to ensure settings within therapeutic range. Order date 07/31/23. Record review of Resident #21's undated care plan indicated Resident #21 had the potential for pressure injury development/skin impairment related to disease process, immobility, and incontinence. On 12/07/23, Resident #21 continues to have skin injury to buttocks related to hidradenitis per wound care medical doctor. Intervention included notify nurse immediately of any new areas of skin breakdown. Record review of Resident #21's weight summary dated 10/17/24 indicated: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*10/07/24 240.3 lbs. *09/07/24 244.3 lbs. *08/28/24 243.4 lbs. During an observation and interview on 10/15/24 at 8:09 a.m., Resident #21 was lying in bed on a pressure relieving mattress. Resident #21's weight setting was 360 lbs. She said she did not know about the bed settings, but the bed made weird noises. During an observation on 10/16/24 at 3:30 p.m., Resident #21 was lying in bed on a pressure relieving mattress. Resident #21's weight setting was 360 lbs. 2. Record review of Resident #51's face sheet dated 10/15/24 indicated Resident #51 was a 60-years-old female admitted on [DATE] and 12/08/20 with diagnoses including metabolic encephalopathy (is a brain dysfunction caused by a chemical imbalance in the blood that affects the brain), muscle wasting and atrophy (shortening), and protein-calorie malnutrition (is a condition that occurs when someone doesn't get enough calories or the right nutrients). Record review of Resident #51's quarterly MDS assessment dated [DATE] indicated Resident #51 was usually understood and usually understood others. Resident #51 had a BIMS score of 04 which indicated severe cognitive impairment. Resident #51 was dependent for ADL care. Resident #51 was always incontinent for bladder and bowel. Resident #51 weighed 78 lbs. Resident #51 was at risk for developing pressure ulcers/injuries. Resident #51 had pressure reducing device for bed. Record review of Resident #51's consolidated physician order active as of 10/16/24 indicated may use low air loss mattress. Check settings every shift to ensure settings within therapeutic range. Order date 08/07/24. Record review of Resident #51's undated care plan indicated Resident #51 had potential/actual impairment to skin integrity related to fragile skin and scratching buttocks and legs due to itching. Intervention included identify/document potential causative factors and eliminate/resolve where possible. During an observation on 10/14/24 at 2:21 p.m., Resident #51 was lying on a low air loss mattress with boundaries. Resident #51's weight bed setting was 210 lbs. During an observation on 10/15/24 at 10:56 a.m., Resident #51 was lying in bed asleep. Resident #51 was lying on a low air loss mattress with boundaries. Resident #51's weight bed setting was 210 lbs. During an observation on 10/16/24 at 3:10 p.m., Resident #51 was lying in bed asleep. Resident #51 was lying on a low air loss mattress with boundaries. Resident #51's weight bed setting was 210 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #79's face sheet dated 10/14/24 indicated Resident #79 was a 55-years-old male admitted on [DATE] and 05/01/24 with diagnoses including paraplegia (is paralysis that affects your legs, making it impossible to stand or walk), dependence on renal dialysis, pressure ulcer (are localized skin and soft tissue injuries that form as a result of prolonged pressure and shear, usually exerted over bony prominences) of sacral region (is a skin injury that occurs in the sacral region of the body, near the lower back and spine), Stage 4 (injuries extend to muscle, tendon, or bone), and muscle wasting and atrophy (shortening). Record review of Resident #79's quarterly MDS assessment dated [DATE] indicated Resident #79 was understood and understood others. Resident #79 had clear speech, adequate hearing, and adequate vision with corrective lenses. Resident #79 had a BIMS score of 12 which indicated moderate cognitive impairment. Resident #79 had an indwelling catheter and was always incontinent of bowel. Resident #79 weighed 125 lbs. Resident #79 had a pressure ulcer/injury and one or more unhealed pressure ulcers/injuries. Resident #79 had two stage 4 pressure ulcers and pressure reducing device for bed and pressure ulcer/injury care for skin and ulcer/injury treatments. Record review of Resident #79's undated care plan indicated: *Resident #79 had stage 4 pressure injury to the sacrum related to immobility and disease process. Interventions included treat wounds as per medical doctor orders and follow facility policies/protocols for the prevention/treatment of skin breakdown. *Resident #79 had a stage 4 pressure injury to his ischium related to disease process, immobility, returned from hospital with pressure injury now unstageable on 05/01/24. Interventions included administer treatments as ordered and monitor for effectiveness and the resident required the use of an air mattress. *Resident #79 had a stage 4 pressure injury to his left ischium from worsening abscess related to disease process, history of ulcers, and immobility. Intervention included administer treatments as ordered and monitor for effectiveness. Record review of Resident #79's consolidated physician order active as of 10/16/24 indicated: *Pressure relieving mattress every shift for preventative. Start date 05/03/24. *Wound care: Cleanse stage 4 pressure injury to left ischium with Dakin's or normal saline and pat dry. Fill dead space with collagen particles and Dakin's moistened gauze. Secure with bordered composite dressing. Change every shift and PRN soiling/saturation. Start date 10/15/24. *Wound care: Cleanse stage 4 pressure injury to right ischium with Dakin's or normal saline and pat dry. Fill dead space with collagen particles and Dakin's moistened gauze. Secure with bordered composite dressing. Change every shift and PRN soiling/saturation. Start date 10/15/24. *Wound care: Cleanse stage 4 pressure injury to sacrum with Dakin's or normal saline and pat dry. Fill dead space with collagen particles and Dakin's moistened gauze. Secure with bordered composite dressing. Change every shift and PRN soiling/saturation. Start date 10/15/24. Record review of Resident #79's MAR dated 10/01/24-10/31/24 indicated: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Wound care: Cleanse stage 4 pressure injury to left ischium with Dakin's or normal saline and pat dry. Fill dead space with calcium alginate. Secure with bordered foam dressing. Change every shift and PRN soiling/saturation, every shift for wound care. Order date 10/05/24. Discontinued 10/13/24. Resident #79's MAR did not have administration of wound care on 10/05/24 (night shift), 10/06/24 (day and night shift), 10/07/24 (night shift), 10/10/24 (day and night shift), 10/11/24 (night shift), and 10/13/24 (night shift) *Wound care: Cleanse stage 4 pressure injury to left ischium with Dakin's or normal saline and pat dry. Fill dead space with collagen particles and Dakin's moistened gauze. Secure with bordered waterproof dressing. Change every shift and PRN soiling/saturation. Order date 10/13/24. *Wound care: Cleanse stage 4 pressure injury to right ischium with Dakin's or normal saline and pat dry. Fill dead space with calcium alginate. Secure with bordered foam dressing. Change every shift and PRN soiling/saturation, every shift for wound care. Order date 10/05/24. Discontinued 10/13/24. Resident #79's MAR did not have administration of wound care on 10/05/24 (night shift), 10/06/24 (day and night shift), 10/07/24 (night shift), 10/10/24 (day and night shift), 10/11/24 (night shift), and 10/13/24 (night shift) *Wound care: Cleanse stage 4 pressure injury to right ischium with Dakin's or normal saline and pat dry. Fill dead space with collagen particles and Dakin's moistened gauze. Secure with bordered waterproof dressing. Change every shift and PRN soiling/saturation. Order date 10/13/24. *Wound care: Cleanse stage 4 pressure injury to sacrum with Dakin's or normal saline and pat dry. Fill dead space with calcium alginate. Secure with bordered foam dressing. Change every shift and PRN soiling/saturation, every shift for wound care. Order date 10/05/24. Discontinued 10/13/24. Resident #79's MAR did not have administration of wound care on 10/05/24 (night shift), 10/06/24 (day and night shift), 10/07/24 (night shift), 10/10/24 (day and night shift), 10/11/24 (night shift), and 10/13/24 (night shift) *Wound care: Cleanse stage 4 pressure injury to sacrum with Dakin's or normal saline and pat dry. Fill dead space with collagen particles and Dakin's moistened gauze. Secure with bordered waterproof dressing. Change every shift and PRN soiling/saturation. Order date 10/13/24. Record review of Resident #79's progress notes dated 10/10/24 by Wound Care DNP indicated .wound follow up .the following wounds were evaluated .Wound 1 Sacrum, Pressure Injury, Stage 4 .Wound 2 Right Ischium, Pressure Injury, Stage 4 .Wound 4 Left Ischium, Pressure Injury, Stage 4 .wound 1: subsequent-improving .wound 2: subsequent-improving .wound 4: subsequent-improving . Record review of Resident #79's weight summary dated 10/17/24 indicated: *10/16/24 136.8 lbs. *10/09/24 134.6 lbs. *10/04/24 130.67 lbs. *10/02/24 127.2 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 10/15/24 at 3:30 p.m., Resident #79 was lying on a LAL mattress after wound care with Treatment Nurse M. Resident #79's weight bed setting was 490 lbs. Resident #79 said he probably weighed about 138 lbs. Treatment Nurse M said she had not noticed Resident #79's weight bed setting being 490 lbs. She said she did not know who was responsible for ensuring the resident's weight settings were accurate. Treatment Nurse M reviewed Resident #79's medical records and said he weighed 134.6 lbs. Resident #79 said sometimes his wound care was not done every day or shift. He said some nurses did not want to mess with it or were too new. He said he mostly missed treatments on the night shift. During an interview on 10/17/24 at 8:15 a.m., RN H said she had been employed at the facility for 3 months. She said she took care of Resident #79. She said Resident #79's wound care was not done sometimes on her shift. She said Treatment Nurse M told her Resident #79's dressing changes were only due on day shift. She said the Treatment Nurse M told her the order only said every shift in case it got soiled or dislodged, there was an order for it. She said Treatment Nurse M told her to only change Resident #79's dressings at night if it got soiled. She said she only changed Resident #79's dressings once on night shift when it got soiled. She said she forgot to document the dressing changes on the TAR. She said she thought she documented the dressing changes on a progress note. She said she did not know she had to document Resident #79's dressing changes on the TAR. She said she should have followed the physicians orders not Treatment Nurse M. She said it was important to follow the physician's order because they ordered it that way for a reason. She said it was important to do the ordered wound care so it could heal faster. She said when wound care was not performed as scheduled, it risked the pressure ulcer not improving and infection. She said she did not know who was responsible for the LAL mattress weight settings. She said the TAR had an order for the resident to have a LAL or pressure relieving mattress but not checking the mattress's settings. She said the mattress settings were important to be set correctly to rotate the pressure off the resident's bony prominences. She said the wrong LAL mattress settings increased the resident's risk of skin breakdown. During an interview on 10/17/24 at 9:34 a.m., Treatment Nurse M said she had been the treatment nurse for a month. She said she did not know who was responsible for checking LAL or pressure relieving mattress settings. She said she would start checking the mattress settings from now on. She said it was important for the mattress settings to be correct to relieve the correct amount of pressure and adjust correctly. She said wrong mattress settings could make pressure ulcers worsen. She said Resident #79's wound care should have been done every shift not once a day. She said she had recently educated the nurses on doing Resident #79's wound care dressing changes every shift. She said she did not remember if she had educated RN F. She said she was responsible for dressing changes Monday-Friday, day shift. She said the weekend supervisor and LVNs were responsible for the night and weekend dressing changes. She said she did not know why there were two day shift days not documented on Resident #79's MAR/TAR. During an interview on 10/17/24 at 10:37 a.m., ADON N said the mattress company set up the resident's LAL or pressure relieving mattress. She said the treatment nurse should be responsible for the resident's weight settings. She said the mattress setting needed to be correct to prevent further pressure ulcer injury. She said wrong mattress setting placed the residents at risk for more damage to the skin and contractures. On 10/17/24 at 11:48 a.m., called and left voicemail for LVN J. A return phone call was not received before or after exit. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/24 at 2:05 p.m., Regional RN FF said the treatment nurse should check the resident's pressure relieving mattress settings daily. She said the correct mattress settings were important because there was a reason the resident was on the LAL mattress, and it needed to function correctly. She said the wrong mattress settings could cause skin issues. She said the DON should ensure the treatment nurse was monitoring LAL mattress settings. She said she expected nursing staff to document wound care dressing changes on the MAR/TAR. She said the treatment nurse or charge nurse should perform the dressing changes every shift or as ordered. She said if the treatment was not documented on the MAR/TAR, it could imply, it was not done. She said not performing wound care as ordered could lead to decreased wound healing, infection, and delayed wound healing. She said the DON should review the MAR/TARs daily to ensure the residents with wounds had scheduled wound care done. During an interview on 10/17/24 at 2:58 p.m., the Interim ADM said the wound care nurse or LVNs should perform the resident's ordered wound care treatment. She said the treatment should be documented on the MAR/TAR by the treatment nurse or LVN. She said if the treatment was not documented, it was not done. She said not doing a resident's ordered treatments could cause infection, poor healing, and possible loss of a limb. She said the DON should be monitoring documentation. She said the treatment nurse or LVNs should check the resident's mattress settings for the current weight of the resident. She said the correct weight setting was important to protect the wound and better healing. She said when the resident had incorrect mattress settings, more skin breakdown could happen, or the pressure ulcer would not heal properly. She said the DON should be doing visual checks and reviewing the charts. Record review of a facility's Wound Management revised date 06/2020 indicated .a resident who has a wound will receive necessary treatment and services to promote healing, prevent infection, and prevent new pressure injuries from developing . Review of Evaluation of a low-air-loss mattress system in the treatment of patients with pressure ulcers (1995) by M A [NAME], J Oldenbrook, C [NAME], www.pubmed.ncbi.nlm.nih.gov/7612140 was accessed on 10/22/2024 indicated .our observation indicate that use of the low-air-loss mattress system reduces the size and facilitates the healing of previously stable, chronic pressure ulcers .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44933 Based on observation, interview, and record review, the facility failed to ensure that each resident who was incontinent of bowel/bladder and each resident with an indwelling catheter received appropriate treatment and services to prevent urinary tract infections, for 3 of 7 residents (Resident #52, Resident #79, and Resident #88) reviewed for indwelling urinary catheters. The facility failed to ensure Resident #52, Resident #79, and Resident #88's indwelling catheter (drains urine from your bladder into a bag outside your body) had a catheter securement device to anchor catheter to their legs on 10/14/24, 10/15/24, and 10/16/24. The facility failed to ensure Treatment Nurse M did not place Resident #79's catheter bag on the bed during wound care on 10/15/24. Theses failures could place residents at risk for urinary tract infections. Findings included: 1. Record review of Resident #52's face sheet dated 10/17/24 indicated Resident #52 was a 77-years-old male admitted on [DATE] with diagnosis including obstructive and reflux uropathy (is a general term for a urinary tract disorder that occurs when urine flow is obstructed, either structurally or functionally). Record review of Resident #52's quarterly MDS assessment dated [DATE] indicated Resident #52 was understood and understood others. Resident #52's BIMS score was 12 which indicated moderate cognitive impairment. Resident #52 had an indwelling catheter and frequently incontinent for bowel. Record review of Resident #52's undated care plan indicated Resident #52 had indwelling foley catheter related to stricture (obstructive uropathy). Intervention included position catheter bag and tubing below the level of the bladder. During an observation and interview on 10/14/24 at 10:49 a.m., Resident #52 was lying in his bed. Resident #52 said he did not have anything on his leg to hold his catheter tubing. Resident #52 did not have an anchoring device on either thigh. During an observation on 10/15/24 at 8:39 a.m., Resident #52 was sitting in his wheelchair eating breakfast in a t-shirt and brief. Resident #52 did not have an anchoring device on either thigh. During an observation on 10/16/24 at 3:00 p.m., Resident #52 was sitting in his wheelchair wearing shorts. Resident #52's catheter tubing could be visualized. Resident #52 did not have an anchoring device on either thigh. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #79's face sheet dated 10/14/24 indicated Resident #79 was a 55-years-old male admitted on [DATE] and 05/01/24 with diagnoses including paraplegia (is paralysis that affects your legs, making it impossible to stand or walk), dependence on renal dialysis, pressure ulcer (are localized skin and soft tissue injuries that form as a result of prolonged pressure and shear, usually exerted over bony prominences) of sacral region (is a skin injury that occurs in the sacral region of the body, near the lower back and spine), Stage 4 (injuries extend to muscle, tendon, or bone.), and obstructive and reflux uropathy (is a general term for a urinary tract disorder that occurs when urine flow is obstructed, either structurally or functionally). Record review of Resident #79's quarterly MDS assessment dated [DATE] indicated Resident #79 was understood and understood others. Resident #79 had clear speech, adequate hearing, and adequate vision with corrective lenses. Resident #79 had a BIMS score of 12 which indicated moderate cognitive impairment. Resident #79 had an indwelling catheter and was always incontinent of bowel. Record review of Resident #79's undated care plan indicated Resident #79 had indwelling catheter related to obstructive and reflux uropathy. Intervention included position catheter bag and tubing below the level of the bladder. During an interview and observation on 10/15/24 at 3:30 p.m., Resident #79 was lying in bed waiting on wound care to be started by Treatment Nurse M. Treatment Nurse M moved Resident #79's indwelling catheter bag from the left side of the bed and laid it flat on the right side of the resident, on the bed. Resident #79's anchor device was around the catheter tubing near the catheter, not attached to Resident #79. Treatment Nurse M completed three wound care treatments then placed Resident #79's catheter bag back on the hooks, on the left side of the bed. After the wound care treatment, Resident #79 said he had an anchoring device to thigh sometimes, but it did not always stay stuck to his leg. 3. Record review of Resident #88 face sheet dated 10/16/24 indicated Resident #88 was a 59-years-old male admitted on [DATE] and 09/09/24 for diagnoses including Asperger's syndrome (is a neurodevelopmental disorder that is part of the autism spectrum and is characterized by difficulties with social interaction and communication, as well as repetitive behaviors and interests), retention of urine, obstructive and reflux uropathy (is a general term for a urinary tract disorder that occurs when urine flow is obstructed, either structurally or functionally), and need for assistance with personal care. Record review of Resident #88's annual MDS assessment dated [DATE] indicated Resident #88 had unclear speech, adequate hearing, and impaired vision. Resident #88 was sometimes understood and sometimes understood others. Resident #88 had a BIMS score of 03 which indicated severe cognitive impairment. Resident #88 had an indwelling catheter and always incontinent for bowel. Record review of Resident #88 undated care plan indicated Resident #88 had an indwelling catheter for diagnosis of obstructive uropathy. Intervention included apply catheter secure device to thigh to decrease the risk of foley tubing pulling. Record review of Resident #88's consolidated physician order active as of 10/15/24 indicated check the catheter securement device each shift and prn for placement, every shift for preventative. Ordered date 08/03/23. (continued on next page)

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	675133	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Nursing Home	1100 N 4th St Longview, TX 75601

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #88's MAR dated 10/01/24-10/31/24, printed 10/16/24 indicated check the securement device each shift and PRN for placement, every shift for preventative. Ordered date 08/03/23. The MAR indicated administration on 10/14/24 (RN Y, LVN Z), 10/15/24 (LVN L, RN H). During an observation and interview on 10/14/24 at 11:17 a.m., Resident #88 was lying in bed with a catheter bag hanging on the right side of his bed. Resident #88 said no he did not have anything on his leg holding his catheter tubing. Resident #88 lifted his gown to the top of his thighs. Resident #88 did not have an anchoring device on his thighs. During an observation on 10/15/24 at 11:01 a.m., a therapist was working with Resident #89's legs. Resident #88 did not have an anchoring device on his thighs. During an interview on 10/17/24 at 8:15 a.m., RN H said the nurses were responsible for ensuring residents with catheters had an anchoring device. She said the anchoring device was important to hold the catheter tubing in place. She said Resident #52 had an anchoring device last week but did not check to see if he had one last night (10/16/24). She said Resident #88 did not have an anchoring device on last night. She said she thought Resident #79 had one on last night but was not for sure. She said when the residents did not have an anchoring device, it placed them at risk for pain in the urethra and bladder. She said the residents could experience irritation and bleeding. During an interview on 10/17/24 at 9:34 a.m., the Treatment Nurse M said Resident #79's catheter bag should have been hung on the other side of the bed, not laid down on the bed. She said the bag should not have been placed on the bed due to infection control and the catheter bag was not below Resident #79's bladder. She said when the catheter bag was not below the bladder, the urine could go back in the bladder and cause an infection. During an interview on 10/17/24 at 10:15 a.m., CNA O said the LVNs were responsible for the anchoring devices for resident's catheters. She said if she noticed a resident did not have one on, she notified the nurse. She said an anchoring device was important so the tubing would not get hung on things and pulled. She said the anchoring device helped the catheter tubing stay in place and secured. She said when a resident did not have an anchoring device it could get pulled out. During an interview on 10/17/24 at 10:37 a.m., ADON N said a catheter bag should not be placed on the bed. She said it was not good practice due to infection control and risk of spillage. She said that also risked the urine going back up to the bladder and causing an infection and pain. During an interview on 10/17/24 at 2:05 p.m., Regional RN FF said the nurses were responsible for the residents with indwelling catheters to also have an anchoring device. She said the residents should have an order to check for an anchoring device. She said the nurses had to sign off the observation on the MAR/TAR. She said the anchoring device prevented tugging which could cause trauma. She said the nurses should be checking for an anchoring device every shift. She said the ADONs, and DON should ensure the LVNs were monitoring anchoring devices. She said a resident's catheter bag should never be placed on the bed. She said the resident's catheter bag should be hooked on either side of the bed. She said this should not be done for infection control and the potential for urine backflow. She said the backflow of the urine, to the resident's bladder could cause a urinary tract infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/24 at 2:58 p.m., the Interim ADM said the nurses were responsible for ensuring residents with foley catheters had an anchoring device. She said the LVNs should be checking for an anchoring device every shift. She said the anchoring device made sure the tubing was not moved and tugged. She said when the residents did not have an anchoring device, it placed residents at risk for the catheter getting pulled out and skin tear. She said the residents could experience bleeding if the catheter was pulled out. She said she expected staff to place the catheter bags on the sides of the beds, not in the bed. She said it was an infection control issue and could irritant the bladder. She said the residents were at risk for bladder infections. Record review of a facility's Catheter-Care of policy revised date 06/2020 indicated .each resident who is incontinent of urine is identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible .a resident, with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible .anchor the catheter with a leg strap to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter .collection bags should always be kept below the level of the bladder .catheter tubing should be secured to prevent dependent loops .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929 Based on observation, interview, and record review, the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals, and preferences for 3 of 5 residents (Resident #25, Resident #16, and Resident #15) reviewed for respiratory care and services. 1. The facility failed to obtain a physician's order for Resident #25's oxygen, prior to surveyor intervention. 2. The facility failed to ensure Resident #25's oxygen concentrator was clean and free of gray/black debris. 3. The facility failed to ensure Resident #15's CPAP mask was stored in bag and oxygen concentrator had a filter on 10/14/24-10/17/24. 4. The facility failed to ensure Resident #16's oxygen concentrator filter was free from gray, fuzzy particles on 10/14/24-10/16/24. These failures could place residents who receive oxygen at risk for developing respiratory complications. Findings included: 1. Record review of Resident #25's face sheet, dated 10/15/24, indicated he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included chronic respiratory failure (a long-term condition that makes it difficult to breathe because the lungs can't exchange oxygen and carbon dioxide properly), heart failure (a serious condition that occurs when the heart can't pump enough blood and oxygen to meet the body's needs), chronic obstructive pulmonary disease (a common lung disease that makes it difficult to breathe) and chronic pulmonary edema (fluid buildup in the lungs over time). Record review of Resident #25's quarterly MDS, dated [DATE], indicated he was able to make himself understood and he was able to understand others. His BIMS score was 11, which indicated moderately impaired cognition. Record review of a screenshot of Resident #25's physician's orders, taken on 10/15/24 at 2:10 PM, indicated the resident did not have an order for oxygen. Record review of a printed copy of Resident #25's physician's orders, provided by ADON A on 10/15/24 at 3:44 PM, and further dated for 10/15/24 at 03:06 PM, indicated these orders: *Change respiratory tubing, mask, bottled water, clean filter every 7 days as needed. The start date was 08/06/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Change respiratory tubing, mask, bottled water, clean filter every 7 days, every night shift every Wednesday. The start date was 08/07/24. *Oxygen at 2-4 liters per minute via nasal cannula every shift. The start date was 10/15/24. Record review of Resident #25's undated care plan indicated the care plan did not address his oxygen use. During an observation on 10/14/24 at 10:19 AM, Resident #25 was lying in bed watching TV in his room. He had oxygen in place via nasal cannula. The oxygen concentrator was set at 2.5LPM. The oxygen concentrator filter was dirty and was covered with gray debris, with black debris at the bottom of the filter. During an observation on 10/14/24 at 2:17 PM, Resident #25 was lying in bed watching TV in his room. He had oxygen in place via nasal cannula. The filter in the oxygen concentrator was dirty and had gray debris, with black debris at the bottom of the filter. During an observation on 10/15/24 at 08:47 AM, Resident #25 was in his room lying in bed. He had oxygen in place via nasal cannula. The filter in the oxygen concentrator was dirty and had gray debris, with black debris at the bottom of the filter. During an interview on 10/15/24 at 03:44 PM, ADON A said Resident #25 did not have an order for oxygen. She said she obtained the order after this surveyor pointed out the missing order to her, and then entered it into the resident's orders. She said the facility did not have a standing order for continuous oxygen use. During an interview on 10/16/24 at 02:01 PM, ADON A said she was not aware of the filter that this surveyor pointed out was dirty. She said the nursing staff check and clean the filters on Wednesdays on night shift. She said she checks the filters herself on Thursday mornings. She said the risk to the resident was potential infection. During an interview on 10/16/24 at 02:20 PM, the DON said the night nurse was responsible for changing the filters on Wednesdays. She said the ADONs were supposed to check, follow up, and ensure completion. She said the risk to the resident was potential infection. During an interview on 10/16/24 at 02:34 PM, the Interim Administrator said the oxygen concentrator filters should be cleaned as needed. She said the risk to the resident was a potential infection. 44933 2. Record review of Resident #15's face sheet dated 10/17/24 indicated Resident #15 was a 96-years-old female admitted on [DATE] and 03/03/19 with diagnoses including respiratory disorders in disease, shortness of breath, chronic obstructive pulmonary disease (is a common lung disease causing restricted airflow and breathing problems), and obstructive sleep apnea (is a common sleep disorder that causes the upper airway to partially or completely collapse during sleep, leading to reduced or absent breathing). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #15's annual MDS assessment dated [DATE] indicated Resident #15 was understood and understood others. Resident #15 had a BIMS score of 15 which indicated intact cognition. Resident #15 received oxygen therapy within the last 14 days. Record review of Resident #15's undated care plan indicated: *Resident #15 had oxygen therapy as needed related to shortness of breath. Intervention included oxygen via nasal prongs as needed. *Resident #15 had altered respiratory status/difficulty breathing related to sleep apnea. Intervention included CPAP settings 10/5 cm via nasal pillow at hour of sleep and PRN. Record review of Resident #15's consolidated physician order active as of 10/17/24 indicated: *CPAP 10/5 cm water heated humidifier via medium size nasal mask at hour of sleep for diagnosis of obstructive sleep apnea. Ordered date 12/15/22. *Oxygen at 2 liters per minute via nasal cannula, every 4 hours as needed, as needed every shift. Ordered date 02/27/24. During an observation on 10/14/24 at 11:40 a.m., Resident #15 was asleep in her recliner. Resident #15's CPAP mask was laying on the machine. Resident #15's mask was not stored in a bag. Resident #15's oxygen concentrator did not have a filter in the compartment. During an observation on 10/15/24 at 8:39 a.m., Resident #15 was asleep in her recliner. Resident #15's CPAP mask was laying on the machine. Resident #15's mask was not stored in a bag. Resident #15's oxygen concentrator did not have a filter in the compartment. 3. Record review of Resident #16's face sheet dated 10/17/24 indicated Resident #16 was a 71-years-old female admitted on [DATE] and 12/08/20 with diagnoses including shortness of breath and congestive heart failure (is a serious condition that occurs when the heart can't pump enough blood to meet the body's needs). Record review of Resident #16's quarterly MDS assessment dated [DATE] indicated Resident #16 was understood and understood others. Resident #16 had a BIMS score of 13 which indicated intact cognition. Record review of Resident #16's undated care plan indicated Resident #16 had oxygen therapy related to congestive heart failure and shortness of breath. Intervention included to provide oxygen as needed at 2-5 liters per minute via nasal cannula PRN for shortness of breath. Record review of Resident #16's consolidated physician order active as of 10/17/24 indicated: *Change respiratory tubing, mask, bottled water, clean filter every 7 days every night every Wednesday. Change all O2 tubing and nasal cannula every Sunday on night shift. Ordered date 06/25/24. *Oxygen at 2-5 liters per minute via nasal cannula every 24 hours as needed for shortness of breath. Ordered date 07/21/23. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #16's MAR dated 10/01/24-10/31/24 indicated: *Change respiratory tubing, mask, bottled water, clean filter every 7 days every night every Wednesday. Change all O2 tubing and nasal cannula every Sunday on night shift. Ordered date 06-25-24. The MAR indicated administration on 10/09/24 (LVN Z) and 10/16/24 (RN H). *Oxygen at 2-5 liters per minute via nasal cannula every 24 hours as needed for shortness of breath. Ordered date 07/21/23. During an observation on 10/14/24 at 11:38 a.m., Resident #16 was lying in bed reading a book. She said she only used her oxygen at night. Resident #16's oxygen concentrator filter had a moderate amount of gray, fuzzy material on it. During an interview and observation on 10/15/24 at 8:37 a.m., Resident #16 was lying in her bed. Resident #16's oxygen concentrator filter had a moderate amount of gray, fuzzy material on it. Resident #16 said staff cleaned the filter sometimes, but they were human and forgot sometimes. During an interview on 10/16/24 at 2:10 p.m., LVN R said night shift nurses on Wednesdays and Sundays were supposed to change oxygen tubing and label and date the tubing. She said the night shift nurses were also supposed to clean the concentrator filters. She said it was also important for infection control. She said when a filter had gray, fuzzy material on it, it affects the oxygenation to the resident and may not work correctly. She said the nurse who took the CPAP mask off the resident, should make sure it was stored correctly. She said the CPAP mask was supposed to be stored in a clear bag when not in use for infection control. She said when a CPAP mask was not stored correctly, it could affect the amount of oxygen the resident received, caused a stuffy nose and risk of infection. During an interview on 10/17/24 at 8:15 a.m., RN H said she worked night shift on the 300 hall. She said she had only been employed at the facility for 3 months. She said she did not know who was responsible for storing a resident's CPAP mask in bag. She said Resident #15 did not use her CPAP machine at night, but the CPAP mask still should be stored in a bag. She said resident's oxygen concentrator filters should be cleaned once a week. She said dust particles could affect the resident oxygen flow to the nasal cannula and back the machine up. She said it was important to label and date oxygen tubing, store oxygen equipment not in use, in a bag and clean filters for infection control. She said the oxygen tubing could grow bacteria when it was not changed weekly. During an interview and observation on 10/17/24 at 10:28 a.m., ADON A said Resident #15's CPAP mask was currently stored in a bag. ADON A and Surveyor went to Resident #15's room. ADON A found Resident #15's missing filter in the resident's bathroom. ADON A said she did not know who was responsible for the internal filter on the oxygen concentrators. She said normally, the oxygen concentrators were only cleaned or swapped out if the resident was discharged . She said she did not know if a service company was supposed to come out and service the oxygen concentrators with interval filters. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/17/24 at 2:05 p.m., Regional RN FF said the nurses were responsible for cleaning and storing resident's oxygen equipment. She said the nursing staff were supposed to do it once a week or every 7 days. She said it was important to clean filters, and store equipment properly for infection control. She said the nurse who cleaned the filter, should make sure to put it back. She said nursing management should be ensuring the nurses are managing resident's oxygen equipment by rounding. She said residents were at risk for respiratory infections when oxygen equipment was not stored correctly or not cleaned properly. During an interview on 10/17/24 at 2:58 p.m., the Interim ADM said nurses were responsible for respiratory equipment. She said the ADON and DON should ensure nursing staff were storing and cleaning equipment. She said if those things were not done, it placed residents at risk for possible infection. She said residents could experience respiratory distress, lung infection, and sinus infection. She said the internal filters on the oxygen concentrator should be handled by trained personnel. Record review of the facility's policy Oxygen Administration, last revised June 2020, stated: .A physician's order is required to initiate oxygen therapy, except in an emergency situation .oxygen items will be stored in plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use .document in patient's record .date and time oxygen is being used . The policy did not address oxygen concentrator filters.

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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** 48958 Based on observation, interview, and record review the facility failed to provide pharmaceutical services to include procedures that assured the accurate dispensing and administering of all drugs to meet the needs of 1 of 12 residents reviewed for pharmaceutical services. (Resident #72) Facility staff failed to remove Lidocaine patches 5% strength from Resident #72's personal refrigerator. These deficient practices could affect residents and place them at risk of not receiving the therapeutic dosage and drug diversion. The findings were: Record review of Resident #72's face sheet, dated 10/14/24 revealed a [AGE] year old male admitted on [DATE] with diagnoses that included chronic respiratory failure with hypoxia (a serious, long-term condition that makes it difficult to breathe and exchange oxygen and carbon dioxide in the body), unspecified protein-calorie malnutrition (a condition that occurs when a person does not get enough calories or the right amount of nutrients, such as proteins, carbohydrates, fats, vitamins, and minerals), mild cognitive impairment of uncertain or unknown etiology (the stage between the expected decline in memory and thinking that happens with age and the more serious decline of dementia), pulmonary fibrosis unspecified (a condition in which the lungs become scarred over time) and chronic obstructive pulmonary disease, unspecified(a group of lung diseases that block airflow and make it difficult to breathe). Record review of Resident #72's quarterly MDS assessment, dated 07/23/24. The MDS indicated a BIMS score of 15 indicating Resident #72's cognition was intact. The MDS indicated Resident #72 was independent with activities of daily living. Record review of Resident #72's Comprehensive Care Plan undated revealed that Resident #72 had impaired cognitive function or impaired thought processes. Is able to make his own decisions although he does not always make wise choices. Record review of Resident #72's Physician Orders, there was no order for Lidocaine patches 5%. During observation on 10/14/24 at 10:01 A.M., Resident #72 had 4 Lidocaine patches 5% strength in the bottom of refrigerator and ice buildup in the top of refrigerator. During an observation on 10/15/24 at 8:33 A.M., Resident #72's refrigerator had 4 Lidocaine patches 5% strength in the bottom of refrigerator and ice buildup in the top of refrigerator. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/24 at 12:28 P.M., with LVN R she said nurses usually keep the Lidocaine patches on the nursing cart. She said the residents are not supposed to have Lidocaine patches in their possession. She said she was not sure who was responsible for checking and cleaning the resident's refrigerators. She said the negative effects of Resident #72 having the Lidocaine patches was they were not used properly. She said residents were not allowed to keep medications in their rooms and all medications should stay on the nurse's cart. She said she would make sure she got the Lidocaine patches out of the refrigerator and out of the resident's possession. During an interview on 10/16/24 at 1:01 P.M., with Restorative Aide CC she said housekeeping were responsible for keeping the resident's refrigerators clean. She said Resident #72's refrigerator looked dirty. She said Resident #72 should not had the Lidocaine patches in his possession. During an interview on 10/16/24 at 1:10 P.M., ADON N said the ADON's were supposed to be doing ambassador rounds and checking the refrigerators in resident's rooms. She said residents were not supposed to have medications such as lidocaine in their possession; all medications should be kept on the nurse's cart. During an interview on 10/16/24 at 2:57 P.M., with Housekeeping JJ said housekeeping was responsible for making sure the resident's refrigerators were clean and checked. She said housekeeping were supposed to clean and check the resident's refrigerators every day and do the temperature logs. She said if housekeeping were to find medications in a resident's refrigerator, they were supposed to notify our supervisor or the nurse. During an interview on 10/17/24 at 8:40 A.M., with LVN DD said the nurses and CNAs were responsible for checking and cleaning the resident's refrigerators. She said residents were not supposed to have Lidocaine patches in their possession unless the nurse has placed them on their body. The nurse should keep the medications on the cart. During an interview on 10/17/24 at 9:00 A.M., with Housekeeping KK she said housekeeping were responsible for keeping the residents' refrigerators clean and checking the temperatures. She said if she would have found a resident's refrigerator with medication in there, she would had reported that to her supervisor or the nurse. During an interview on 10/17/24 at 9:08 A.M., with CNA EE she said she was not sure who was responsible for making sure the resident's refrigerators are clean and checked. She said lidocaine patches were not supposed to be in a resident's room and if she would have found them; she would have reported it to the nurse. During an interview on 10/17/24 at 10:36 AM., with ADON A she said housekeeping are supposed to be cleaning and monitoring the refrigerators, but the facility was going to change the monitoring process to prevent this from happening again. She said Resident #72 should not have had the Lidocaine patches, unless the facility got permission from the doctor for him to have them. She said she knew the facility did not have permission from the doctor for Resident #72 to have the Lidocaine patches. During an interview on 10/17/24 at 10:54 A.M., with the Administrator she said it would depend on the facility to decide who was responsible for cleaning and monitoring the refrigerators. She said she was not sure exactly who was responsible or who was required to make sure the refrigerator was cleaned. She said Resident #72 should not have had the Lidocaine patches in the refrigerator. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy Storage of Medications, revision date 08-2020, stated Medications and biologicals are stored safely, and properly, following manufacture's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administered medications Record review of the facility's policy Personnel Authorized to Handle Medications in the Facility, revision date 08-2020, stated . only authorized personnel have access to medications in the facility .unlicensed personnel may not have access to medication storage areas .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications (is a medication used: In excessive doses (including duplicate therapy); or For excessive duration; or Without adequate monitoring; or Without adequate indication for its use; or In the presence of adverse consequences which indicate the dose should be reduced or discontinued) for 1 of 5 residents (Resident #21) reviewed for unnecessary medications in that: The facility failed to ensure Resident #21 had documented diagnoses for the use of Atorvastatin (is used together with a proper diet to lower cholesterol and triglyceride (fats) levels in the blood), Furosemide (is a strong diuretic ('water pill')), Lasix (is a loop diuretic (water pill) that prevents your body from absorbing too much salt, causing it to be passed in your urine), Gabapentin (is a medicine used to treat partial seizures, nerve pain from shingles and restless leg syndrome), Melatonin (is used to combat jet lag and ease sleep problems like insomnia), and Allopurinol (is commonly used to treat gout, which is a form of arthritis caused by too much uric acid in your blood and joints) in her medical records. Atorvastatin was prescribed for hyperlipidemia, Furosemide for heart failure, Gabapentin for neuropathy, Lasix for congestive heart failure, Melatonin for insomnia and Allopurinol for gout. This failure could place residents at risk for adverse drug reactions (unintended, harmful events attributed to the use of medicines) and receiving unnecessary medications. Findings include: Record review of Resident #21's face sheet dared 10/14/24 indicated Resident #21 was a 69-years-old female admitted on [DATE] with diagnoses including need for assistance with personal care, chronic kidney disease (is a long-term condition that occurs when the kidneys are damaged and can't filter blood properly), weakness, pain in right and left shoulder, diabetes mellitus (a group of diseases that affect how the body uses blood sugar (glucose)), and hidradenitis suppurativa (is a painful, long-term skin condition that causes skin abscesses and scarring on the skin). Resident #21 face sheet did not reflect diagnoses of hyperlipidemia, (congestive) heart failure, neuropathy, insomnia, or gout. Record review of Resident #21's quarterly MDS assessment dated [DATE] indicated Resident #21 was understood and understood others. Resident #21 had clear speech, adequate hearing, and adequate vision. Resident #21 a BIMS score of 12 which indicated moderate cognitive impairment. Resident #21's MDS assessment did not reflect diagnoses of hyperlipidemia, (congestive) heart failure, neuropathy, insomnia, or gout. Record review of Resident #21's undated care plan indicated Resident #21 was on diuretic therapy related to hypertension. Intervention included may cause dizziness, postural hypotension, fatigue, and an increased risk for falls. Observe for possible side effects every shift. Resident #21's care plan did not reflect diagnoses of hyperlipidemia, (congestive) heart failure, neuropathy, insomnia, or gout or being on a medication to treat those diagnoses. Record review of Resident #21's consolidated physician order active as of 10/16/24 indicated: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Allopurinol Tablet 100mg, give 1 tablet by mouth two times a day for Gout. Ordered date 12/03/22. *Atorvastatin Calcium Tablet 20mg, give 1 tablet by mouth at bedtime for Hyperlipidemia. Ordered date 12/03/22. *Furosemide Tablet 40mg, give 1 tablet by mouth one time a day for Heart Failure. Ordered date 12/03/22. *Gabapentin Capsule 100mg, give 1 capsule by mouth two times a day for Neuropathy. Ordered date 12/17/22. *Gabapentin Capsule 400mg, give 1 capsule by mouth at bedtime for Neuropathy pain. Ordered date 12/03/22. *Lasix Oral Tablet 20mg (Furosemide), give 1 tablet by mouth in the evening for Congestive Heart Failure. Ordered date 03/09/24. *Melatonin Tablet 3mg, give 2 tablets by mouth at bedtime for Insomnia. Ordered date 12/03/22. Record review of Resident #21's MAR dated 10/01/24-10/31/24 indicated: *Allopurinol Tablet 100mg, give 1 tablet by mouth two times a day for Gout. Ordered date 12/03/22. Resident #21 had received scheduled doses. *Atorvastatin Calcium Tablet 20mg, give 1 tablet by mouth at bedtime for Hyperlipidemia. Ordered date 12/03/22. Resident #21 had received scheduled doses. *Furosemide Tablet 40mg, give 1 tablet by mouth one time a day for Heart Failure. Ordered date 12/03/22. Resident #21 had received scheduled doses. *Gabapentin Capsule 100mg, give 1 capsule by mouth two times a day for Neuropathy. Ordered date 12/17/22. Resident #21 had received scheduled doses. *Gabapentin Capsule 400mg, give 1 capsule by mouth at bedtime for Neuropathy pain. Ordered date 12/03/22. Resident #21 had received scheduled doses. *Lasix Oral Tablet 20mg (Furosemide), give 1 tablet by mouth in the evening for Congestive Heart Failure. Ordered date 03/09/24. Resident #21 had received scheduled doses. *Melatonin Tablet 3mg, give 2 tablets by mouth at bedtime for Insomnia. Ordered date 12/03/22. Resident #21 had received scheduled doses. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 9:49 a.m., LVN K said the MDS Coordinator added diagnoses to the resident's medical record. She said when a nurse received an order from the physician, the nurse added the diagnosis the physician said the medication was for. She said the nurse added the diagnosis to the order from what diagnoses were available in the computer system. She said the nurse should notify the MDS Coordinator when a diagnosis needed to be added to the resident's medical records. She said she did not know who was responsible for ensuring the resident's medication had an appropriate or documented diagnosis. She said it was important the resident's medication had a documented or appropriate diagnosis, so staff knew why the resident was taken the medication. She said the residents should only take medications they need. She said Resident #21 had neuropathy from her diabetes. She said she did not know about the other diagnoses not listed on her diagnoses list. During an interview on 10/17/24 at 10:28 a.m., ADON A said Resident #51's neuropathy was related to her Type 2 diabetes. She said the facility found an old progress note with the new diagnosis listed. During an interview on 10/17/24 at 10:37 a.m., ADON N said he had only been in the ADON position for one week. She said when a resident had a medication with a diagnosis not listed on their profile, staff should review the discharge records or call the NP/ MD to get a diagnosis. She said the staff could also get with the MDS Coordinator if the diagnosis was not on the resident's profile the MD gave the order for. She said it was important to know what the ordered medication was treating. She said certain medications needed lab monitoring and staff could potential not be watching for the desired effect of the medication. She said the ADONs should be monitoring this by doing chart audits. She said the MDS Coordinator was also responsible. She said if it was not clear why a resident was receiving a medication, the resident could be taking an unnecessary medication. During an interview on 10/17/24 at 10:45 a.m., the MDS Coordinator V said the MDS Coordinator added diagnoses to the resident's profile upon admission. She said if a resident received a new or missed diagnosis, the nurse needed to notify the MDS Coordinator to add it. She said sometimes the MDS Coordinator meet with the MD to discuss resident's diagnoses that may need to be added. She said a LVN could added an indication for use to a physician order but not a diagnosis. She said she had talked to nursing staff about notify the MDS Coordinator of new diagnoses that needed to add to the resident's diagnosis list. She said it was important for the resident's diagnosis and medication to be correct, so the physician knew what they were treating. She said the diagnosis and medication needed to be accurate because the information was placed on the MDS assessment. She said it was important to make sure the resident was not getting unnecessary medications. During an interview on 10/17/24 at 2:05 p.m., Regional RN FF said the MDS Coordinator put in documented diagnoses and got orders from the physician to add new diagnoses. She said the MDS Coordinator and nurse managers were responsible for ensuring a medication had an appropriate or ordered diagnosis. She said the resident's medication and diagnosis had to match because it could lead to an inaccurate assessment. She said if there was no appropriate diagnosis, it could be considered an unnecessary medication. She said the IDT should be reviewing orders daily and during weekly standard of care meetings. During an interview on 10/17/24 at 2:58 p.m., the Interim ADM said the MDS Coordinator was responsible for ensuring resident had appropriate diagnoses for medications. She said physician orders were monitored during morning meetings. She said if there was not an appropriate or listed diagnosis for a medication, it could be considered an unnecessary medication. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility's Ordering and Receiving Non-Controlled Medications revised date 08/2020 indicated .medications orders .or entered into the facility's EMR system and transmitted to the pharmacy .the written entry includes .indication for use .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35295 Based on interview and record review, the facility failed to ensure the resident's PRN orders for psychotropic drugs were limited to fourteen (14) days for 1 of 24 residents selected for unnecessary medications review. (Resident #59). Resident #59 had a PRN order for Lorazepam, a psychotropic medication, for more than fourteen days without physician documentation re-evaluating the medication to continue it PRN or to become a scheduled medication. This failure could place residents who receive PRN psychotropic medications at risk of receiving unnecessary medications. Findings included: Record review of the undated face sheet indicated Resident #59 was an [AGE] year-old male that admitted on [DATE] and readmitted on [DATE]. Record review of the quarterly MDS dated [DATE] indicated Resident #59 had clear speech, was understood by others, and understood others. He had a BIMS score of 9 indicating moderate cognitive impairment. Record review of the care plan dated 8/29/24 indicated Resident #59 required psychotropic medications for a diagnosis of anxiety. The care plan indicated he was on hospice care and had impaired cognitive function related to dementia. Record review of the physician's orders dated 10/15/24 indicated Resident #59 had diagnoses that included: Acute and chronic respiratory failure (inadequate gas exchange in the respiratory system that cannot be kept at normal levels), dementia (thinking and social symptoms that interfere with daily functioning), psychotic disturbance (a severe mental disorder that causes a person to lose touch with reality and have abnormal perceptions and thoughts), and mood disturbance (change in a person's mental state that can involve feelings of distress, sadness or anxiety). The physician's orders for Resident #59 indicated: -8/29/24 Lorazepam oral tablet 1 mg, give one tablet by mouth every 4 hours as needed for anxiety/restlessness. No end date was noted for the order. Record review of the MAR for August 2024 indicated Resident #59 had not received Lorazepam. Record review of the MAR for September 2024 indicated Resident #59 received Lorazepam oral tablet, 1 mg once on 9/5/24 and on once on 9/25/24. Record review of the MAR for October 2024 indicated Resident #59 had not received Lorazepam. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the pharmacy book for September of 2024 indicated: Resident #59, Lorazepam 1 mg every 4 hours for anxiety/restlessness ordered 8/29/24. There were no recommendations. During an interview on 0/16/24 at 1:29 PM, ADON A per the CMS regulations, residents could not have a PRN order for antianxiety medication longer than 2 weeks. During an interview on 10/16/24 at 2:07 PM, the DON said no resident should have a PRN order for Lorazepam or any psychotropic drug for more than 14 days. She said if the order was more than 14 days the MD had to give some sort of rational as to why the medication was needed more than 14 days. The DON said the risk of psychotropics was oversedation and there was a greater risk of the medication not working properly if used for a longer period of time. She said she did not realize Resident #59 had a PRN order for Lorazepam. During an interview on 10/16/24 at 2:23 PM, the ADM said she was not aware if any resident should have an order for antianxiety or psychotropics for longer than 2 weeks. Record review of a Psychotherapeutic Drug Management Policy provided by the Regional RN indicated: Purpose 1.To implement the most desirable and effective interventions to change, modify, decrease, or eliminate behaviors that are distressing to the r resident, and/or are decreasing or negatively impacting the residents' quality of life. 2.To help promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, promote resident safety and security, and to enhance the resident's ability to interact positively with his/her environment . Policy .2.The Facility will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications in the long-term care facility to include regular review for continued need, appropriate dosage, side effects, risks and/or benefits. Procedure I. Residents should not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. 1.PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rational in the r resident's medical record and indicate the duration for the PRN order . 3.PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident in person, for the appropriateness of that medication .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observation, interview and record review, the facility failed to ensure that it was free of medication error rate of 5 percent or greater. The facility had a medication error rate of 14.81%, based on 4 errors out of 27 opportunities, which involved 2 of 5 residents (Resident #39, Resident #90) reviewed for medication administration. 1. The facility failed to administer Resident # 39's [NAME] vitamin B-complex (contains essential vitamins such as B-complex, vitamin C, and folic acid, which help manage or prevent deficiencies common in individuals with compromised renal function.) and administered incorrect dose of Vitamin D3 25 mcg (a nutrient your body needs for building and maintaining healthy bones) on 10/15/2024. 2. The facility failed to administer Resident # 90's Oxybutynin (to treat an overactive bladder) and Protonix (a medication used to decrease the amount of acid produced in the stomach as ordered on 10/15/2024. These failures could place residents at risk for not receiving the intended therapeutic benefit of their medications or receiving them as prescribed, per physician orders. Findings included: Error #1 and #2 1. Record review of Resident #39's face sheet, dated 10/16/2024, indicated she was an [AGE] year-old female, who was readmitted to the facility on [DATE] , with the diagnoses which cerebral infarction (An ischemic stroke occurs when the blood supply to part of the brain is blocked or reduced), type II diabetes (refers to a group of diseases that affect how the body uses blood sugar (glucose) , dysphagia (difficulty swallowing) and GERD (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach, called the esophagus). Record review of Resident #39's quarterly MDS, dated [DATE], indicated she was rarely or never understood, and no BIMS score indicated. Record review of Resident #39's MAR dated 10/1/2024-10/31/2024 indicated Resident #39 was prescribed [NAME]-vitamin to be administered one time daily for supplement. Resident # 39's medication record indicated she was to have Vitamin D3 25 mcg 1000IU administered via PEG tube one time daily for supplement. During observation of medication pass on 10/15/2024 at 7:59 AM, RN Y said Resident #39 was out of her [NAME] Vitamin and she administered Vitamin D3 1000 IU via PEG tube with Resident # 39's scheduled medications. RN Y said she was going to reorder the medication and was not sure why it was not reordered. Error #3 and #4 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2 Record review of Resident #90's face sheet, dated 10/16/2024, indicated he was a [AGE] year-old male, who was admitted to the facility on [DATE], with the diagnoses which fracture of fifth lumbar vertebra (a fracture of the lumbar spine located in the lower part of the back), muscle weakness, cognitive communication deficit (problems with communication that have an underlying cause in a cognitive deficit rather than a primary language or speech deficit.), and intellectual disabilities (a learning disability characterized by below average intelligence.) Record review of Resident #90's quarterly MDS, dated [DATE], indicated he was rarely or never understood by others and BIM score was not completed. Record review of Resident #90's MAR dated 10/1/2024-10/31/2024 indicated resident was prescribed oxybutynin chloride Extended release 10 mg, 1 tablet by mouth one time daily for history of traumatic brain injury and protonix delayed release 40 mg, 1 tablet by mouth one time daily for GERD. Record review of Resident # 90's undated care plan, indicated the resident had bowel and bladder incontinence and was on a routine medication for overactive bladder. The care plan indicated Resident #90 had GERD with interventions in place for medication to be given as ordered and monitored and document side effects and effectiveness. During an interview on 10/17/2024 at 9:30 AM, LVN AA said Resident #39 was prescribed Vitamin D3 (25 mcg) 1000 Units. LVN AA said there were different doses of Vitamin D3 on the cart. LVN AA said the facility was currently out of the [NAME]-Vit B complex vitamin. LVN AA said Resident #39 did not receive her B complex on 10/15/2024 or 10/16/2024. LVN AA said the night shift nurse stocks the cart. LVN AA said she was not sure who was responsible for restocking the vitamins. LVN AA said a resident not receiving the proper dose or vitamin supplement depended on what diagnosis a resident had. She said if a resident missed their supplements, it may delay healing, not get better. During an interview on 10/17/2024 at 9:59 AM, ADON N said vitamins and supplements are ordered by central supply and the facility makes sure the nurses have what they need and order. ADON N said the nurses were responsible for verbally notifying and writing it down on a sheet and handing it to central supply. The ADON N said central supply would order or go to the store and pick up supplement, so the residents do not go without vitamins. ADON N said she considered it a med error if a medication was not administered due to being out of the medication. She said if the facility has the medication on the pyxis, the nurse will get it from there. ADON N said the nurses would contact the physician for an alternative. ADON N said the facility would try to get alternative meds. ADON N said it could cause harm, or a resident could get worse if they did not receive a medication that was ordered for them. Attempted to contact Central supply but unavailable during interview due to transporting a resident for a Physician appointment. During an interview on 10/17/2024 at 11:43 AM, Regional Nurse FF said she expected medications to be ordered in a timely manner. She said she considered the observed medication pass errors if not given or incorrect dose administered. Regional Nurse FF said the central supply is responsible for reordering OTC and supplements. Regional Nurse FF said the floor nurses were responsible for reordering prescribed medications. She said there was a reason why a resident is on the medication. Regional Nurse FF said not taking Protonix could cause GI issues. And Oxybutynin could cause urinary issues. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 12:06 PM, the ADM said the central supply is responsible for ordering the OTC and supplements. She said the nurses were responsible for reordering the prescription medications. Regional Nurse FF said if a resident does not receive medication, they could die or have a change in condition. The ADM said she expected the nurses and central supply to reorder medication prior to a resident running out. Record review of the facility's policy Medication Administration undated stated: .To provide practice standards for safe administration of medication for residents in the facility. Medication must be given to the resident by the Licensed Nurse preparing the medication, or as consistent with state law . The licensed nurse must know the following information about any medication they are administering A: The drug name .B. the drug's route of administration . C The drug's action .D. The drug's indication for use and desired outcome .E. The drug's usual dosage .F. The drug's side effects .G. Any precautions and special considerations. VIII. Medication will not be left at the bedside. VIII. Compare the Licensed Practitioner's prescription and order with the MAR. XVII. Holding medications .A. Whenever a medication is held for any reason, the Licensed Nurse will initial the appropriate area on the MAR and circle his/her initials. The Licensed Nurse will document the reason the medication was help on the back of the MAR.

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	675133	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Nursing Home	1100 N 4th St Longview, TX 75601

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure that residents were free of significant medication errors for 1 of 10 residents (Residents #51) reviewed for pharmacy services. The facility failed to ensure Resident #51 received Acetaminophen-Codeine Oral Tablet 300-60mg (is used to help relieve mild to moderate pain; Tylenol #4 contains 60 mg of Codeine) as scheduled on 10/13/24 (8am and 3pm) and 10/14/24 (8am). This failure could place residents at risk of discomfort and pain. Findings included: Record review of Resident #51's face sheet dated 10/15/24 indicated Resident #51 was a [AGE] year-old female admitted on [DATE] and 12/08/20 with diagnoses including metabolic encephalopathy (is a brain dysfunction caused by a chemical imbalance in the blood that affects the brain), muscle wasting and atrophy (shortening), pain in left leg and hip, anxiety (is a mental illness that causes excessive and uncontrollable feelings of fear or anxiety that can significantly impair a person's daily life), and bipolar disorder (is a mental illness that causes extreme shifts in mood, energy, and activity levels). Record review of Resident #51's quarterly MDS assessment dated [DATE] indicated Resident #51 was usually understood and usually understood others. Resident #51 had a BIMS score of 04 which indicated severe cognitive impairment. Resident #51 had fluctuating behaviors of inattention and altered level of consciousness. Resident #51 was dependent for ADL care. Resident #51 received scheduled pain medication regimen. Record review of Resident #51's undated care plan indicated Resident #51 required pain management chronic pain related to disease process. Intervention included anticipate need for pain relief and respond immediately to any complaint of pain. Record review of Resident #51's consolidated physician order active as of 10/15/24 indicated Acetaminophen-Codeine Oral Tablet 300-60mg, give 2 tablets by mouth three times a day for pain. Ordered date 11/05/23. Record review of Resident #51's MAR dated 10/01/24-10/31/24 indicated: *Acetaminophen-Codeine Oral Tablet 300-60mg, give 2 tablets by mouth three times a day for pain. Ordered date 11/05/23. Resident #51's MAR indicated other/see nurse notes on 10/13/24 (8am and 3pm) by MA U and 10/14/24 (8am) by MA U. *Pain Assessment every shift using PAINAD /Verbal Scale 0-10 for chronic pain. Resident #51's MAR indicated on 10/13/24 (0 for day and night shift) by RN Y and LVN Z and 10/14/24 (0 for day shift) by RN Y. Record review of Resident #51's progress note dated 09/14/24-10/15/24 indicated: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*On 10/13/24 at 10:33 a.m. by MA U. Acetaminophen-Codeine Oral Tablet 300-60mg, give 2 tablets by mouth three times a day for PAIN, on order (not given). *On 10/13/24 at 2:11 p.m., by MA U. Acetaminophen-Codeine Oral Tablet 300-60mg, give 2 tablets by mouth three times a day for pain, on order (not given). *On 10/14/24 at 8:17 a.m., by MA U. Acetaminophen-Codeine Oral Tablet 300-60mg, give 2 tablets by mouth three times a day for pain, on order (not given). During an interview on 10/17/24 at 9:25 a.m., MA U said she had been employed at the facility for one week. She said she was assigned the 300 hall. She said she passed medication to Resident #51. She said medications were documented on the MAR when administered. She said if a medication was unavailable on the medication cart, she notified the nurse to get it out of the emergency kit. She said then an order would be placed for the medication if the facility did not have it. She said when she passed medication on 10/13/24 and 10/14/24 to Resident #51, Resident #51's blister packet said Tylenol #4, but the EMR order said Tylenol #3, 300-60 mg. She said she did not give Resident #51 three scheduled doses because she thought the blister pack order did not match the EMR order. She said hospice came to visit Resident #51 on 10/13/24 and said the medication in the blister pack was correct. She said Resident #51 missed three doses of Acetaminophen-Codeine but received her Lorazepam (antianxiety). She said a nurse knew about the missed doses, but she could not remember who it was. She said the nurse knew she did not administer Resident #51's pain medication because the medication order seemed wrong, and it was not given. She said when Resident #51 missed three doses, she seemed more anxious. She said Resident #51 was cussing and threw water at her. She said her pain medication was not for her anxiety, but it would have helped controlled her temper and anxiety as well. During an interview on 10/17/24 at 10:37 a.m., ADON N said she worked the 300 hall on either Sunday or Monday. She said MA U did not report to her she had not given Resident #51 her pain medication. She said she thought MA U reported to the 6pm-6am shift the issue. She said she still did not know why MA U did not give Resident #51 her schedule Acetaminophen-Codeine 300-60mg, which was considered Tylenol #4. She said Resident #51 needed her medication for pain management. She said MA U not giving Resident #51 her pain medication could have increased her behaviors and pain. She said Resident #51 had behaviors, but she also had a urinary tract infection and GDR (tapering residents antipsychotic and psychotropic medication) done on an antipsychotic medication that week. She said MA U should have told a nurse immediately she held Resident #51's pain medication. During an interview on 10/17/24 at 2:05 p.m., Regional RN FF, acting DON, said MA U should have notified the LVN to clarify the medication order. She said she expected nursing staff to give medication as scheduled. She said Resident #51 not receiving her pain medication could have increased her pain if she did not have PRN pain medication available. She said competencies and skill checks were done to ensure nursing staff administrated medication correctly. She said the nurse should have checked the MAR and log to ensure the resident's medications were being administered. She said the ADON and DON should be monitoring resident's MAR/TARs for accurate administration. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 2:58 p.m., the Interim ADM said she expected the MAs to administer medication as scheduled. She said she expected MAs to ask the LVN or DON for assistance with medication orders. She said when pain medication was not administered, a resident's blood pressure could be elevated due to the pain. She said the DON was responsible for ensuring the nursing staff administered medication as scheduled. She said the DON should be ensuring it was happening with training, auditing MARS and controlled substance logs. Record review of an undated facility's Medication-Administration policy indicated .medication must be given to the resident by the Licensed Nurse preparing the medication, or as consistent with state law .compare the Licensed Practitioner's prescription/order with the MAR (first check) .compare the Licensed Practitioner's order with the pharmacy label on the medication package (second check) .compare the pharmacy label and MAR (third check) .any discrepancies identified during the first, second, and/or third check must be resolved prior to administration of any medication .administer the medication to the resident .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observation, interview, and record review the facility failed to ensure drugs and biologicals were stored in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 2 of 38 residents. (Resident #274 and Resident # 54) 1. The facility failed to ensure Santyl and Mupirocin ointment 2% was properly stored and locked in accordance with currently accepted professional standards for Resident # 54. 2. The facility failed to ensure Triamcinolone Acetonide Ointment 1% was properly stored and locked in accordance with currently accepted professional standards on [DATE] for Resident # 274. This failure could place residents at risk for adverse effects and reduced therapeutic effects of medication and supplies. Findings included: 1. Record review of Resident #54 s face sheet, dated [DATE], revealed he was an [AGE] year-old male, who was admitted to the facility on [DATE], with the diagnoses which included Type II Diabetes (Diabetes mellitus refers to a group of diseases that affect how the body uses blood sugar (glucose), Muscle weakness, and Hypertension (he force of the blood pushing against the artery walls is consistently too high. The heart must work harder to pump blood. Record review of Resident #54's quarterly MDS, dated [DATE], indicated he had a BIMS of 12, which indicated he was moderately cognitively impaired. Resident #54's MDS did not indicate he had any skin conditions or issues. Record review of Resident #54's care plan, undated revealed the resident had focus on non-compliant with medication administration related to he brought in old, outdated ointments from home to self-apply. He became upset when the ADON explained he could not self-treat with ointments that MD was unaware of. During observation and interview on [DATE] at 10:46 AM, Resident #54 had 2 tubes of ointment on bedside table: Mupirocin 2 % 22 g and Santyl Collagenase 250 units. Resident said both creams are the same and he applies the cream to his arms . Resident #54 did not recall where the medications came from. No dates observed on ointments. 2. Record review of Resident #274 s face sheet, dated [DATE], revealed she was a [AGE] year-old female, who was readmitted to the facility on [DATE], with the diagnoses which included embolism and thrombosis of arteries of the upper extremities (conditions affecting the flow of blood through blood vessels), Arteriovenous fistula (connects an artery to a vein in your arm), seizures (a sudden, uncontrolled burst of electrical activity in the brain)and combined systolic and diastolic congestive heart failure (can lead to very high left ventricular end-diastolic pressures that can cause pulmonary congestion and edema). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #274's quarterly MDS, dated [DATE], indicated she had a BIMS of 14, which indicated she was cognitively intact. Resident #274s MDS did not indicate any wounds. Record review of Resident #274's medication administration record, revealed she did not have a prescription for Triamcinolone Acetonide ointment 0.1 %. Resident #274 was unavailable at time of observation due to out of facility. During observation on [DATE] at 10:21 AM, Resident #274 was not in her room and observed to have Triamcinolone Acetonide 0.1 % ointment on bedside table. During an interview on [DATE] at 2:58 PM, CNA HH said she would notify the nurse if she observed a medication or ointment on a resident's bedside table and medications should not be in a resident room. CNA HH said the nurse who passes medications was responsible for ensuring medications are stored properly on the medication cart. During an interview on [DATE] at 3:16 PM, CNA Q said she would report a medication to my DON if found in a resident room. CNA Q said a resident should not have medication in room and stated the nurse was responsible for ensuring a resident medication is stored properly on the medication cart. CNA Q said if another resident or visit got a hold of medication and used it, it could make them sick. During an interview on [DATE] at 3:30 PM, LVN GG said residents can have barrier cream in room or aftershaves. She said ointments or prescribed medications should not be at resident bedside. During an interview on [DATE] at 8:19 AM, LVN AA said residents should not have ointments or medication sitting on bedside table. She said the roommate, visitor, or staff could use the medication improperly or have a reaction they do not know about. LVN AA said the charge nurse was responsible for ensuring medications are properly stored and labeled on the medication cart or treatment cart. During an interview on [DATE] at 11:00 AM, LVN M said all the staff are all responsible for medications being locked up and secured. She said the nurse carts should have ointments locked on their carts unless it is part of the resident wound care. LVN M said Santyl would be a medication on the cart but currently there was no resident prescribed Santyl. LVN M said Santyl was a debriding agent and could cause damage to good skin and could cause a resident harm if they got medication that was not prescribed to them. During an interview on [DATE] at 9:56 AM, ADON N said residents should not have medications in room such as ointments, creams, or eye drops. ADON N said some residents bring things from the outside and back to the facility. She said it could cause harm if a medication was not prescribed. ADON N said the staff check residents when they make rounds. She said ointments should be stored on the treatment cart or medication cart. ADON N said all medication should be labeled with Resident's name and stored properly on carts. ADON N said she removed the ointments from the from resident room. She said Santyl could destroy good tissue. ADON N said Resident # 54 does go out on visits. She said Resident #54 told her the medication came from his doctor and was upset she removed the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:40 AM, Regional Nurse FF said Santyl was a mechanical debridement agent and could cause harm to a resident or other resident if applied to good skin. Regional Nurse FF said she expected all ointments and medications to be stored in medication carts. Regional Nurse FF said residents should not have medications on bedside table. She said the staff should report and have an order for the medication. Regional Nurse FF said if another staff member identified medication, they should notify the nurse. During an interview on [DATE] at 12:00 PM, the ADM said Santyl could harm good skin. She said medications should not be stored in resident's rooms and the ointments should be stored in the medication cart. The ADM said it should be labeled with name of resident, dose and ordered by Physician and discarded if expired. The ADM said she expected staff to notify the nurse if a medication was identified in a resident room. Record review of the facility's policy Storage of Medication revised ,d+[DATE] stated: .Medication and biologicals are stored safely, securely, and properly, following manufacture's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing, personnel, pharmacy personnel, or staff members lawfully authorized to administer medication. Procedures 1. The provider pharmacy dispenses medications that meet regulatory requirements .2. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are permitted to access .3. All medications dispensed by the pharmacy are store in the pharmacy container with the pharmacy label. 6. Medications labeled for individual residents are stored separately from floor stock .III. 1. Expiration dates if dispensed medication shall be determined by pharmacist at the time of dispensing . Record review of the facility's policy Medication Administration undated stated: .To provide practice standards for safe administration of medication for residents in the facility. Medication must be given to the resident by the Licensed Nurse preparing the medication, or as consistent with state law . The licensed nurse must know the following information about any medication they are administering A: The drug name .B. the drug's route of administration . C The drug's action .D. The drug's indication for use and desired outcome .E. The drug's usual dosage .F. The drug's side effects .G. Any precautions and special considerations. VIII. Medication will not be left at the bedside. VIII. Compare the Licensed Practitioner's prescription and order with the MAR. XVII. Holding medications .A. Whenever a medication is held for any reason, the Licensed Nurse will initial the appropriate area on the MAR and circle his/her initials. The Licensed Nurse will document the reason the medication was help on the back of the MAR.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 5 of 24 resident personal refrigerators reviewed for food safety (Resident #42, Resident #49, Resident #51, Resident #72, and Resident #81). 1.The facility failed to ensure the refrigerator for Resident #72 was cleaned, clutter free and free from meat with green mold. 2.The facility failed to ensure Resident #42, Resident #49, Resident #51, and Resident #81's refrigerator temperature was checked and logged daily. These failures could place resident at risk for food borne illnesses. The Findings were: 1.Record review of Resident #72's face sheet, dated [DATE] revealed a [AGE] year old male admitted on [DATE] with diagnoses that included chronic respiratory failure with hypoxia (a serious, long-term condition that makes it difficult to breathe and exchange oxygen and carbon dioxide in the body), unspecified protein-calorie malnutrition (a condition that occurs when a person does not get enough calories or the right amount of nutrients, such as proteins, carbohydrates, fats, vitamins, and minerals), mild cognitive impairment of uncertain or unknown etiology (the stage between the expected decline in memory and thinking that happens with age and the more serious decline of dementia), pulmonary fibrosis unspecified (a condition in which the lungs become scarred over time) and chronic obstructive pulmonary disease, unspecified(a group of lung diseases that block airflow and make it difficult to breathe). Record review of Resident #72's quarterly MDS assessment, dated [DATE]. The MDS indicated a BIMS score of 15 indicating Resident #72's cognition was intact. The MDS indicated Resident #72 was independent with activities of daily living. Record review of Resident #72's Comprehensive Care Plan undated revealed that Resident #72 had impaired cognitive function or impaired thought processes. Is able to make his own decisions although he does not always make wise choices. During an observation on [DATE] at 10:01 A.M., in Resident #72's personal refrigerator was observed not clean, cluttered and had meat with green mold. The top of Resident's #72's refrigerator had ice build-up in to top. During an observation on [DATE] at 8:33 A.M., in Resident #72's personal refrigerator had ice build-up in the top, cluttered, not clean and had meat with green mold . (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 12:28 P.M., with LVN R she said she thought all the food probably came from when Resident #72's wife was here, because he does not go to the store and she did, but she passed a couple weeks ago . She said she never went into Resident #72's refrigerator. She said she was not sure who was responsible for checking and cleaning the resident's refrigerators. She said she was sure he would not eat the molded food. She said it looked like everything in the refrigerator needed to be thrown away. She said the negative effects of Resident #72 having a nasty refrigerator with molded items in it was he could get sick from ingesting the molded food. During an interview on [DATE] at 1:01 P.M., with Restorative Aide CC she said housekeeping was responsible for keeping the resident's refrigerators clean. She said Resident #72's refrigerator looked nasty. She said the molded meat could affect everything in Resident #72's refrigerator and make him sick. She said she would not want any molded items in her refrigerator. During an interview on [DATE] at 1:10 P.M., with ADON N she said as an ADON we were supposed to be doing ambassador rounds, such as checking the resident's rooms. She said there was no excuse for Resident #72's refrigerator to look like that. She said any staff member can check temps and clean refrigerators. She said the facility would follow up on Resident #72's refrigerator and buckle down on staff to make sure the refrigerators in resident's rooms are cleaned and checked. During an interview on [DATE] at 2:57 P.M., with Housekeeping JJ she said housekeeping was responsible for making sure the resident's refrigerators were clean. She said they was supposed to clean the resident's refrigerators every day and do the temperature logs. She said the pictures of Resident #72's refrigerator looked nasty. She said they was supposed to notify their supervisor if we had any issues with refrigerators. She said the molded items in the refrigerator could have made the resident very sick, cause vomiting, diarrhea or maybe a trip to the hospital. During an interview on [DATE] at 8:40 A.M., with LVN DD she said the nurses and CNAs were responsible for checking and cleaning the resident's refrigerators. She said Resident #72's refrigerator looked nasty. She said consuming the molded meat could be an upper respiratory issue, possibly food poisoning and could make the resident sick. During an interview on [DATE] at 9:00 A.M., with Housekeeping KK she said housekeeping was responsible for keeping the resident's refrigerators clean and checking the temperatures. She said the residents usually told staff if their refrigerators were dirty. She said the negative affect of the items in the refrigerator could have on the resident if he ate them was, they could make the resident sick. She said the refrigerator was unacceptable. During an interview on [DATE] 09:08 A.M., with CNA EE she said she was not sure who is responsible for making sure the resident's refrigerators were cleaned. During an interview on [DATE] at 10:36 A.M., with ADON A she said sometimes she left things too long in her refrigerator at home. She said housekeeping were supposed to be cleaning and monitoring the resident's refrigerators, but the facility was going to change the monitoring process to prevent that from happening again. She said the negative effects that could had happened to Resident #72 for having molded items in his refrigerator would be it would make him sick if he was to eat it, it could cause nausea and vomiting or food poisoning. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:54 A.M., with the Administrator she said who was responsible for the resident's refrigerator depend on who the facility decided who was responsible for cleaning and monitoring the refrigerators. She said she was not sure exactly who was responsible or who is required to make sure the refrigerator was cleaned. She said the negative effects of Resident #72's refrigerator was a potential for food poisoning. 2. During an observation and interview on [DATE] at 10:49 a.m., Resident #49 was lying in bed. Resident #49's refrigerator temperature log sheet had a temperature only on [DATE]. Resident #49 said he did not know about the refrigerator log. Resident #49 said he was in a hospital and did not know what was going on. Resident #49 was only oriented to person but not place or time. Resident #49 was not interviewable. During an interview and observation on [DATE] at 12:07 p.m., Resident #42 was in her room. Resident #42's refrigerator log sheet was missing temperatures from [DATE]-[DATE]. Resident #42 said she saw staff occasionally check the temperature. During an interview and observation on [DATE] at 2:21 p.m., Resident #51 was laying in her bed cursing with delusions of being pregnant. Resident #51 was not interviewable. Resident #51's refrigerator log sheet was missing temperatures from [DATE]-[DATE]. During an interview on [DATE] at 8:33 a.m., Resident #81 was lying in her bed. Resident #81 said staff did not check her personal refrigerator every day. She said Housekeeping Supervisor T came yesterday to check the refrigerator temperature and logged a bunch of temps. Resident #81's refrigerator log sheet had documented temps from [DATE]-[DATE] all by Housekeeping Supervisor T. During an interview on [DATE] at 2:10 p.m., LVN R said housekeeping was responsible for checking resident's personal fridge and log temperature daily. She said housekeeping was supposed to check the fridge for expired foods and make sure the freezer section was good. She said when housekeeping did not check resident's fridges, the resident's food could spoil if it was too warm. She said the resident's food could also get freezer burned if the freezer was too cold. She said residents could get sick and possible have diarrhea. During an interview on [DATE] at 3:10 p.m., Housekeeper S said housekeeping was responsible for resident's refrigerator logs. She said the logs should be completed daily. She said she checked the refrigerators every day on the rooms she cleaned. She said she sometimes did not put the temperatures on the log sheet but on a piece a paper. She said she was supposed to put the temperatures on the log sheet every day. She said it was important to check resident's fridge temps and put the temperature on the log sheet to see if the food stayed good and not bad. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:10 a.m., the Housekeeping Supervisor T said housekeeping was responsible for checking resident's personal fridges daily. She said the temperatures should be documented on the log sheet which was normally on the fridge or the wall above the fridge. She said she went to rooms daily for ambassador rounds and checked the fridge log sheets to ensure it was being done. She said she had been working 7 days a week due to short staffing. She said Resident #81's fridge log had been done. She said Resident #49's fridge had been locked and the key was lost. She said Resident #49's fridge had been recently opened so the temperatures should have been done for the last few days. She said Resident #51 was missing temps on the log sheet. She said Resident #42's temperatures were written on pieces of paper instead of the log sheet. She said she had lost Resident #42's temperatures on the pieces of paper. She said checking temperatures on resident's fridges was important to make sure they do not go out, check to make sure the freezer did not need to be thawed out. She said staff and residents would not know and the food would go bad. During an interview on [DATE] at 10:15 a.m., CNA O said housekeeping was responsible for the resident's refrigerator logs. She said housekeeping was supposed to do it daily. She said the fridges needed to be checked daily to make sure food did not go bad. She said the bad food could make the resident's sick. During an interview on [DATE] at 10:28 a.m., ADON N said resident's fridges needed to be checked and temperatures logged daily. She said during ambassador rounds, those staff members should be making sure temperatures were logged or fill out the log themselves. She said anyone who viewed the log sheet could fill it out. She said the nurses, housekeeping supervisor, and ambassadors should be ensuring the temps were done daily. She said it was important to check and document the temperatures daily to ensure food was not spoiled. She said residents had the potential to get sick for eating spoiled food. During an interview on [DATE] at 2:05 p.m., the Regional Nurse FF, acting DON, said housekeeping was responsible for resident's refrigerator log sheets. She said the log sheets could also be completed by the nursing staff. She said the log sheets should be completed daily. She said the Housekeeping Supervisor and ambassadors should be ensuring staff completed the log sheets daily. She said it was important to document the refrigerator logs daily to make sure things were kept at the right temperature and food did not go bad. She said residents were at risk for food poisoning. During an interview on [DATE] at 2:58 p.m., the interim ADM said she had only been at the facility for a few days. She said she would think maintenance, housekeeping, and ambassadors were responsible for personal fridge temperature logs. She said those staff members should log temperatures daily on the log sheets. She said temperatures logs needed to be completed daily to make sure the refrigerator worked so the resident's food did not get spoiled. She said if a resident ate spoiled food, they could get a stomach virus or food poisoning. Record review of a facility's Refrigerator/Freezer Temperature Records policy revised date ,d+[DATE] indicated .a daily temperature record is to be kept for refrigerated and frozen storage areas . (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility's Refrigerator-Personal policy dated ,d+[DATE] indicated .it is the policy of this home that resident's refrigerators will be checked weekly for cleanliness and remaining sanitary. Procedure: the housekeeping Supervisor/designee will monitor resident's refrigerators weekly . inform resident prior to checking fridge . clean and remove expired food as needed . keep thermometer in refrigerator and maintain at 41 degrees or below . log temperature weekly when checked . notify ADM/ DON/ Designee of any issues for immediate intervention . notify family of concern/ issues . 44933

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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** 35295 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 6 of 24 residents reviewed for infection control practices (Resident #'s 2, 7, 37, 39, 91, and 100), 1.The facility failed to ensure CNA C changed her gloves and performed hand hygiene appropriately while providing incontinent care to Resident #2. 2. The facility failed to ensure Resident #7 had enhanced barrier precautions sign posted on door with storage container for PPE on 10/14/2024 for resident with a feeding tube. 3. The facility failed to ensure Resident # 37 had enhanced barrier precautions in place with proper PPE storage containers available to care for foley catheter and wound care. 4. The facility failed to ensure Resident # 39 has enhanced barrier precautions in place with PPE containers available for resident with feeding tube. 5. The facility failed to ensure Resident # 91 had enhanced barrier precautions posted and PPE storage containers available for use while performing IV antibiotic therapy. 6. The facility failed to ensure CNA BB and Restorative Aide CC donned PPE (disposable gown and gloves) prior to performing catheter care on Resident #100 on 10/15/24. The resident was on enhanced barrier precautions. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: 1.Record review of the undated face sheet indicated Resident #2, was a [AGE] year-old female admitted [DATE], and readmitted [DATE]. Record review of the physician's orders dated 10/15/24 indicated Resident #2 had diagnoses that included: Chronic Obstructive Pulmonary Disease (chronic respiratory symptoms with airflow limitation), aphasia (slight or serious difficulty with speech), unspecified dementia with agitation (thinking and social symptoms that interfere with daily functioning with restless, worried and unable to settle down), disorders of bone density and structure (weakened bones and increased risk of fractures). Record review of the significant change MDS dated [DATE] indicated Resident #2 had no speech was rarely or never understood and was rarely or never understood by others. Resident #2 had long-term and short-term memory problems. The MDS indicated she was always incontinent of bowel and bladder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the undated care plan indicated Resident #2 had impaired cognitive function or impaired thought processes related to dementia and encephalopathy. Resident #2 had episodes of bowel and bladder incontinence. During an observation on 10/16/24 at 9:50 AM, CNA B assisted CNA C to provide incontinent care for Resident #2. CNA B cleaned Resident #2's front area and did not change her gloves before touching Resident #2's bed sheet, gown, draw sheet, and the cast on Resident #2's left leg. CNA B then cleaned her back area. She did not change her gloves or sanitize her hands until she had finished cleaning her back/bottom area. During an interview on 10/16/24 at 10:06 AM, CNA C said she should have changed her gloves after cleaning Resident #2's front area and before touching her sheet, cast, gown, and draw sheet. She said she was taught to change her gloves after a dirty procedure, but she did not do that. She said there was a risk of cross-contamination and infection to the resident. She said she was very nervous because someone was watching her. During an interview on 10/16/24 at 10:08 AM, CNA B said she did not notice that CNA C did not change her gloves after cleaning the front area of Resident #2. She said CNA C should have changed her gloves and cleaned her hands before touching anything. She said touching things with dirty gloves could cause cross-contamination and infection. During an interview on 10/16/24 at 1:29 PM, ADON A said she expected staff to change their gloves and wash or sanitize their hands after a dirty procedure such as incontinent care. She said staff should change their gloves during incontinent care after cleaning the front area and before going to the back area of a resident because cleaning the front area was considered a dirty procedure. She said there was a risk of infection when not changing gloves or washing hands appropriately. During an interview on 10/16/24 at 2:07 PM, the DON said staff should always change their gloves and wash their hands after a dirty procedure. She said CNA C should have changed her gloves and washed or sanitized her hands after cleaning the front area of Resident #2. The DON said CNA C should not have touched anything with her dirty gloves because it was a potential risk of infection to staff and residents. During an interview on 10/16/24 02:23 PM, the ADM said it was a definite no-no for staff to touch a resident or clean items with gloves that were considered dirty and was potentially an infection risk for residents and/or staff. She said CNAs were trained when to changed their gloves. Record review of an Incontinent Care for the Female Resident competency dated 8/28/24 indicated CNA C was competent to perform incontinent care. Record review of a Hand Washing Competency Checklist competency dated 8/28/24 indicated CNA C was competent to perform hand washing. (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 Resident #7s face sheet, dated 10/16/2024, indicated she was a [AGE] year-old female, who was readmitted to the facility on [DATE], with the diagnoses which included encephalopathy (a medical term used to describe a disease that affects brain structure or function. It causes altered mental state and confusion), vascular dementia (a general term describing problems with reasoning, planning, judgment, memory, and other thought processes caused by brain damage from impaired blood flow to your brain), bipolar (a mental health condition that causes extreme mood swings) and anxiety (intense, excessive and persistent worry and fear about everyday situations). Record review of Resident #7's quarterly MDS, dated [DATE], indicated Resident # 7 was rarely or never understood. Record review of Resident #7's care plan, undated indicated the resident had feeding tube related to weight loss due to not eating and dysphagia. Resident #7's care plan indicated she had a deep tissue injury that was resolved on 8/24/2023. During observation on 10/14/2024, Resident # 7 did not have enhanced barrier precautions sign posted on her door. During record review on 10/16/2024, Resident # 7 was on enhanced barrier precautions related to feeding tube and staff members should wear clean gown and gloves while performing high contact activities including dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs or toileting assistance and or caring for indwelling medical devices like central lines, catheters, feeding tubes, trach/ventilators. 3. Record review of Resident 37's face sheet, dated 10/15/2024, indicated he was a [AGE] year-old male, who was admitted to the facility on [DATE], with the diagnoses which included metabolic encephalopathy (a change in how your brain works due to an underlying condition that causes confusion, memory loss and loss of consciousness) , cystitis (infection or inflammation of the urinary bladder or any part of the urinary system caused by a type of bacteria called Escherichia coli (E. coli), sepsis (an infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever.) and dementia (a group of symptoms affecting memory, thinking and social abilities.) Record review of Resident #37's quarterly MDS, dated [DATE], indicated he had a BIMS of 11, which indicated he was moderately impaired cognitively. Resident #37's MDS indicated he had an indwelling catheter related to obstructive uropathy. Record review of Resident #37's undated care plan, indicated Resident # 37 had a focus on history of ESBL and urinary tract infections and foley catheter requiring him to be on enhanced barrier precautions with interventions as follows: o Enhanced Barrier Precautions R/T history of ESBL/UTI/Foley. Staff members will wear clean gown and gloves while performing high contact activities to included: Dressing, Bathing, Showering, transferring, providing hygiene, changing linens, changing briefs or toileting assistance, and/or caring for indwelling medical devices like central lines, catheters, feeding tubes, trach/ventilator. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Monitor/document/report to MD PRN for signs and symptoms of UTI: frequency, urgency, malaise, foul smelling urine, dysuria, fever, nausea and vomiting, flank pain, supra-pubic pain, hematuria, cloudy urine, altered mental status, loss of appetite, behavioral changes During an observation on 10/14/2024 at 9:50 AM, Resident # 37 was observed to have a sign posted on door indicating he was on enhanced barrier precautions. Resident # 37 did not have a storage box of personal protective equipment outside his door. Resident # 37 had an indwelling catheter. During an observation on 10/15/2024 at 12:40 PM, Resident # 37 said since when did you start wearing gowns with my wound care. During an interview on 10/17/2024 at 9:30 AM, the Treatment nurse said enhanced barrier precautions were new to her. She said she was required to wear PPE while performing care to residents with wounds, IV, G-tube, foley catheter, dialysis. She said personal protective equipment included gown and gloves and the surgical mask was not required. The Treatment nurse said the facility had multiple containers on the halls with PPE for staff. The Treatment nurse said she was not sure why Resident #37 said that was the first time for seeing staff wearing gowns. She said she always wore the gowns while performing treatment. The Treatment nurse said a staff member could spread infection if not wearing the proper PPE. The Treatment nurse said residents on enhanced barrier precautions should have a sign on their door and the Kardex should have the precautions for the CNA's to be aware when PPE is required. The Treatment nurse said she was not sure who was responsible making sure the signs were on the door or care planned. She said everyone was responsible for ensuring PPE was worn correctly. She said she had educated staff on proper PPE and report any staff not following protocol. 4.Record review of Resident #39' s face sheet, dated 10/16/2024, indicated he was a [AGE] year-old male, who was admitted to the facility on [DATE], with the diagnoses which included cerebral infarction, type II diabetes, GERD, Dysphagia, Cognitive communication disorder. Record review of Resident #39's quarterly MDS, dated [DATE], indicated he was rarely and never understood by others and no BIMS score was conducted. Resident #39's MDS indicated he had a diagnosis of malnutrition requiring feeding tube for nutrition. Record review of Resident #39's undated care plan indicated the resident required tube feeding related to dysphagia secondary to cerebral vascular accident with interventions in place as follows: Check for placement and gastric contents/residual volume per facility protocol and record. Hold feed if greater that 100 cc aspirated. Provide local care to G-tube site as ordered and monitor for signs and symptoms of infection. The resident is dependent with tube feeding and water flushes. See MD orders for current feeding orders. During an interview and observation on 10/15/2024 at 9:15 AM, LVN Y observed administering Resident # 39's medication as ordered through feeding tube only wearing gloves. LVN Y said she was not required to wear PPE while administering medication to Resident # 39's feeding tube. Resident # 39 did not have an enhanced barrier precaution sign on door or storage container with PPE available outside the door. (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 and interview on 10/17/202 at 4 8:52 AM, Resident # 39 and Resident #91 did not have a sign on the door indicating PPE or EBP cautions. Resident #91 said the nurses only use PPE when changing his PICC line dressing but not when they are admin IV therapy. Resident #91 said the nurse came in today wearing gowns. He said something must have been said. Resident #91 did not have a PPE storage box outside his door or a sign. During an interview on 10/17/2024 at 8:59 AM, LVN DD said she had administered IV antibiotics to Resident # 91 this morning. LVN DD said Resident # 91 was not on any precautions. LVN DD said Resident #91 should be on EBP precautions for IV therapy. LVN DD said residents who receive IV, feedings, foley care should be on EBP precautions. LVN DD said if a nurse assesses a resident and identifies a need for precautions, she said she would report to the DON to see if a resident should be placed on precautions. LVN DD said if a staff was not wearing proper PPE, they could spread infection to other residents. During an interview on 10/17/2024 at 9:50, ADON N said a residents should be on EBP with any wounds, open area, feeding tubes, catheters, and IV therapy. She said any staff member can place EBP precautions on the door. ADON N said PPE should be wearing (gown, gloves, head covers, face shields, or goggles, surgical mask unless covid). ADON N said the staff had been in-serviced on EBP. ADON N said EBP prevented spread of infection protecting the staff and residents. ADON N said the CNAs should check the Kardex with care plans to see if the resident was on EBP precautions and it should be care planned. ADON N said there would be storage carts with PPE at the resident door with signs posted indicating a resident required PPE before providing care. During an interview on 10/17/2024 at 11:30 AM, the Regional Nurse FF said the staff should don PPE for residents who had feeding tube, foley, IV, wound care and MDRO (Multidrug-resistant organism) and colonized. The Regional Nurse FF said PPE (gown, gloves, mask if droplet) should be worn when performing close contact care. She said cross contamination could occur if proper PPE was not worn. Regional Nurse FF said an EBP sign should be posted on the resident door if PPE should be worn while providing care. Regional Nurse FF said EBP should have an order and be on the care plan. She said she had in serviced the EBP and instructed facility staff to review charts and update the orders and proper care plan and PPE in place. She said a container should be outside each door. We can share a container if the rooms are close. During an interview on 10/17/2024 at 11:58 AM, the ADM said the infection control preventionist and the DON are responsible for ensuring the EBP precautions are posted, and care planned. The ADM said there was potential for cross contamination if PPE was not worn for a resident on EBP. She said she expected the nurses to be wearing PPE and stocked. The ADM said PPE containers can be between two rooms and she said she was not sure of what PPE was available in the facility. 6. Record review of a face sheet dated 10/15/24 indicated Resident #100 was a [AGE] year-old male who admitted on [DATE] with the diagnosis of cervical disc disorder with myelopathy, high cervical region (a condition that occurs when the spinal cord in the neck is compressed by a herniated disc or other issue) obstructive and reflux uropathy unspecified (conditions that damage the kidneys and upper urinary tract due to a blockage or other impediment in urine flow) and benign prostatic hyperplasia with lower urinary tract symptoms (needing to urinate frequently (during the day and night), a weak urine stream, and leaking or dribbling of urine). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a comprehensive care plan undated indicated Resident #100 was incontinent of bladder and was dependent for toileting. The care plan interventions for Resident #100 included position catheter bag and tubing below the level of the bladder. Check tubing for kinks and maintain the drainage bag off the floor. Enhanced barrier precautions related to foley catheter care. Staff members will wear clean gown and gloves while performing high contact activities to include: dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs or toileting assistance, and/or caring for indwelling medical devices like central lines, catheters, feeding tubes, trach/ventilator. Monitor/document for pain/discomfort due to catheter. Monitor/record/report to MD for signs and symptoms urinary tract infection: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Record review of comprehensive care plan undated indicated Resident #100 has a foley catheter and is at risk of multidrug-resistant organism and is on enhanced barrier precautions. The care plan included interventions for enhanced barrier precautions related to multidrug-resistant organism. Staff members will wear clean gown and gloves while performing high contact activities to include: dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs or toileting assistance, and/or caring for indwelling medical devices like central lines, catheters, feeding tubes, trach/ventilator. Monitor/document/report to MD as needed abnormal laboratory values (e.g., white blood cell count and differential, serum protein, serum albumin, and cultures). Record review of the Quarterly MDS dated [DATE] indicated Resident #100 understands and was understood. The MDS indicated Resident #100 had moderate cognitive impairment. The MDS in Section E-Behavior indicated he had not rejected care. The MDS in Section GG-Functional Abilities and Goals indicated Resident #100 was dependent with the helper providing all the effort for toileting. The MDS in Section H-Bladder and Bowel indicated Resident #100 was always incontinent of bowel and had a catheter for bladder. Record review of physician orders dated 5/2/24, enhanced barrier precautions related to foley catheter. Staff members will wear clean gown and gloves while performing high contact activities to include: dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs or toileting assistance, and/or caring for indwelling medical devices like central lines, catheters, feeding tubes, trach/ventilator. During an observation on 10/15/2024 at 11: 03 a.m., CNA BB and Restorative Aide CC performed catheter care on Resident #100 but did not don their PPE (disposable gown and gloves). There was not a PPE cart outside Resident #100's door, but there was an enhanced barrier precautions sign on the door. During an interview on 10/16/24 at 12:38 P.M., with LVN AA she said staff were supposed to wear PPE when duties were performed with residents on enhanced barrier precautions. She said depending on what the residents are on the enhanced barrier precautions can affect the residents differently. She said wearing PPE can protect the resident and staff from infections. During an interview on 10/16/24 at 12:42 P.M., with Treatment Nurse M she said when a resident was on enhanced barrier precautions staff were supposed to wear their PPE. She said residents with opened wounds, catheters and g-tubes were usually on enhanced barrier precaution residents. She said wearing PPE can protect the resident and staff from infections. (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 10/16/24 at 12:52 P.M., with CNA BB she said she knew she supposed to wear PPE during catheter care. She said the facility informed the staff a while back about enhanced barrier precautions protocol, but when she was doing the catheter care for Resident #100 she forgot. She said enhance barrier precautions was something new. She said CNAs used to only wear PPE when residents were on contact precautions. She said the facility want us to wear PPE to protect staff and the residents from infections. During an interview on 10/16/24 at 1:01 P.M., with Restorative Aide CC she said she knew she was supposed to wear PPE during catheter care. She said she did not remember the date, but remembered an in-service was done over enhanced barrier precautions. She said the enhanced barrier precautions and wearing PPE was to protect the residents and staff from infections. During an interview on 10/16/24 at 1:10 P.M., ADON N she said during any interaction with an enhanced barrier precaution resident CNA's and nurses should be wearing full PPE. She said enhanced barrier precautions resident usually had a catheter, a wound or a peg-tube. She said when staff were to perform catheter care they should be wearing full PPE. She said enhanced barrier precautions was to prevent the residents and staff as well from infections and germs. During an interview on 10/17/24 at 8:40 A.M., with LVN DD she said when CNA's or nurses are performing catheter care they should be washing their hands and wearing gloves along with PPE. She said staff should be wearing PPE for residents that are on enhanced barrier precautions and during catheter care. She said the negative affect on staff not wearing PPE for enhanced barrier precautions can cause infections and cross contamination. During an interview on 10/17/24 at 9:08 A.M., with CNA EE she said when she did catheter care she wore her PPE. She said wearing PPE for enhanced barrier precautions residents was to prevent the spread of infection. She said the negative affect of not wearing PPE on enhanced barrier precaution resident is cross contamination and a system failure. During an interview on 10/17/24 at 10:36 A.M., with ADON A she said I expect the CNAs to wear PPE when performing catheter care, because the residents are very acceptable to get infections. The negative effects of staff not following enhance barrier precautions guidelines, because residents can get infections from staff members and staff can get infections from residents. During an interview on 10/17/24 at 10:54 A.M., with Administrator she said she expected all staff to follow the enhancement barrier precautions guidelines. She said the negative affect on residents if staff do not follow enhanced barrier precautions is a potential for cross contamination. During an interview attempt on 10/17/24 at 12:12 P.M., the DON was called, but no answer. Record review of a facility's Infection Prevention and Control Program policy dated 10/24/2022 indicated .the ensure the facility establishes and maintains an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with Federal and State requirements. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675133	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Nursing Home	1100 N 4th St Longview, TX 75601

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility's Perineal Care policy dated revised 6/2020 indicated .purpose, to maintain cleanliness of the genital area, to reduce odor, and to prevent infection or skin breakdown policy . perineal care is provided as [NAME] of a resident's hygienic program a minimum of once daily and per resident need. Procedure .XII .after peri care, remove gloves. Wash hands or use alcohol-based hand sanitizer. Note: Do not touch anything with soiled gloves after procedure (i.e. curtain, side rails, clean linen, call bell, ect.). XIII . put on clean gloves. XIV .clean and return all equipment to its proper place. XV .place soiled linen in proper container. XVI .remove gloves. XVII .wash hands . Record review of a facility's Catheter-Care of policy revise date 6/2020 indicated . to prevent catheter-associated urinary tract infections while ensuring the residents are not given indwelling catheters unless medically necessary . III. Proper techniques for urinary catheter maintenance: use standard precautions, including the use of gloves and gown as appropriate, during any manipulation of the catheter or collecting system . Record review of a facility's Standard and Enhanced Precautions policy dated 4/1/2020 indicated .V. Enhanced Barrier Precautions . A. EBP should be used for any residents who meet the criteria, wherever they reside in the facility . the facility has discretion in using EBP for residents who do not have chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC . for residents whom EBP are indicated, EBP should be used when performing the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube and tracheostomy/ventilator. 48958 49019