STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675138	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inspiration Hills Rehabilitation Center	1939 Bandera Rd San Antonio, TX 78228

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47564 Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 5 (Residents #8, #15, #31, #62, and #77) of 18 residents reviewed for care plans. 1. The facility failed to develop care plan interventions for Resident #77's hospice services. 2. The facility failed to develop care planning related to Resident #15's ordered Wanderguard device and known tendencies to wander the facility in attempts to elope. The care planning for this resident also did not include monitoring for the resident's ordered, psychotropic medications. 3. The facility failed to develop care planning related to Resident #62's known tendency to wander the facility in attempts to elope as well as care planning monitoring the resident's specific medication regimen. 4. The facility failed to implement care plan interventions for Resident #8 and identify interventions for Resident #31 for contractures. These failures could place residents at risk of not receiving care and services related to their identified needs to maintain or reach their highest practicable physical, mental, and psychosocial wellbeing. The findings included: 1. Record review of Resident #77's Admission Record, dated [DATE], reflected a [AGE] year-old resident with an initial admitted [DATE] and diagnoses including parkinsonism (a clinical syndrome characterized by tremor, bradykinesia, rigidity, and postural instability), cerebral infarction (the pathologic process that results in an area of necrotic tissue in the brain), and type 2 diabetes. Further review revealed Resident #77 was on hospice and expired on [DATE]. Record review of Resident #77's Order Summary Report, dated [DATE], reflected, Resident has been admitted to Hospice Services with an order date of [DATE]. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #77's Comprehensive Person-Centered Care Plan, dated printed [DATE], did not reflect a focus area relating to Resident #77's hospice care, goals for the hospice care, or interventions/tasks related to hospice care. Interview on [DATE] at 1:55 PM, the DON stated that care plans should have hospice care included. The DON stated that the care plan including hospice should describe and include how to ensure a resident on hospice remains comfortable. 2. Review of Resident #15's face sheet reflected an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included psychotic disorder with delusions due to known physiological condition, vascular dementia (a progressive disorder that affects a person's cognition), mood disorder due to known physiological condition with depressive features, anorexia (lack of food intake related to low appetite), and history of falling. Review of the resident's quarterly MDS submitted on [DATE] reflected that a BIMS score was unable to be assessed as the resident was unable to be understood during interviews. A review of the resident's active orders on [DATE] revealed that the following orders: a. May have wander guard bracelet (order date [DATE]) b. Ativan gel 0.5mg/mL Gel, apply to wrist topically every 8 hours as needed for anxiety (order date [DATE]) c. Dronabinol capsule 2.5mg, give 1 capsule by mouth two times a day for appetite stimulant/store in locked narcotic box in refrigerator (order date [DATE]) d. Hydroxyzine Hcl Oral tablet 25 mg, give 1 tablet by mouth three times a day for anxiety (order date [DATE]) e. Sertraline HCl tablet 100mg, give 1 tablet by mouth one time a day for MDD [major depressive disorder] (order date [DATE]) f. Trazodone HCl oral tablet 50mg, give 1 tablet by mouth at bedtime for insomnia (order date [DATE]) Resident #15 was observed with Wanderguard bracelet in place on her right wrist on [DATE] at 11:50 AM. In an interview on [DATE] at 11:54 AM, LVN L was questioned about Resident #15's wandering tendencies. LVN L explained that Resident #15 has days where she is good and didn't wander and some nights where she was confused, tell staff that she needed to leave, and moved in her wheelchair to the exit. LVN L was then asked how the wander guard is monitored for placement on every shift. LVN L stated it is checked during skin assessments. A record review revealed 7 total documented skin assessments between the dates of [DATE] and [DATE]. None of the 7 assessments contained documentation describing the Wandergard device. Additionally, all 7 assessments included the statement resident does not have an external device. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the TAR on for [DATE] did not reveal any documentation of the wander guard device nor a task requesting staff to ensure placement. A record review of Resident #15's active care plan, date printed [DATE], also did not reveal any care planning related to the Wanderguard or safety measures related to wandering. The care plan contains planning for falls (last revised [DATE]) and cognitive loss/alteration (last revised [DATE]), but neither of these focus areas mention the Wanderguard or tendency to wander. It was also noted during record review of the care plan that the areas related to psychotropic medication failed to specifically state the medications, related diagnosis, and symptoms for monitoring. Examples included: a. I use psychotropic medications (specify medications) r/t [no additional text] date initiated: [DATE] b. Monitor/record occurrence of for target behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc.) and document per facility protocol. Date initiated [DATE] c. I use antidepressant medication (Specify medications) r/t [no additional text] date initiated [DATE] 2. Review of Resident #62's face sheet reflected a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included unspecified dementia, unspecified severity, with other behavioral disturbance; major depressive disorder, recurrent, unspecified; anxiety disorder; Alzheimer's disease (a progressive brain disorder that primary affects memory, thinking, and behavior); unsteadiness on feet; and unspecified abnormalities of gait and mobility. Resident #62 was observed on [DATE] at 9:40 AM resting in her wheelchair in the hallway near the nurse's station. CNA A was present at the time of observation and stated Resident #62 has a tendency to wander and needed continuous monitoring. Similar observations of Resident #62 at the nurse's station were also made on [DATE] at 2:57 PM and [DATE] at 4:26 PM. Record review on [DATE] of the resident's quarterly MDS submitted on [DATE] reflected that a BIMS score was unable to be assessed as the resident was unable to be understood during interviews. Section E of the MDS indicated that Resident #62 exhibited wandering behavior ,d+[DATE] days of the 2 week period included in the evaluation period. Record review of Resident #62's current care plan, date printed [DATE], did not reveal care planning related to wandering or the need for increased observation. Focus areas were noted for fall risk planning (last revised [DATE]) and cognitive loss (last revised [DATE]), but interventions did not include the interventions reflected in the aforementioned CNA interview (increased observation). Furthermore, review of the care plan reflected care areas and planning without specific details related to the resident. Examples included: a. I have (acute/chronic) pain r/t [no additional text] date initiated: [DATE] (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. I use anti-anxiety medications (Specify medications) r/t [no additional text] date initiated: [DATE] c. I use antidepressant medication (Specify medications) r/t [no additional text] date initiated [DATE] An interview was conducted on [DATE] at 1:55 PM with the Admin and the DON. They were asked how staff are expected to ensure placement of the wander guard. The DON responded that it is a task documented on the TAR. When told that Resident #15 does not have the task on the TAR, the Admin explained that the front door receptionist will often serve as an added alert to notify staff that a resident is attempting to leave the facility. The Admin also stated that the need for the wander guard was being re-evaluated during care plan meetings as the resident no longer exhibited wandering tendencies. The interview with LVN L describing the resident's continued wandering behavior was recounted to the Admin. The DON and the Admin were then asked if the wander guard should be included on the care plan, and they both stated yes, wander guard planning and wander risks should both be on the care plan. The DON and the Admin were also notified of the non-specificity of care plans reviewed by the survey team. The DON and Admin stated care plans should include medication names and symptoms specific to the resident. 4. Record review of Resident #8's face sheet revealed a [AGE] year-old female admitted [DATE] and readmitted [DATE]. Resident 38's diagnoses include paranoid schizophrenia (a type of brain disorder than can cause a person to experience paranoia), anxiety, MDD (a mental disorder characterized by persistent low mood, loss of interest), glaucoma (a group of eye diseases that can lead to damage of the optic nerve), osteoporosis (a condition that causes bones to become weak and brittle, making them more susceptible to fractures), dysphagia (difficulty swallowing), cerebral palsy (a group of disorders that affect movement and muscle tone or posture), dementia (a group of symptoms affecting memory, thinking and social abilities). Record review of Resident #8's Quarterly MDS dated [DATE], of Section C revealed BIMS Score 99 indicating severe cognitive impairment. Section GG revealed impairment to one side upper extremity and bilateral (both left and right side) impairment of lower extremity and total dependence in all areas of ADL concern. Section O revealed the resident was not receiving a Restorative Nursing Program and did not indicate use of splint or brace assistance. Record review of Resident #8's OT Evaluation & Plan of Treatment dated [DATE] revealed the resident had contracture of the muscle, multiple sites to include left hand flexion contracture of all digits with pain upon attempting passive stretch. Record review of Resident #8's physician's order dated [DATE] revealed Patient may wear Left palm protector to patient tolerance, and order dated [DATE] Patient may wear left hand palm protector. Record review of Resident #8's care plan focus problem dated [DATE], revised [DATE] revealed impaired physical mobility related to contractures to bilateral lower extremities, left upper extremity, let hand, right ankle secondary to Cerebral Palsy. Interventions/Tasks revealed splints may be applied per physicians' orders dated [DATE]. Focus problem dated [DATE] revealed resident will wear left palm protector. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's Restorative Nursing Program Communication Form dated [DATE] revealed application of palm protector to left hand 5 times per week. In an interview with CNA B on [DATE] at 10:29 a.m. revealed she does not put anything in Resident #8's hand to prevent further contracture. In an interview with CNA J on [DATE] at 10:29 a.m. revealed she will clean inside Resident #8's hand with a wipe but does not put anything in hand to prevent further contracture. In an interview with CNA H, Rehabilitation Technician on [DATE] at 2:14 p.m. revealed he applies left hand palm protector to Resident #8, Monday-Friday, 4 hours / day. CNA H stated he applied left hand palm protector for Resident #8 after lunch. Stated he applied palm protector on [DATE]. Interview with CNA G on [DATE] at 8:47 a.m. revealed she will utilize positioning pillows under Resident #8's lower back or side to help relieve pressure but does not put anything on her hand to prevent contracture. In an interview with DON on [DATE] at 10:12 a.m. revealed therapy identifies contractures and puts interventions in place. DON stated she will review with DOR to see if nursing should monitor. In an interview with DOR I on [DATE] at 10:46 a. m. revealed the RNP for Resident #8 was initiated on [DATE] and includes application of palm protector to left hand. Record review of Resident #31's face sheet revealed a [AGE] year-old male admitted [DATE] and readmitted [DATE]. Diagnoses include apraxia (difficulty with movements even when a person has the ability to do them) follow intracranial hemorrhage (bleeding in the brain), Hypertension, anemia (a condition in which the blood does not have enough healthy red blood cells to carry oxygen all through the body), CVA (Cerebrovascular accident or stroke, damage to the brain from interruption of its blood supply), seizure disorder, psychotic disorder with delusions, mood disorder with depressive features, anxiety. Record review of Resident #31's Quarterly MDS dated [DATE] of Section C revealed resident unable to complete cognitive testing indicating severe cognitive deficit. Section GG revealed impairment to upper and lower extremity and resident was dependent in toileting, bathing, UB/LB dressing, required maximum assistance in bed mobility and set-up assistance with ambulation. Review of Resident #31's Quarterly MDS dated [DATE] of Section O, revealed resident was not receiving a Restorative Nursing Program for range of motion or splint/brace assistance. Record review of Resident #31's Restorative Nursing Program revealed no Occupational Therapy Restorative Nursing Program was implemented. Record review of Resident #31's physician's orders printed [DATE] revealed no orders in place for contracture management / prevention device or monitoring. Record review of Resident #31's Care Plan printed [DATE] revealed impaired physical mobility related to contracture(s) to left arm .secondary to CVA with interventions to include PROM and AROM joint exercises to prevent contractures, stimulate circulation and build endurance. In observation of Resident #31 on [DATE] at 10:32 a.m., [DATE] at 8:20 a.m., [DATE] at 12:20 p.m. revealed resident right hand contracture with no assistive device in place. In an interview with DOR I on [DATE] at 10:46 a.m., DOR stated she completed spot checks to ensure the RNP programs were implemented and she was responsible for ensuring RNP program were initiated and on-going. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an iterview with the DON on [DATE] at 10:12 a.m. revealed that not utilizing palm protector for Resident #8 could increase contractures. In an interview on [DATE] at 10:24 a.m. the DON revealed that request for contracture management device for Resident #31 had been requested thru Medicaid and denied. The DON stated she advised the DOR to identify the appropriate device for Resident #31 and purchase / implement the device for the resident. DON stated that failure to address contractures could lead to increase of contractures, pain concerns and potential alteration in skin integrity. Review of Contracture Prevention Policy and Procedure, revised [DATE], revealed a 1. Contracture Risk Assessment will be performed . to determine a residents risk score for having contractures, 3. Plan of care established by physical therapy or nursing .and physician's orders obtained, 9. Contracture prevention programs may include .A. positioning .E. splints, F. prevented by exercise. Record review of Facility Policy titled, Care Planning - Interdisciplinary Team, dated reviewed [DATE], reflected, Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. 50531 51512

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512 Based on observations, interviews, and record reviews, the facility failed to revise the comprehensive care plan after each assessment for 1 (Resident #64) out of 8 residents reviewed for care planning. The facility failed to revise the care plan after investigating a fall sustained by Resident #64. The facility investigation included planned interventions that were not included care plan revision. This failure could result in the resident not receiving planned care or additional falls. The findings included: Review of Resident #64's face sheet, dated 4/04/2025, reflected a [AGE] year-old female with an initial admitted [DATE]. Relevant diagnoses included muscle wasting and atrophy, other lack of coordination, unspecified dementia (a progressive disorder that affects a person's thinking skills), unsteadiness on feet, weakness, and muscle weakness. Review of the quarterly MDS for Resident #64 submitted on 3/11/2025 revealed a BIMS score of 04, indicating severe cognitive impairment . On 2/28/2025, the facility self-reported an incident regarding a fall sustained by Resident #64. Per the provider report, the resident fell from the bed, causing a facial injury. An initial x-ray indicated a possible right-sided orbital fracture (the bone surrounding the eye area), and the facility transferred the resident to the hospital for treatment. The hospital determined that the resident did not have a fracture through additional diagnostic testing, and the resident returned to the facility. The facility reported an investigation process that included the planned interventions of bed was lowered, call light w/in [within] reach, fall mats. Resident #64 was interviewed on 4/02/2025 at 08:20 AM. The resident recalled the fall and stated she was trying to reach an object that had fallen from the bed at the time of the fall. The resident denied concerns with care provided by the facility. At the time of the interview, the resident was observed in bed with the call light within her reach, and the bed was lowered. Fall mats were not observed to be present next to the bed. Resident #64 was again observed on 4/03/2025 at 1:02 PM. The resident was in bed, the bed was lowered, and the call light was in the bed near the resident. Fall mats were not present next to the bed. Resident #64 was observed a third time on 4/04/2025 at 7:40 AM. At that time, the resident was asleep in the low-positioned bed. The location of the call light could not be determined due to the position of the resident and the blankets covering her. Fall mats were not present next to the bed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #64's current care plan, date printed 4/03/2025, reflected an update signifying the fall occurrence in the focus area of I am at risk for falls r/t [related to] NEED FOR ASSISTANCE WITH PERSONAL CARE, MUSCLE WASTING AND ATROPHY, NOT ELSEWHERE CLASSIFIED MULTIPLE SITES [sic]. The interventions/tasks associated with the focus area showed most recent updates on 8/08/2024. Fall mats were not listed as an associated intervention, nor was bed in lowered position. An interview was conducted with the DON on 4/4/2025 at 1:55 PM. The DON was asked to review the investigation process for the fall incident for Resident #64. The DON stated staff were educated to make sure that beds were low, to make sure that call lights were within reach, residents should be wearing non-skin socks, and decluttering rooms. The DON also reported changes were made because of the investigation, and she reported instituting a fall mat when she was in bed and ensuring that the resident had an electric bed that could be easily lowered. The DON was then asked if the care was updated to reflect these changes, and the DON reported that yes, it should be updated .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47564 Based on interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 3 of 8 residents (Resident #9, #28, and #40) reviewed for personal hygiene. 1. The facility failed to provide Resident #9, 8 of 13 scheduled showers between 03/04/2025 and 04/03/2025. 2. The facility failed to provide Resident #28, 8 of 13 scheduled showers between 03/04/2025 and 04/03/2025. 3. The facility failed to provide Resident #40, 4 of 14 scheduled showers between 03/04/2025 and 04/03/2025. This failure could place residents who require assistance from staff for personal hygiene at risk of not receiving care and services contributing to overall poor hygiene, risk of experiencing a diminished quality of life, and possible skin infections. The findings included: 1. Record review of Resident #9's Admission Record, dated 04/04/2025, reflected a [AGE] year-old resident with an initial admitted [DATE]. Resident #9 had diagnoses that included dysphagia (difficulty swallowing), cerebral infarction (the pathologic process that results in an area of necrotic (dead) tissue in the brain) and need for assistance with personal care. Record review of Resident #9's Quarterly MDS Assessment, signed and completed on 02/03/2025, reflected Resident #9 had a BIMS score of 4, indicating the resident was severely cognitively impaired. Resident #9's MDS assessment indicated that Resident #9 was Dependent (helper does ALL of the effort) for showering/bathing. Record review of Resident #9's Comprehensive Person-Centered Care Plan, undated, reflected I have an ADL Self Care Performance Deficit Cerebral Infarction, abnormalities in gait and mobility, with interventions, I require (X1) staff participation with bathing. Resident #9's Comprehensive Person-Centered Care Plan does not describe behaviors of refusals of showers, or refusals of any other type of care. Record review of Resident #9's tasks in his electronic health record reflected that the resident's shower days were Monday, Wednesday, and Friday in the evening. Further review revealed Resident #9 did not receive 8 of the 13 showers scheduled. Between 03/04/2025 and 04/03/2025, Resident #9 received showers on the following dates: 03/08/2025, 03/22/2025, 03/25/2025, 03/29/2025, and 04/01/2025. There were no other showers documented on the resident's electronic health record. An interview was attempted on 04/04/2025 at 10:47 AM with Resident #9, who was unable to answer questions relating to their showers due to their cognitive status. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #28's Admission Record, dated 04/04/2025, reflected a [AGE] year-old resident with an initial admitted [DATE]. Resident #28 had diagnosis of cerebral infarction (the pathological process that results in an area of necrotic tissue in the brain), contractures (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of the right hand, right thigh, right knee, left knee, left shoulder, left elbow, and multiple other sites. Record review of Resident #28's Quarterly MDS, signed and completed on 02/14/2025, reflected Resident #28 had a BIMS score of 0, indicating the resident was severely cognitively impaired. Resident #28's MDS assessment indicated that Resident #28 was Dependent (helper does ALL of the effort) for showering/bathing. Record review of Resident #28's Comprehensive Person-Centered Care Plan, undated, reflected, I have an ADL Self Care Performance Deficit r/t chronic pain syndrome, dyspnea/resp. abnormalities, seizure d/o, muscle weakness, lack of cord. And contractures to BLE, with interventions, I require extensive total assistance from staff participation with bathing. Resident #28's Comprehensive Person-Centered Care Plan does not describe behaviors of refusals of showers, or refusals of any other type of care. Record review of Resident #28's tasks in her electronic health record reflected that the resident's shower days were Monday, Wednesday, and Friday in the evening. Further review revealed Resident #28 did not receive 8 of the 13 showers scheduled. Between 03/04/2025 and 04/03/2025, Resident #28 received showers on the following dates: 03/08/2025, 03/15/2025, 03/17/2025, 03/27/2025, and 04/02/2025. There were no other showers documented on the resident's electronic health record. An interview was attempted on 04/04/2025 at 11:14 AM with Resident #28, who was unable to answer questions relating to their showers due to their cognitive status. 3. Record review of Resident #40's Admission Record, dated 04/04/2025, reflected a [AGE] year-old resident with an initial admitted [DATE]. Resident #40 had diagnoses that included dementia (a group of thinking and social symptoms that interferes with daily functioning), transient cerebral ischemic attack (a brief stroke-like attack that is caused by a brief blockage of blood flow to the brain), and need for assistance with personal care. Record review of Resident #40's Quarterly MDS Assessment, signed and completed on 03/22/2025, reflected Resident #40 had a BIMS score of 4, indicating the resident was severely cognitively impaired. Resident #40's MDS assessment indicated that Resident #40 was Dependent (helper does ALL of the effort) for showering/bathing. Record review of Resident #40's Comprehensive Person-Centered Care Plan, undated, reflected I have an ADL Self Care Performance Deficit r/t OTHER LACK OF COORDINATION, with interventions, I require (X) staff participation with bathing. Resident #40's Comprehensive Person-Centered Care Plan does not describe behaviors of refusals of showers, or refusals of any other type of care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #40's tasks in his electronic health record reflected that the resident's shower days were Tuesday, Thursday, and Saturday in the evening. Further review revealed Resident #40 did not receive 4 of the 14 showers scheduled. Between 03/04/2025 and 04/03/2025, Resident #40 received showers on the following dates: 03/07/2025, 03/17/2025, 03/19/2025, 03/21/2025, 03/24/2025, 03/26/2025, 03/28/2025, 04/02/2025, and 04/03/2025. There were no other showers documented on the resident's electronic health record. An interview was attempted on 04/04/2025 at 11:20 AM with Resident #28, who was unable to answer questions relating to their showers due to their cognitive status. Interview on 04/04/2025 at 12:23 PM, CNA M stated he works any shift at the facility that was available for him to pick up, and that he was able to see when each resident showers by going into their task schedule in PCC, the facilities electronic health record. CNA M stated there was also a paper schedule at the nurse's station. CNA M stated that if any CNA is not able to bathe a scheduled resident on their shift, they will discuss it with the nurse and typically it is assigned to the next shift to complete. Interview on 04/04/2025 at 12:26 PM, the ADON stated that typically if a CNA does not have time to complete any assigned and scheduled showers on their shift, it should be communicated to the nurse and a progress note would be written. Interview on 04/04/2025 at 1:59 PM with the ADM and DON, the DON stated she was not aware residents were not receiving showers as scheduled, and that while it was unlikely the residents did not receive a shower, they did not have documentation apart from what was in each residents Electronic Health Record. The DON stated her expectation for if a resident refuses a shower is for it to be documented by the CNA and Nurse. The DON stated the risk to residents could include breakdown in skin integrity. The DON stated that all residents who were listed as not having a shower have a long history of refusals which is care planned and documented. The ADM stated that in their morning rounds that are completed on residents as administration staff, they sometimes have to tell nursing staff that a resident needs to be showered. Record review of facility policy, dated reviewed December 2024, titled, Shower/Tub Bath reflected The following information should be recorded on the resident's ADL record and/or in the resident's medical record: 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inspiration Hills Rehabilitation Center	1939 Bandera Rd San Antonio, TX 78228

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512 Based on observation , interview and record review, the facility failed to ensure that residents receive proper treatment to maintain vision abilities and assist the resident in making appointments for 1 (Resident #18) of 6 residents reviewed for communication and sensory problems. The facility failed to reschedule an ophthalmology appointment for Resident #18 to evaluate and treat the resident's medical condition affecting her eyesight. This failure could lead to diminished or loss of vision and decreased quality of life. The findings included : Record review of Resident #18's face sheet reflected she was an [AGE] year-old female originally admitted on [DATE]. Relevant diagnoses included type 2 diabetes mellitus without complication (a medical disorder that causes difficulty in regulating blood sugar levels), dementia (a progressive disorder that impairs thought processes such as memory, thinking, and reasoning), and cognitive social or emotional deficit following unspecified cerebrovascular disease. A review of the resident's Quarterly MDS submitted 11/11/2024 reflected a BIMS score of 08, indicating moderately impaired cognition . In an interview and observation conducted on 4/01/2025 at 3:25 PM, Resident #18 reported difficulty participating in facility hosted activities due to vision problems. The resident was wearing glasses at the time of interview and stated that even with the glasses, she had difficulty seeing. She was unsure if she had seen an optometrist or if she had any diagnoses related to her vision other than requiring glasses . A record review of Resident #18's current orders indicated a standing order for ophthalmology to evaluate and treat, effective 2/18/2025. A scanned photocopy of an evaluation by an optometrist dated 10/03/2024 was located within the medical record . This document indicated that Resident #18 complained of blurred vision to both eyes and watery eyes. The optometrist included a diagnosis of cataracts to both eyes as well as prolif diab rtnop with macular edema [sic] (proliferative diabetic retinopathy with macular edema, or damage to the nerves of the eye from diabetes causing vision loss) to both eyes. The note from the optometrist indicates refer to an ophthalmologist for retinal evaluation and cataract evaluation. A list of referrals for ophthalmology physicians was included with instructions to schedule an appointment. Further record review of Resident #18's medical record revealed a progress note documented by LVN L on 9/25/2024 that reflected: (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident was sent to eye doctor appointment with arrangements for [family member] to go meet her at her appointment. The family member was reminded of this appointment and out it on her phone on her last visit to see resident. Eye dr office called back stating the family member did not show up and they will have to reschedule appointment. This nurse called RP to inform her of the no show and she stated she didn't know if her car would be working and couldn't go. This nurse told her eye dr will reschedule and call her back with new appointment [sic]. No additional progress notes or scanned documents regarding the rescheduled appointment were located within the entirety of the electronic medical record. In an interview with LSW K on 4/04/2025 at 09:28 AM, LSW K recalled the need for an appointment relating to vision services for Resident #18. Written documentation was in LSW K's files reflecting the ophthalmology appointment on 9/25/2024. LSW K was unaware that the resident was not able to be evaluated at theis appointment and the need for a rescheduled appointment. LSW K stated that she would research the issue further and discuss again when she had obtained more information. In an interview on 4/04/2025 at 11:20 with LVN L recalled the unsuccessful ophthalmology appointment and was unsure if the appointment had been rescheduled . LVN L felt that Resident #18's vision had been declining and that it was affecting her (the resident's) ability to do things. LVN L stated she was going to call the physician's office to see if the appointment had been rescheduled and would schedule an appointment if one had not been created. On 4/04/2025 at 01:02 PM, LVN L provided an update to survey team regarding the opthalmology appointment appointment. LVN L reported that after speaking with surveyor, she called the opthalmology office and scheduled a new appointment for the end of April. She had arranged for facility staff to accompany the resident to ensure that she was evaluated successfully. Documentation from the ophthalmology office was provided by LVN L on 4/04/2025 at 2:00 PM. Review of the document reflected the missed appointment on 9/25/2024 with rationale Patient was note seen due to family member not present for exam to assist the patient. Transport was called to pick-up.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50531 Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for two of two (Resident #8 & Resident #31) residents reviewed for range of motion. The facility failed to ensure Resident #8's left palm protector (medical device used to treat hand contractures, permanent tightening of the muscles, tendons, skin and surrounding tissues that causes stiffness, placed in the hands to help improve range of motion) was in place to her left hand. The facility failed to identify a medical device for Resident #31's right hand to help improve range of motion. The failures could place residents at increased risk for decrease in mobility and range of motion and contribute to worsening of contractures. Findings included: Record review of Resident #8's face sheet revealed a [AGE] year-old female admitted [DATE] and readmitted [DATE]. Resident #8's diagnoses include paranoid schizophrenia (a type of brain disorder than can cause a person to experience paranoia), anxiety, MDD (a mental disorder characterized by persistent low mood, loss of interest), glaucoma (a group of eye diseases that can lead to damage of the optic nerve), osteoporosis (a condition that causes bones to become weak and brittle, making them more susceptible to fractures), dysphagia (difficulty swallowing), cerebral palsy (a group of disorders that affect movement and muscle tone or posture), dementia (a group of symptoms affecting memory, thinking and social abilities). Record review of Resident #8's Quarterly MDS dated [DATE] Section C revealed BIMS Score 99 indicating severe cognitive impairment. Section GG revealed impairment to one side upper extremity and bilateral (left and right side) impairment of lower extremity and total dependence in all areas of ADL concern. Section O revealed resident is not receiving a Restorative Nursing Program and did not indicate use of splint or brace assistance. Record review of Resident #8's OT Evaluation & Plan of Treatment dated 1/14/25 revealed the resident had contracture of muscle, multiple sites to include left hand flexion contracture of all digits with pain upon attempting passive stretch. Record review of Resident #8's physician's order dated 3/22/25 revealed Patient may wear Left palm protector to patient tolerance, and order dated 4/2/25 Patient may wear left hand palm protector. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #8's care plan focus problem dated 1/10/25, revised 1/24/25 revealed impaired physical mobility related to contractures to bilateral lower extremities, left upper extremity, let hand, right ankle secondary to Cerebral Palsy. Interventions/Tasks revealed splints may be applied per physicians' orders dated 1/10/25. Focus problem dated 3/14/25 revealed resident will wear left palm protector. Record review of Resident #8's Restorative Nursing Program Communication Form dated 3/26/25 revealed application of palm protector to left hand 5 times per week. In observation of Resident #8 on 4/1/25 at 11:40 a.m., 4/2/25 at 2:30 p.m., 4/3/25 at 10:11 a.m., 4/3/25 at 2:23 p.m., 4/4/25 at 8:49 a.m., and 4/4/25 at 1:48 p.m. revealed no palm protector to left hand. Interview with CNA B on 4/3/25 at 10:29 a.m. revealed she but does not put anything in Resident #8's hand to prevent further contracture. Interview with CNA J on 4/3/25 at 10:29 a.m. revealed she will clean inside Resident #8's hand with a wipe but does not put anything in hand to prevent further contracture. Interview with CNA H, Rehabilitation Technician on 4/4/25 at 2:14 p.m. revealed he applies left hand palm protector to Resident #8, Monday-Friday, 4 hours / day. CNA H stated he applied left hand palm protector for Resident #8 after lunch. CNA H stated he applied palm protector on 4/2/25. In an interview with CNA G on 4/4/25 at 8:47 a.m., CNA G revealed she will utilize positioning pillows under Resident #8's lower back or side to help relieve pressure but does not put anything on her hand to prevent contracture. In an interview with DON on 4/4/25 at 10:12 a.m., the DON revealed therapy identifies contractures and puts interventions in place. DON stated she will review with the DOR to see if nursing should monitor. In an iterview with DOR I on 4/4/25 at 10:46 a.m., DOR I revealed the RNP for Resident #8 was initiated on 3/26/25 and includes application of palm protector to left hand. Record review of Resident #31's face sheet revealed a [AGE] year-old male admitted [DATE] and readmitted [DATE]. Resident #31's diagnoses include apraxia (difficulty with movements even when a person has the ability to do them) follow intracranial hemorrhage (brain bleeding), Hypertension, anemia (a condition in which the blood does not have enough healthy red blood cells to carry oxygen all through the body), CVA (Cerebovascular accident or stroke, damage to the brain from interruption of its blood supply), seizure disorder, psychotic disorder with delusions, mood disorder with depressive features, anxiety. Record review of Resident #31's Quarterly MDS dated [DATE] of Section C revealed resident unable to complete cognitive testing indicating severe cognitive deficit. Record review of Resident #31's Quarterly MDS dated [DATE] of Section GG revealed impairment to upper and lower extremity and resident was dependent in toileting, bathing, UB/LB dressing, required maximum assistance in bed mobility and set-up assistance with ambulation. Record review of Quarterly MDS dated [DATE] of Section O, revealed resident was not receiving a Restorative Nursing Program for range of motion or splint/brace assistance. Record review of Resident #31's Restprative Restorative Nursing Program revealed no Occupation Therapy program implemented for contracture management. Record review of Resident #31's physician's orders printed 4/3/25 revealed no orders in place for contracture management / prevention device or monitoring. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #31's Care Plan printed 4/3/25 revealed impaired physical mobility related to contracture(s) to left arm .secondary to CVA with interventions to include PROM (passive range of motion)and AROM (active range of motion) joint exercises to prevent contractures, stimulate circulation and build endurance. In an observation of Resident #31 on 4/1/25 at 10:32 a.m., 4/3/25 at 8:20 a.m., 4/3/25 at 12:20 p.m. revealed the resident's right hand contracture with no assistive device in place. In an iterview with DOR I on 4/4/25 at 10:46 a.m. revealed she will complete spot checks to ensure RNP programs are implemented and she is responsible for ensuring RNP program is initiated and on-going. In an iterview 4/4/25 at 10:12 a.m. with the DON revealed that not utilizing a palm protector for Resident #8 could increase contractures. In an iterview on 4/4/25 at 10:24 a.m. with the DON revealed that request for contracture management device for Resident #31 had been requested thru Medicaid and denied. The DON stated she advised the DOR to identify the appropriate device for Resident #31 and purchase / implement device for the resident. The DON stated that failure to address contractures could lead to increase of contractures, pain concerns and potential alteration in skin integrity. Review of Contracture Prevention Policy and Procedure, revised 7/5/24, revealed a 1. Contracture Risk Assessment will be performed . to determine a residents' risk score for having contractures, 3. Plan of care established by physical therapy or nursing .and physician's orders obtained, 9. Contracture prevention programs may include .A. positioning .E. splints, F. prevented by exercise.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512 Based on observations, interviews, and records review, the facility failed to ensure that the resident environment remained as free of accident hazards as is possible and each resident receives adequate assistance devices to prevent accidents for 3 of 3 resident halls reviewed for infection control and 1 resident (Resident #64) of 3 residents reviewed for accidents and hazards. 1. The facility failed to store hand sanitizer in a way that prevented residents to access the hazardous substance without supervision. 2.The facility failed to ensure that fall mats were in place for Resident #64. These failures could place resident at risk for injuries due to not having adequate supervision or devices. 1.Observation and interview during the initial facility tour on 4/01/2025 beginning at 09:49 AM, it was observed that hand sanitizer dispensers were not present outside of resident rooms in Hall B or within the PPE cart located in front of room B7. Surveyors on Halls A and C confirmed that dispensers were not present on their respective halls at this time. LVN L was present during this observation and asked about the availability of hand sanitizer. LVN L stated hand sanitizer was kept at the nurse's station and provided a bottle for surveyor use. LVN L was overheard notifying the DON that the surveyor was asking about hand sanitizer. At 10:21 , full bottles of hand sanitizer were noted to be present on top of the EBP carts in Hall B. The DON was present during this observation stocking hand sanitizer. Surveyors on Halls and C confirmed similar observations at this time. An interview was conducted with the DON and the Admin on 4/04/2025 at 1:55 PM. When asked about the availability of hand sanitizer, the DON and the Admin both confirmed that storing individual bottles of hand sanitizer on top of the EBP carts for staff and visitor use is the usual storage method for the facility. The Admin clarified that on Hall C, staff will hide the sanitizer within the EBP drawers because there are several residents residing in the hall that have altered cognition and will steal supplies. As the EBP carts at the facility consisted of unlocked, plastic drawers, the Admin was asked how residents who are at risk for misusing the substance are kept safe from obtaining the hand sanitizer. The Admin stated that staff will monitor the residents and act as physical barriers between the hand sanitizers and the drawers, if necessary. At the conclusion of the interview, the facility MSDS book was reviewed to ensure that the hand sanitizer was included, in the event of ingestion. The information was not contained within the book. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.Review of Resident #64's face sheet, dated 4/04/2025, reflected a [AGE] year-old female with an initial admitted [DATE]. Relevant diagnoses included muscle wasting and atrophy (the loss and breakdown of muscle), other lack of coordination, unspecified dementia (a progressive disorder that affects a person's thinking skills), unsteadiness on feet, weakness, and muscle weakness. Review of the quarterly MDS submitted on 3/11/2025 reported a BIMS score of 04, indicating severe cognitive impairment. On 2/28/2025, the facility self-reported an incident regarding a fall sustained by Resident #64. P ER the provider report, reviewed 3/31/2025, the resident fell from bed, causing a facial injury. An initial x-ray indicated a possible right-sided orbital fracture (the bone surrounding the eye area), and the facility transferred the resident to the hospital for treatment. The hospital determined that the resident did not have a fracture through additional diagnostic testing, and the resident returned to the facility. The facility reported an investigation process that included the planned interventions of bed was lowered, call light w/in [within] reach, fall mats. The resident was interviewed on 4/02/2025 at 08:20 AM. The resident recalled the fall and stated she was trying to reach an object that had fallen from the bed at the time of the fall. The resident denied concerns with care provided by the facility. At this time, the resident was observed in bed with the call light within her reach, and the bed was lowered. Fall mats were not observed to be present next to the bed. The resident was again observed on 4/03/2025 at 1:02 PM. The resident was in bed, the bed was lowered, and the call light was in the bed near the resident. Fall mats were not present next to the bed. The resident was observed a third time on 4/04/2025 at 7:40 AM. At that time, the resident was asleep in the low-positioned bed. The location of the call light could not be determined due to the position of the resident and the blankets covering her. Fall mats were not present next to the bed. An interview was conducted with the DON on 4/4/2025 at 1:55 PM. The DON was asked to review the investigation process for the fall incident for Resident #64. The DON stated staff was educated to make sure that beds are low, to make sure that call lights are within reach, residents should be wearing non-skin socks, and decluttering rooms. The DON also reported changes were made because of the investigation, and she reported instituting a fall mat when she was in bed and ensuring that the resident had an electric bed that could be easily lowered.

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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** 51512 Based on observations, interview, and record review, the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 8.11% based on 3 errors out of 37 opportunities, which involved two residents (Resident #22 and Resident #3) of four reviewed for medication administration. 1. CMA B administered Fingolimod HCl oral capsule 0.5mg 1 capsule for personality disorder to Resident #2 at 09:34 AM that was ordered for administration at 08:00 AM. CMA B administered Sertraline HCl oral tablet 25mg 1 tablet for anxiety to Resident #22 at 09:34 AM that was ordered for administration at 08:00 AM. 2. CMA B documented administration of medication Cholecalciferol Tablet 1000 units 1 tab for vitamin deficiency during medication administration at 09:49 AM. However, this medication was not observed as administered at this time . These failures could place residents at risk of not receiving the intended therapeutic benefits of their medications or not receiving them as prescribed, per physician orders. The findings included: 1. Review of Resident #2's face sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included anxiety, schizoaffective bipolar disorder (mental health condition that combines symptoms of schizophrenia- a condition causing difficulty distinguishing reality from their own thoughts- and bipolar disorder- a condition characterized by periods of extreme depression and elevated mood). Record review of Resident #2's electronic medical record reflected physician orders for the following medications: 1. Fingolimod HCl oral capsule 0.5mg 1 capsule, give 1 capsule by mouth one time a day for personality disorder. Start date 9/24/2024 with scheduled administration time of 08:00 AM. 2. Sertraline HCl oral tablet 25mg, give one tablet by mouth one time a day for anxiety. Start date 9/24/2024 with scheduled administration time of 08:00 AM. In an observation on 4/03/2025 at 09:34, CMA B was observed preparing ten total medications for administration to Resident #2, including the above-named medications. Resident #2 accepted the morning medications without complication. A record review of Resident #2's MAR after the observation reflected that two of the ten medications were scheduled for 08:00 AM administration, thus equating to the medications being administered 1 hour and 34 minutes late. The remaining eight medications that were administered had scheduled 09:00 AM administration times. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 4/02/2025 at 07:15 AM, the DON explained that routine morning medications are timed for administration at 09:00 AM due to the working schedules of the CMAs, which are 09:00 AM to 06:00 PM. She also explained that the physician's have agreed to this practice and that any medications with scheduled administration times outside of this window will be administered as ordered, by the nursing staff. In an interview on 4/03/2025 at 09:34 AM, CMA B explained that there are two medication aides at the facility assigned to administer oral medications for 1 hall and half of another hall, which can occasionally cause a delay in medication administration. In an interview on 4/04/2025 at 1:55 PM, the Admin was asked about the morning medication administration, as the CMAs do not begin work hours until the medications are already due. The Admin reported an expectation of nursing staff assisting if there are anticipated delays. She also explained that the CMAs administer medications to 1 hallway and an additional half hallway due to budgetary constraints. 2. Review of Resident #3's face sheet reflected he was an [AGE] year-old male admitted on [DATE] with relevant diagnoses of vitamin deficiency, type 2 diabetes mellitus (a disorder requiring medication to regulate blood sugar levels), and moderate intellectual disabilities. Review of Resident #3's reflected an order for the medication Cholecalciferol tablet 1000 units, give 1 tablet by mouth one a day for vitamin deficiency with start date of 3/21/2024 with a scheduled administration time of 09:00 AM. In an observation on 4/03/2025, CMA B was observed preparing six total medications for administration. During the observation, CMA B removed each package of medication from the locked cart drawers individually prior to removing the individual tablet(s)/capsules(s) for surveyor review. After reviewing all medications, the CMA then removed the appropriate tablet(s)/capsules(s) from the package and then returned the packages to the locked drawers. The medications were documented by the surveyor as they were presented. After preparation and review, resident #3 accepted the medications without complication. Immediately following the medication administration observation, Resident #3's MAR was reviewed, and it was discovered that the medication Cholecalciferol tablet 1000 units (1 tablet) was documented as administered. However, this medication was not one of the six medications that were reviewed with CMA B and observed as administered. There was no additional notation on this medication. Record review of facility policy Medication Administration General Guidelines dated 12/24 item #2. reflected if a dose of regularly scheduled is withheld, refused, or given at other than the scheduled time . the eMAR for that dosage administration is notated with the appropriate code and an explanatory note is entered in the resident's Progress Notes. Record review of facility policy titled Medication Administration General Guidelines dated 12/24 reflected item #14. medications are administered within 60 minutes of scheduled time, except before or after meal orders .

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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** 47564 Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors for 1 of 8 residents (Resident #24) reviewed for medication administration. The facility provided Resident #24 with the medication Carvedilol outside of physician parameters. This failure could place residents at risk for not receiving the therapeutic effects of their prescribed medications. The findings included: Record review of Resident #24's Admission Record, dated 04/04/2025, reflected a [AGE] year-old resident with diagnosis including dysphagia (difficulty swallowing), cerebral infarction (the pathologic process that results in an area of necrotic tissue in the brain), and human immunodeficiency virus [HIV] disease (a virus that attacks cells that help the body fight infection). Record review of Resident #24's quarterly MDS assessment, dated signed 03/09/2025, reflected Resident #24 was assessed with a BIMS score of 0, indicating the resident was severely cognitively impaired. Record review of Resident #24's comprehensive person-centered care plan, dated printer 04/03/2025, reflected that Resident #24 had hypertension and interventions to, Monitor/record medication side effects. Report to MD as necessary. Record review of Resident #24's Order Summary Report, dated 04/04/2025, reflected an order for Coreg Tablet 25 MG (Carvedilol) Give 1 tablet via PEG-Tube two times a day for htn Hold if SBP is <110 or HR is <60, indicating the medication should not be provided to the resident if their systolic blood pressure (the top number, which measures the pressure in your arteries when your heart beats) was over 110 or when the residents heart rate was under 60 beats per minute with a start date of 11/16/2024. Record review of Resident #24's Medication Administration Record for March 2025, dated 04/03/2025, reflected that Resident #24 could have been provided Carvedilol 62 times from 03/01/2025 through 03/31/2025 and was administered Carvidelol outside of parameters as follows: 1. On 03/05/2025, LVN N administered Carvedilol to Resident #24 while his SBP was 109 at 4:00 PM. 2. On 03/28/2025, LVN O administered Carvedilol to Resident #24 while his SBP was 108 at 9:00 AM. 3. On 03/29/2025, LVN P administered Carvedilol to Resident #24 while his HR was 58 at 4:00 PM. (continued on next page)

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	675138	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inspiration Hills Rehabilitation Center	1939 Bandera Rd San Antonio, TX 78228

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/04/2025 at 12:28 PM, the ADON stated that all medications that have parameters should be given within parameters and that if the medication was given out of parameters, the physician would have to be notified. The ADON stated she was not aware of medications being given out of parameters. Interview on 04/04/2025 at 2:12 PM, the DON stated that if a blood pressure is out of parameters, it should be checked manually and if it was still out of parameters, a nurse could use their best nursing judgement to provide the medication. The DON stated that if this occurred, the physician would need to be notified. The DON stated that the risk to residents for their medications being given out of parameters is the risk of not receiving the therapeutic effects of the medication or adverse side effects. Record review of facility policy titled, Medication Administration General Guidelines, dated, 12/24 reflected, Medications are administered in accordance with written orders of the prescriber .Obtain and record any vital signs as necessary prior to medication administration.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47564 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for 1 of 1 facility reviewed for food service safety. 1. The facility failed to maintain the cleanliness of the facility ice maker. 2. Two open food items were observed in the medication storage fridge, undated and unlabeled. 3. Three open and unrefrigerated containers of fluid drinks intended for residents were observed on two medication carts. This failure could place residents who receive food and/or snacks from the facility at risk for food borne illness. The findings included: 1. Observation on 04/03/2025 at 11:32 AM revealed a black substance build-up within the ice maker. The ice machine was observed to have a sticker on it stating the contracted cleaning company had last cleaned the ice machine in March of 2025, and it would next be cleaned in September of 2025. Observation on 04/03/2025 at 11:45 AM revealed water pitchers with ice in them and an ice chest in the hallway with ice in it for staff to provide to residents with water and/or ice when requested. Interview on 04/04/2025 at 2:19 PM, the DON stated that all she saw in the photo of the ice machine was condensation. The DON stated the risk to residents with having ice from a dirty ice machine was illness. Interview on 04/04/2025 at 2:19 PM, the ADM was shown a photo of the ice machine and stated that it was dirty and she expected it to be cleaner, since the contracted cleaning company had recently come to clean it. The ADM stated the facility had a company who was contracted to clean the ice machine every 6 months. The ADM stated that other than the contracted cleaning service every 6 months, there was not a schedule for cleaning the facility ice machine, and that if they notice the machine needs to be cleaned then maintenance will clean it. The ADM stated the risk to residents with having ice from a dirty ice machine is the possibility of residents becoming sick. 2. During an observation and interview on 04/02/2025 at 1:55 pm, the medication refrigerator in Hall C was observed to have two opened food containers on the top shelf - a Styrofoam container of red liquid and a clear, plastic container with orange liquid. No medications were located on this shelf. Neither item was labeled with a date indicating when it was opened. The DON stated the food items should not be stored in the medication refrigerator. The DON then disposed of the items into a nearby trashcan. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During an observation on 04/03/2025 at 11:3 am, an open container of Sysco brand thickened lemon flavor water was observed on the medication cart for Hall C. This container was labelled with an open date of 2/17/2025. On the back of the carton, the manufacturer label stated: Refrigerate prior to serving. Shake well before using. Twist the cap to open, then pour and serve. After opening, may be kept up to 7 days under refrigeration. The carton was warm to the touch, and no ice or cooling method was observed on the cart. Observation on 04/05/2025 at 11:35 AM revealed an additional carton of the same thickened lemon flavor water within a locked drawer of the medication cart in Hall B with an open date of 03/31/2025. The carton was warm to the touch, and no ice or cooling method was observed on the cart. An interview was conducted with CMA C on 4/03/2025 at 11:35 AM. CMA C stated she was unaware that the thickened lemon flavor water required refrigeration. She was unsure when it should be discarded after opening. CMA C also reported that it was routine practice at the facility to keep the thickened lemon flavor water stored in the medication carts, unrefrigerated after opening. A third observation was made on 4/02/2025 at 07:35 AM of Sysco brand Med Plus 2.0 Vanilla flavored nutritional drink on top of the medication cart in hall B. The carton was warm to the touch, and no ice or refrigeration method was observed. The carton was labelled as opened on 4/3. An interview was conducted with RN D on 4/02/2025 at 07:25 AM. RN D stated that the carton was present when he arrived for his shift at 06:00 AM and was likely put there by the overnight staff from the previous shift. RN D stated that the facility practice is to store these cartons on ice on top of the medication cart. An interview was conducted with the DON and the Admin on 4/04/2025 at 1:55PM, and the observations made by the survey team of the thickened water and nutritional supplement were reviewed. The DON disagreed with the surveyor assessment that the cartons required refrigeration after opening and stated that she would consult with the facility pharmacist. A review of the manufacturer's website (www.sysco.com) indicated the following: 1. Med Plus 2.0 Vanilla: refrigerate after opening and use within three days 2. Thickened lemon flavored water: refrigerate for up to 7 days after opening No follow-up information from the facility pharmacist was offered by the DON or Admin before the survey team exited. Record review of facility policy titled, Production, Storage, and Dispensing of Ice, undated, reflected, The ice dispenser will be cleaned and sanitized at least monthly and/or as needed. Inside and outside of the machine and the area around the machine will be cleaned.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 51512 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanity, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #69) of 4 residents reviewed for medication administration. The facility also failed to handle and transport linens so as to prevent the spread of infections for infection control practices in 1 of 3 resident hallways observed for infection control. 1. The facility failed to ensure CNA A removed soiled gloves prior to exiting a room, as well as securing soiled linen in a bagged or contained method at the point of collection prior to transporting. 2. The facility failed to ensure CMA B sanitized a reusable blood pressure cuff between residents while obtaining vital signs needed for medication administration. These failures could lead to the spread of infection. The findings included: 1. While performing initial tour of the facility on 4/01/2025, CNA A was observed at 09:53 AM exiting a resident's room into the hallway while carrying unbagged, soiled linen with gloved hands. In an interview conducted on 4/01/2025 at 10:08 AM, CNA A acknowledged and confirmed the observation made by the surveyor. CAN A reported working at the facility for three years. CNA A stated that he was freaked out by the presence of state survey team and had exited the room quickly to avoid interaction. CNA A reported that the facility process regarding transporting soiled linen is to put the used linens in a trash bag prior to exiting the resident's room. He always stated that the facility's policy is to not wear soiled gloves in the hallway, but he explained that he was wearing them because he was carrying unbagged, soiled linen. CNA A stated that the potential harm to residents from transporting unbagged, soiled linen and wearing soiled gloves is contamination to other residents. In an interview with the DON on 4/04/2025 at 1:55 PM, the observation of CNA A was reviewed, and the DON was asked what the facility's expectation is regarding transporting linen. The DON stated linen needs to be bagged prior to exiting a resident's room. The DON informed the survey team that she was aware of the breach in infection control and that CNA A was still new and required reminders of proper infection control practices. The DON reaffirmed that she considered three years of employment history as still new. 2. On 4/03/2025 beginning at 09:45 AM, CMA B was observed obtaining a blood pressure on Resident #22 using a reusable electronic blood pressure monitoring device. CMA B was then observed obtaining a blood pressure on Resident #69 using the same device. CMA B was continuously observed during this time, and CMA B did not clean/sanitize the device between the two residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted during medication administration observations, CMA B was asked how frequently she cleans the device between residents. CMA B answered that she usually cleans every two to three residents. CMA B was unsure what the facility policy was is regarding cleaning equipment between residents but stated they could probably want [her] to clean between every resident. CMA B identified the risk to residents of not cleaning equipment between residents is that you will spread whatever they have to others. CMA B was asked if she stores sanitizing wipes inside of the medication cart for this purpose, and she answered yes. However, observation of the medication cart did not reveal the presence of any cleaning agent for the device. In an interview with the ADON, who also serves as the Infection Preventionist for the facility, on 4/04/2025 at 11:15 AM, the observation was reviewed, and the ADON explained that her expectation is that staff will clean equipment between every resident and allow the equipment to dry before being used again. The ADON stated wipes are available to the staff and should be stored in the medication carts. Record review of the facility policy titled Standard Precautions (undated) reflected item 5.b. ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed and single use items are properly discarded. Record review of facility policy titled Standard Precautions (undated) reflected item 2.g. remove gloves promptly after use, before touching non-contaminated items and environmental surfaces . The policy also revealed item 7.a. handle, transport, and process used linen . in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other residents and environments.