STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675162	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcliff Nursing and Rehabilitation Center	3201 N Ware Rd McAllen, TX 78501

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 48278 Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 3 residents out of 6 (Resident #119, Resident #124, and Resident #205) and 1 shower bed (hall 300) out of 4 that were reviewed for safe environment. 1. The facility failed to ensure bathroom sinks' hot water temperatures were below 110 degrees Fahrenheit in occupied rooms for Resident #119, Resident #124, and Resident #205. 2. The facility failed to ensure the shower bed in Hall 300 shower room was in good condition. These failures could affect residents by placing them at risk for diminished quality of life due to the lack of a well-kept environment and water temperatures over 110 degrees Fahrenheit, placing residents at risk of being in an unsafe environment and at risk for burn injuries. Findings Included: During an observation on 03/24/2025 at 04:14 p.m. with the Maintenance Director and using the maintenance director's digital thermometer, the bathroom sink hot water temperatures were: 1.Resident #119's bathroom sink hot water temperature was 124 degrees Fahrenheit, Resident #124's hot water temperature was 118 degrees Fahrenheit and Resident #205's hot water temperature was 116 degrees Fahrenheit. Record review of Resident #119's face sheet dated 03/24/2025 revealed the resident was an [AGE] year-old male admitted to the facility on [DATE] with original admitted [DATE]. His pertinent diagnoses included Vascular Dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), Mood Disorder, Muscle wasting and Atrophy (loss of muscle tissue), Peripheral Vascular Disease (reduced circulation of blood to a body part, other than the brain or heart), Essential Hypertension (high blood pressure). Record review of Resident #119's quarterly MDS assessment, dated 03/06/2025 revealed a BIMS score of 05, indicating Resident #119 was severely cognitively impaired. He required minimal assistance for mobility. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #119's care plan revised dated 03/11/2025 revealed he had limited physical mobility. Interventions: The resident was able to ambulate self with a walker. Record review of Resident #124's face sheet dated 03/26/2025 revealed the resident was an [AGE] year-old male admitted to the facility on [DATE], with original admitted [DATE]. His pertinent diagnoses included Vascular Dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), Type 2 Diabetes Mellitus, Muscle wasting and Atrophy (loss of muscle tissue), Essential Hypertension (high blood pressure), Anxiety Disorder. Record review of Resident #124's quarterly MDS assessment, dated 01/25/2025 revealed a BIMS score of 03, indicating Resident #124 was severely cognitively impaired. He required supervision for mobility. Record review of Resident #124's care plan revision dated 08/05/2024 revealed he had Alzheimer's. Interventions: the resident requires supervision for toileting hygiene. Record review of Resident #205's face sheet dated 03/24/25 reflected the resident was a [AGE] year-old female with an admission of 01/15/24 and initial admitted [DATE]. Her relevant diagnoses included need for assistance with personal care, and lack of coordination. Record review of Resident #205's quarterly MDS dated [DATE] reflected she had a BIMS score of 14, which revealed her cognition was intact. In an interview on 3/24/2025 at 4:20 p.m. with the Maintenance Director, he stated that he has a maintenance assistant who does rounds every day in the morning. His assistant was not working this afternoon. He stated the assistant checks the water temperatures at least one room in each hall every day and the last time he checked them was this morning (3/24/2025). The Maintenance Director stated that his assistant documented the temperature readings on a paper, and he received it on Fridays. He stated if they were not within range, that he would get notified right away. The Maintenance Director stated the hot water temperature should be between 100-110 degrees Fahrenheit. The Maintenance Director stated the negative outcome of the water temperature being too hot in the resident's restroom was that the residents can get burned since they have thinner skin. In an interview on 03/24/2025 at 5:02 p.m. with Resident #124, he stated that he does use the restroom sink and he has not been burned. He stated that he adjusted the water temperature before he used it. In an interview on 03/24/25 at 5:30 p.m., Resident #205 said she used the sink in her restroom daily but had not sustained any burns. She said she would open the cold and hot water at the same time to wash her hands. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/25/2025 at 2:08 p.m. with the maintenance assistant, he stated that he checks the water temperatures every day. He stated that he checks one room in each hall randomly. He then documents these temperatures in a paper log. He enters this information in TELS on Fridays. He gives this log to his supervisor, the maintenance director, at the end of the week. He stated if he gets an out-of-range reading, he calls his supervisor right away at the time. He stated the hot water temperature should be between 100-105 degrees Fahrenheit. He checked them yesterday, 03/24/2025 in the morning and the temperature was within range. He stated the hot water does not come out hot right away, but the residents can get burned. In an interview on 03/26/2025 at 1:45 p.m. with Resident #119, he stated that he does use the restroom sink to wash his hands. He stated he had not been burned. In an interview on 03/27/2025 at 10:10 a.m. with the Administrator, she stated that the maintenance assistant randomly checked the water temperatures daily and enters the temperatures weekly in TELS. She stated that she does not look at these temperatures unless she receives an alert. The alert would be triggered when the temperature was out of range. The range should be between 100 -110 degrees Fahrenheit. The administrator stated there had not been any residents burned by hot water in their rooms. She stated the plumber was here on Tuesday, 03/25/2025, troubleshooted the water heater and tested the room temperatures. She stated the negative outcome of the hot water being too hot was that the resident's skin could be affected. Record Review of the Water Temperature Log dated 03/24/2025 revealed residents' rooms were within normal range between 106 to 110 degrees Fahrenheit. Further review of the TELS Logbook documentation for the week of 03/17/2025-03/21/2025 revealed minimal variation of temperature between 101 to 105 degrees Fahrenheit. Review of facility's incident and accidents logs dated 01/2025, 02/2025, and 03/2025 did not reveal any injuries to residents due to hot water. Review of the facility's Grievance logs dated 01/2025, 02/2025, and 03/2025 did not reveal any complaints of water temperature being too hot. 2. In an observation on 03/25/25 at 5:45 p.m., the shower bed in Hall 300 made of pvc (polyvinyl chloride) and a blue mesh fabric. It had a have a white and black film in the middle of the shower bed that extended from the top to the bottom of the bed. Parts of the mesh were worn out and frayed throughout the shower bed. In an observation and interview on 03/25/25 at 5:00 p.m., with the Central Supply Director as he inspected the shower bed in the Hall 300 shower room. He said the mesh on the sides were frayed and could potentially cause the mesh to tear. He described the middle part of the shower bed as having mold, dirty and frayed. He said the bottom pan of the shower bed had water residue. He said it was the CNA's responsibility to inspect the shower beds as they were the ones that used them on a daily basis. He said in his opinion, the shower bed needed to be replaced. The Central Supply Director said no one had told him that particular shower bed had signs of wear and tear. He said if the Administrator approved a new shower bed he would be responsible for ordering one. The Central Supply Director was not able to say what negative outcome that shower bed would have on the residents. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 03/25/25 at 6:00 PM, the DON was observed as she inspected the shower bed. The first thing the DON said when she saw the shower bed was, oh it needs to be sanitized. She was not able to say what if anything was the negative outcome to the residents in hall 300 for having a shower bed with frayed and dirty mesh. She said it was the responsibility of the CNAs to report any wear and tear to the administration. The DON said she had not been informed by any staff member that the shower bed was not in good condition. In an observation and interview on 03/25/25 at 6:07 p.m., the Administrator said after seeing the shower bed that it needed to be taken out of commission and replaced. She said the frayed mesh needed to be replaced. She said she would be authorizing the Central Supply Director to order a new shower bed immediately. The Administrator said she had not been informed by any staff member that the shower bed was showing signs of wear and tear. She was not able to say if there were any negative outcomes to residents for having a shower bed that needed to be replaced. The Administrator said the facility did not have a policy related to shower beds. In an interview on 03/26/25 at 8:15 am, CNA P said she used the shower room in hall 300. She said she had not noticed the shower bed needed repair. She said if she had noticed the shower bed needed repairs she would have immediately reported it to her charge nurse or the DON. She said she was regularly in-serviced on the topic of reporting anything that needed to be repaired as soon as possible to her charge nurse or administration in order to avoid resident accidents. Review of the facility's Instructions Direct Supply TELS provided the following information: 1. Ensure patient room water temperatures are between 100 degrees and 110 degrees Fahrenheit or as specified by state requirement). Texas 100-110 degrees Fahrenheit 5. Common area bathrooms, public bathrooms and any other areas having sinks should be checked and recorded as well. Record results in the water temperature log 1. Note any discrepancies 2. Adjust water heater setting as required 3. Retest as necessary

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 50487 Based on observation, interview and record reviews the facility failed to ensure the residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 10 residents (Resident #101) reviewed for abuse. The facility failed to ensure Resident #101 was free from abuse. CNA H slapped Resident #101 on the face on 8/1/24. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 08/01/24 and ended on 08/01/24. The facility had corrected the noncompliance before the survey began. The facility was informed about the past non-compliance on 3/26/2025 at 12:32pm. This failure affected one resident and placed additional 9 residents who were on the memory unit at risk of abuse. Findings included: Record review of Resident#101's admission record dated 3/25/2025 reflected an [AGE] year-old female initially admitted on [DATE] with diagnoses of Alzheimer's Disease (a progressive neurodegenerative disorder that affects memory, thinking, and behavior), cognitive communication deficit (difficulties with communication arising from problems with cognitive process like, attention, memory, or reasoning, rather than speech or language difficulties themselves), dementia (a general term for a group of brain disorders that cause a progressive decline in cognitive abilities, memory and behavior). Record review of Resident #101's comprehensive care plan dated 5/9/2022 indicated she had a history of physical aggression and agitation/combative behavior towards staff and other residents. Resident #101 had severe cognitive impairment and needed moderate assistance with all ADLs. Record review of Resident #101's quarterly MDS dated [DATE] reflected a BIMS score of 00, indicating Resident #101 was severely cognitively impaired and had a wandering behavior that occurred daily. Record Review of Resident #101's incident report dated 8/1/24 reflected she had been slapped on the face by CNA H. The incident was witnessed by CNA I and RN J. The incident occurred while CNA H and CNA I tried to render care to Resident #101. Resident #101 became agitated and hit CNA H, and in response CNA H slapped Resident#101. The incident report revealed that the facility's investigation was confirmed for abuse. During an observation on 3/24/25 at 10:00 am, Resident #101 was in the dining room watching television and eating a snack. During an observation on 3/25/25 at 11:25 am, Resident #101 was in the dining room eating a snack. During an observation on 3/26/25 at 12:10 pm, Resident #101was in the dining room eating lunch. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/24/25 at 10:00 am Resident #101 was not able to recall the incident. In a telephone interview on 3/24/25 at 4:00 PM, CNA H denied that she had slapped Resident#101 on the face. CNA H said that she simply raised her hand to scare her. CNA H said RN J immediately intervened and instructed her to report to the Administrator's office. CNA H said the Administrator immediately suspended her and later terminated her. Record Review of CNA H's written statement (not dated) reflected in part that Resident #101 hit my face with force and I instantly hit her back not hard. I know it was wrong, but it was instinct. In an interview on 3/25/25 at 10:26 AM, CNA I said the incident occurred while she tried to convince Resident#101 to go back to her room to render perineal care. CNA I said Resident#101 refused and became agitated. CNA I said she went to ask CNA H for assistance. CNA I said Resident #101 followed her and at that time CNA H and CNA I tried to redirect Resident#101 back to her room. CNA I said Resident #101 became physically combative and suddenly slapped CNA H on the face. CNA I said CNA H reacted by slapping Resident #101 on the face. CNA I said the incident was witnessed by RN J who immediately protected Resident#101 and instructed CNA H to report to the Administrator's office. In an interview on 3/25/25 at 10:35 AM, RN J said she heard Resident#101 yelling at CNA H and CNA I while they tried to redirect her back to her room. RN J said that she immediately went to check on Resident #101. RN J said she observed CNA H slap Resident#101 on the face. RN J said that she immediately separated Resident #101, and CNA H. RN J said she instructed CNA H to exit the memory unit and report to the Administrator's office. RN J said she immediately a head to toe assessment was done for Resident#101 for any physical injuries and then reported the incident to the Administrator. RN J said that CNA H was removed from the facility after the incident. In an interview on 3/25/25 at 11:00 AM, the DON said that after the 8/1/24 incident CNA H was immediately suspended, and later terminated. The DON said all staff were in-serviced on 8/1/24 on of the topics of Dealing with challenging residents; Abuse Prohibition Policy. The DON said the following interventions were initiated: Resident #101 was closely monitored by staff and to monitor for any psychosocial behaviors. In an interview on 3/25/25 at 11:15 AM, the Administrator said that when CNA H reported to her office on 8/1/24 she was immediately suspended and instructed to leave the facility. The Administrator said she immediately reported the incident to the state. The Administrator said after the investigation the facility confirmed the allegation of abuse and CNA H was terminated. It was determined these failures placed Resident #101 in an Immediate Jeopardy situation on 08/01/24. The facility had corrected the noncompliance before the survey began. Record Review of the facility resident report dated 8/1/2024 of the following interventions were put in place: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Resident #101 was immediately protected by RN J. In an interview on 3/25/25 at 10:35 AM, RN J said she heard Resident#101 yelling at CNA H and CNA I while they tried to redirect her back to her room. RN J said that she immediately went to check on Resident #101. RN J said she observed CNA H slap Resident#101 on the face. RN J said that she immediately separated Resident #101, and CNA H. RN J said she instructed CNA H to exit the memory unit and report to the Administrator's office. RN J said she immediately a head to toe assessment was done for Resident#101 for any physical injuries and then reported the incident to the Administrator. RN J said that CNA H was removed from the facility after the incident. 2. CNA H was immediately removed from the facility. Record reveiw of incident report dated 8/1/24 revealed resident was suspended on 8/1/24. Record Review of incident report dated 8/1/24 CNA H was terminated on 8/6/24. 3. A head-to-toe assessment was conducted on Resident #101 on 8/1/24. Record review dated 8/1/24 of resident assessment revealed no physical harm, pain or mental anguish. 4. The facility's social worker assessed Resident #101 for signs of psychosocial harm on 8/1/24 and later referred Resident#101 to counseling. Interview with social worker revealed that she assessed the resident and there were not signs of psychosocial harm and was referred for counseling evaluation on 8/1/24. Record review dated 8/1/24 revealed social worker had done an assessment and referred resident for counseling. 5. Staff were in-serviced on 8/1/24 on the topics of Dealing with challenging residents and Abuse Prohibition Policy. Record review dated 8/1/24 revealed all staff were in-serviced on dealing with challenging residents and abuse prohibition policy. 6. All residents in the memory unit were interviewed and observed for abuse on 8/1/24 with no concerns mentioned. 7. Staff in the memory unit were interviewed on 3/24/25, 3/25/25 and 3/26/25 and all were familiar with the facility's protocol when dealing with residents with cognition impairment and aggressive behaviors and abuse prohibition policy. 4 CNAs were interviewed from different shifts, 3 License Vocational Nurses and 1 registered nurse. 3/24/25 at 1:39 PM, CNA EE 3/25/25 at 10:35 AM, RN J 3/25/25 at 10:26 AM, CNA I 3/25/25 at 1:34 PM, LVN F 3/25/25 at 1:49 PM, CNA DD (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3/25/25 at 2:48 PM, ADON 3/25/25 at 2:25 PM, LVN CC 3/26/25 at 10:49 AM, CNA S Record Review of the facility's policy titled abuse, neglect and exploitation, date implemented 8/15/22, stated It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Physical Abuse includes, but is not limited to hitting, slapping, biting, and kicking. It also includes controlling behavior through corporal punishment.

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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** 47828 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial need that were identified in the comprehensive assessment for 2 of 10 residents (Resident #101 and Resident #82) reviewed for comprehensive person-centered care plans. 1.The facility failed to develop a comprehensive person-centered care plan for Resident #101 to address assist feeding. 2. The facility failed to develop a comprehensive person-centered care plan for Resident #82 to address identifiable triggers to his active diagnosis of Post Traumatic Stress Disorder. This deficient practice could place residents at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs. The Findings include: Record review of Resident #101's face sheet, dated 3/25/2025, reflected an [AGE] year-old female who was originally admitted to the facility on [DATE]. Resident #101 had a diagnosis which included: Vascular Dementia (a type of cognitive decline caused by damaged to the blood vessels in the brain), Alzheimer's disease (caused by problems with blood supply to the brain, leading to damage and impaired function, and often involves difficulties with thinking, planning and problem solving), Needs assistance with personal care. Record review of Resident #101's Care Plan initiated on 5/11/23 reflected she has an ADL self-care deficit related to decreased cognition secondary to Alzheimer's Dementia, and Amnesia. Resident #101's functional performance with eating: the Resident requires (supervision/or touching assistance) for eating. Record review of Resident #101's quarterly MDS assessment, dated 1/30/25, reflected a BIMS score of 00, which indicated Resident #00's cognition was severely impaired. Eating assistance was marked on the MDS as 04 which indicated supervision or touching assistance (helper provides verbal cues and/or touching/steady and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. During an observation on 3/24/25 at 12:00PM Resident #101 was in the dining room, CNA was sitting next to resident and was assisting with feeding. During an observation on 3/25/25 at 5:00PM, Resident #101 was in the dining room, CNA was sitting next to resident and was assisting with feeding. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/24/25 at 4:00PM with CNA I stated that Resident #101 needs assistance with feeding because she was not able to feed by herself because of the resident's had Alzheimer's. CNA I stated Resident #101 did not know how to use the utensils. CNA I stated resident had been fed with all meals. During an interview on 3/26/25 at 11:35AM with RN L stated Resident #101 needed total assistance with feeding with all her meals because of the resident's Alzheimer's disease. RN L stated that a negative outcome of care plan not been accurate could place Resident#101 at risk for weight loss. During an interview on 3/26/25 at 10:00 AM with LVN K, MDS nurse, stated that the resident was able to grab finger food. LVN K, MDS nurse stated that she did not know that resident needed a lot of assistance. LVN K, MDS nurse stated that she did not update the care plan because she was not aware that resident was being assisted with feeding every meal. During an interview on 3/26/25 at 4:40 PM, the DON said she was not aware that resident was needing total assistance with feedings. DON said Resident#101's care plan had to be accurate and this way all staff could know what the resident needed. 2. Record review of Resident #82's face sheet dated 03/27/25 reflected resident was a [AGE] year-old male admitted to the facility on [DATE] with original admitted [DATE]. His pertinent diagnoses included post-traumatic stress disorder (mental condition that develops after experiencing or witnessing a traumatic event, war, violent crime, or personal loss), bipolar (a disorder associated with episode of mood swings ranging from depressive to manic highs), dementia (a group of thinking and social symptoms that interferes with daily function), cognitive communication deficit (a group of conditions that affect a person's ability to communicate effectively due to underlying cognitive impairments), major depressive disorder (mental condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), delusional disorder (mental illness that caused people to have unshakeable false beliefs for at least a month), and schizoaffective disorder (disorder that affects a person's ability to think, feel, and behave clearly). Record review of Resident #82's quarterly MDS assessment dated [DATE] reflected his BIMS score question was left blank, indicating his cognition was severely impaired. His active psychiatric/mood disorder diagnoses included depression, bipolar disorder, schizophrenia, post-traumatic stress disorder and psychotic disorder (mental disorder characterized by a disconnection from reality). It further reflected he had physical (hitting, kicking, pushing, scratching, grabbing, abusing others sexually), verbal (threatening others, screaming at others, cursing at others) and other behavioral (not directed towards others, physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) symptoms that occurred 1 to 3 days during the review period. Record review of Resident #82's order summary reflected he had a diagnosis of post-traumatic stress disorder effective 03/25/21. Record review of Resident #82's quarterly comprehensive care plan dated 03/06/25 reflected he: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. used to be a boxer and suffered from post-traumatic stress disorder (date initiated/revised 08/25/23). His interventions included to administer medications as ordered, behavioral health consults as needed, monitor/document/report PRN any risk for harm to self (date initiated 01/10/24), monitor/record/report to MD prn mood patters signs and symptoms of depression, anxiety, sad mood as per facility behavior monitoring protocols (date initiated 11/24/23 and revised 11/25/23) and monitor/record/report to MD prn risk for harming other, increased anger, labile mood (a neurological condition that involves rapid and exaggerated mood changes) or agitation, feels threatened by others or thoughts of harming someone (date initiated 01/10/24 2. had a psychosocial well-being problem related to post-traumatic disorder, bipolar disorder, dementia, and schizoaffective disorder (dated initiated/revised 11/19/24). Interventions included to encourage participation from resident who depended on others to make his own decisions, increased communication between resident/family/caregivers about care and living arrangements, provide opportunities for the resident and family to participle in care, should conflict arise, remove resident to a calm safe environment and allow to vent/share feelings. In an observation on 03/24/25 at 10:35 a.m., Resident #82 was observed lying in bed awake and mumbling to himself with a blank stare. In an interview on 03/25/25 at 10:00 a.m., the SW said when a resident was admitted , they were screened for any trauma. She said Resident #82 was admitted to the facility on [DATE] and diagnosed with post-traumatic stress disorder on 03/25/21. She said she would have to review her records to see if he had any identifiable triggers. In an interview on 03/26/25 at 8:00 a.m., CNA R said she had cared for Resident #82 for almost one year. She said since she had cared for him he had not displayed any behaviors. She said he was bed bound, required total assistance for all ADLs, and was not able to communicate. CNA R said she would round Resident #82 more frequently because he was not able to communicate or use the call light. She said by rounding more often than every 2 hours, staff could anticipate his needs better. In an observation and interview on 03/26/25 at 8:11 a.m., LVN F said Resident #82 used to be a hospice patient but had recently been discharged from hospice. She said for the most part his way to communicate was to moan. LVN F said, it was rare but there had been times in which Resident #82 was able to answer yes or no but for the most part he would just moan. She said staff were able to meet his needs by making more rounds to his room and trying to anticipate his needs better. LVN F said Resident #82 had a diagnosis of post-traumatic disorder. She was observed as she reviewed Resident #82's care plan and said she was not able to find any triggers listed under his problem of post-traumatic stress disorder. She said CNAs and nursing staff would constantly monitor Resident #82 for any signs or symptoms of any behaviors not only because of his diagnosis of post-traumatic stress disorder but for all his other mental disorders. She said in her experience as a nurse, Resident #82 had not displayed any behaviors that she could identify as triggers. She said there were no negative outcome for Resident #82 not having any triggers identified on his care plan because staff were monitoring all his behaviors because of his overall mental disorders. LVN F said she would be in-serviced at least every 12 months on the topic of post-traumatic disorder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/26/25 at 10:30 a.m., LVN S-MDS said Resident #82 was the only resident in the facility with an active diagnosis of post-traumatic stress disorder. She said she had not included any triggers because there were no identifiable triggers for him. She said in her opinion, if a resident with an active diagnosis of post-traumatic disorder did not have any identifiable triggers their care plan should include a statement that reflected no identifiable triggers, which she acknowledged Resident #82's care plan did not. She said there were no negative outcome to Resident #82 not having triggers listed on his care plan, because he was being monitored for all his other mental disorders which included post-traumatic stress disorder. In an interview on 03/26/25 at 4:08 p.m., the Social Worker said she had reviewed Resident #82' progress notes and his counseling notes but had not found any documentation that identified any triggers for his post-traumatic stress disorder. She said Resident #82 had been referred to counseling in the past for his diagnosis of bipolar. She said when Resident #82 was initially admitted , he had behavior problems like wanting to punch staff and other residents. She said since his admission, Resident #82's health had declined and at one point he was under hospice. She said he was no longer under hospice, but his health continued declining. She said Resident #82 was not able to communicate, was bed bound. She said she had not been told by staff Resident #82 displayed any behaviors that could be identified as triggers. She said when Resident #82 was initially admitted , he was in the secure unit. She said since his health declined, he was transferred to a regular room as he was no longer displaying any behaviors or able to ambulate. In an interview on 03/26/25 at 4:27 pm the DON said the care Resident #82 received was based on his current physical status/psychosocial status. She said his diagnosis of post-traumatic stress disorder did not infringe in the care he received. She said there were no negative outcome to Resident #82 not having triggers identified on his care plan because his dementia was too advanced, and he was being monitored for any behavior issues. In an interview on 03/27/25 at 8:45 am, the Nurse Practitioner (Psychiatry) said when Resident #82 had initially been admitted to the facility, staff had a very hard time trying to diagnose him. She said Resident #82 was very aggressive, agitated, and difficult to manage. She Resident #82 was not a very good historian and it had taken a long time to stabilize him. She said she diagnosed Resident #82 with post-traumatic stress disorder along with other mental issues after his admission. She said at the time of his diagnosis, she was not able to identify any triggers and focused on his other more severe mental disorders. She explained Resident #82 had been a boxer in his younger years and had also been kidnapped for several weeks and severely beaten up in another country. She said the resident has had a rapid decline in health and in her medical opinion, he is beyond the point of having identifiable triggers because his dementia is too advanced. Record review of the Comprehensive Person-Centered Policy, date implemented 10/24/2022, read in part It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 50487

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 1 of 8 residents (Resident #13) reviewed for accidents and hazards: The facility failed to ensure Resident #13 did not have disposable razors in his room. This failure could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health. The findings included: Record review of Resident #13's admission record, dated 03/24/25, reflected a [AGE] year-old male admitted to facility on 11/14/24. His relevant diagnoses included the need for assistance with personal care, epilepsy (disorder in which nerve cells activity in the brain is disturbed causing seizures), and intellectual disabilities (below average intelligence and set of life skills). Record review of Resident #13's quarterly MDS dated [DATE] reflected he had a BIMS score of 08, which indicated his cognition was moderately impaired. Record review of Resident #13's quarterly care plan dated 02/09/25 reflected he had an ADL self-care performance deficit related to weakness, history of spinal fractures, poor balance. His interventions in part included functional performance of personal hygiene, Resident #13 required partial or moderate assistance for personal hygiene (date initiated 11/14/24 and revised on 11/23/24). An observation on 03/24/25 at 11:14 a.m., Resident #13 was observed sitting on his wheelchair. Surveyor asked him for permission to inspect his restroom, and he consented. In the restroom sink there was one disposable razor with the lid still on. In an interview on 03/24/25 at 11:17 a.m., Resident #13 said he had just come back from the shower room where he had been showered and shaved. He said at times he preferred to shave himself. He said he kept a bag of disposable razors in his dresser drawer. Resident #13 said whenever he decided to shave himself, the CNAs would pull out a new disposable razor from his drawer for him to use. In an interview and observation on 03/24/25 at 1:00 p.m., CNA A said Resident #13 had been showered earlier that day by CNA B. She was observed walking into Resident #13's restroom where she acknowledged seeing a disposable razor on his sink, she said she did not know who had placed it there. She said Resident #13 was independent and at times would shave himself while a CNA would observe him. She said her shift began at 6 am that day and had made several rounds to Resident #13's room but had not noticed the disposable razor on the sink. CNA A was not able to explain the facility's protocol regarding sharps. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/24/25 at 1:30 p.m., CNA B said she had showered Resident #13 earlier that day and she had also shaved him while in the shower room. She said she did not know who had placed a disposable razor in his bathroom. She said on 03/24/25, her duties were to shower residents only. In an interview and observation on 03/24/25 at 5:32 p.m., RN C said the facility's protocol regarding razors were that they needed to be kept under lock and key in the shower room or in a medication cart. She said if a family member provided residents with razors, facility staff would label them and would place them under lock and key in the shower room or in a medication cart. She said residents were not allowed to keep razors in their rooms. RN C was observed as she checked Resident #13's dresser drawer and pulled out a plastic bag that contained 18 new disposable razors. RN C said the negative outcome for residents having razors in their rooms could be that they could cut themselves or others and if another resident wandered into their restroom, they too could cut themselves or others. RN C advised Resident #13 that she needed to place his disposable razors under lock and key. In an interview on 03/24/25 at 5:42 p.m., the DON said residents were not allowed to keep razors in their rooms. She said razors should be kept under lock and key in the shower room or medication cart. The DON said a negative outcome to Resident #13 having a razor in his room could be that he could cut himself or others and if another resident walked into his room, they too could cut themselves or others.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based on observation, interviews, and record review, the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice for 1 of 18 (Resident #39) residents reviewed for respiratory care. The facility failed to ensure Resident #39 had an oxygen sign posted on their door to alert everyone that he was on oxygen. This deficient practice could place residents who receive respiratory care at risk for developing respiratory complications, make others unaware oxygen was in use, and of receiving inappropriate and inadequate care. The findings included: Record Review of Resident #39's face sheet, dated 03/24/2025, revealed an [AGE] year-old male admitted to the facility on [DATE] with pertinent diagnoses of Acute and Chronic Respiratory Failure with Hypoxia (low levels of oxygen in the body), Acute combined Systolic and Diastolic Congestive [NAME] Failure (occurs when the heart can't pump enough blood to meet the body's needs), Essential Hypertension (high blood pressure), Hyperlipidemia (high cholesterol), Peripheral Vascular Disease (reduced circulation of blood to a body part, other than the brain or heart), and Type 2 Diabetes Mellitus. Record review of Resident #39's quarterly MDS assessment, dated 01/23/2025, a BIMS score of 05 revealed the resident's cognition was severely impaired. Record review of Resident #39's active orders, dated 03/24/2025, revealed Oxygen at 2LPM via nasal cannula greater than 92% as needed for hypoxia. Record review of Resident #39 ' s care plan revision date unknown revealed he had oxygen therapy r/t Hypoxia. Interventions Oxygen settings: O2 via nasal cannula as ordered. During an observation on 03/24/2025 at 10:20 a.m., Resident #39 was lying on a bed with his eyes closed and had on a nasal cannula with the oxygen concentrator set at 2 liters per minute. No sign was posted on the outside of Resident #39's door or doorframe to indicate he had oxygen in use in the room. In an interview on 03/24/2025 at 10:25 a.m. with LVN D, she stated that she was Resident #39 ' s nurse. LVN D stated she was responsible for posting the oxygen sign on the outside of the resident's door. She stated that she was supposed to put the oxygen sign as soon as possible after she gets the oxygen order. LVN D stated Resident #39 should have a sign, but she was busy this morning and forgot. She stated the oxygen sign was an identifier in case of fires. She stated the negative outcome would be that it was dangerous for Resident #39 and other residents in the facility. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/24/2025 at 10:45 a.m. with ADON E, she stated that anybody from nursing was responsible for posting the oxygen sign outside of the resident's door or door frame. She stated that she does not know if there was a timeframe, but they do it as soon as they get the physician order. ADON E stated that it was important for the O2 sign to be posted on the door to alert staff that the resident was on oxygen and for safety reasons. In an interview on 03/24/2025 at 5:30 p.m. with the DON, she stated that the charge nurses are responsible for posting the O2 sign on the resident ' s door. The administration was also responsible when they care plan. The nurses know where the signs are located. She stated that the managers were also responsible for posting the O2 sign on the resident's door who are on oxygen. The DON stated that it was important for the O2 sign to be posted on the door to alert the staff that the resident was on oxygen. Record review of the facility's Lippincott Manual of Nursing Practice 11th edition Administering Oxygen Therapy, revealed Assess need for oxygen by observing for symptoms of hypoxia: Assess the patient's current oxygenation Post no smoking signs

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 (Resident #66 and Resident #145) of 8 residents observed for infection control. 1. LVN F failed to sanitize hands before administering G-tube medications to Resident #66. 2. CNA O did not remove their contaminated gloves after catheter care prior to cleansing Resident #145 of bowel movement. CNA O proceeded to clean without performing hand hygiene and maintained usage of dirty gloves while cleaning posterior area and used the same gloves to apply a clean brief. These deficient practices could place residents at-risk for healthcare associated cross contamination and the spread of infection due to improper care practices. Findings included: 1. Record review of Resident #66's face sheet dated 03/26/2025 revealed the resident was a [AGE] year-old female admitted on [DATE] with an original admitted [DATE]. Her pertinent diagnoses included Cerebral Infarction (stroke), Gastrostomy (a tube inserted through the wall of the abdomen directly into the stomach), Dysphagia following Cerebral Infarction (difficulty swallowing following a stroke), Muscle wasting and Atrophy (loss of muscle tissue), and Type 2 Diabetes Mellitus. Record review of Resident #66's quarterly MDS assessment, dated 02/04/2025 revealed a BIMS score of 00, indicating Resident #66 was severely cognitively impaired. Record review of Resident #66's physician order summary dated 11/17/2022 revealed Resident #66 Enteral Feed Order every shift flush feeding tube with 30mls of water before and after medication administration. Record review of Resident #66's comprehensive care plan, revision date 05/02/2024, reflected Resident #66 has a gastric tube r/t Dysphagia Interventions: Monitor/document/report as needed signs and symptoms of . infection at tube site. During an observation in Resident #66's room on 03/25/2025 at 07:42 a.m. LVN F washed her hands then touched the privacy curtain and donned gloves without sanitizing her hands. She touched the bed remote with the gloves, to adjust the height of the bed, and with the same pair of gloves she proceeded to touch the resident's G-tube and administer the medications. In an interview on 03/25/25 at 08:02 a.m. with LVN F, she stated that she did well during the G-tube medication administration. She stated she does not use hand sanitizer because her skin gets irritated and washes her hands instead. LVN F stated that she was supposed to wash her hands before administering medications. She stated sanitizing hands after touching the privacy curtain and touching the bed remote was important to prevent infection to the resident. LVN F stated that we carry microbes all over our hands and Resident #66's G-tube site was a port of entrance for infection. (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 on 03/26/2025 at 10:40 a.m. with ADON G, she stated staff were trained to sanitize hands in between glove changes and to perform hand hygiene using soap and water for 20 seconds if their hands were visibly soiled. She stated LVN F should have sanitized after touching the privacy curtain without gloves after washing her hands. ADON G stated that when it comes down to touching the resident's bed remote it was iffy because it was the residence germs and not anyone else's germs. She stated that they were to wash their hands with soap and water if hand sanitizer was causing irritation. She stated she has not had any staff voice that they could not use hand sanitizer due to causing irritation. She stated there were other various hand sanitizers readily available. ADON G stated it was important to sanitize or wash hands to break the chain of infection. In an interview on 03/27/2025 at 10:59 a.m. with the DON, she stated staff were trained to sanitize hands before patient care, in between glove changes, and when done with care that they were providing. She stated the privacy curtains were dirty and staff was to sanitize hands afterwards. The DON stated after touching the bed control, staff was to remove gloves, sanitize hands, and don a new pair of gloves. She stated if staff hands get irritated with hand sanitizer, they were encouraged to use soap and water, but they also have aloe vera hand sanitizer. The DON stated that the staff should sanitize or wash their hands to prevent infection. 2. Record review of Resident #145's Face Sheet dated 03/24/2025 revealed an [AGE] year-old male admitted originally on 08/15/2024. His diagnoses included, chronic kidney disease (a condition in which the kidneys gradually lose their ability to filter waste products and excess fluid from the blood), benign prostatic hyperplasia with lower urinary tract symptoms (a condition in which the prostate gland, located below the bladder in men, enlarges), retention of urine (the inability to completely empty the bladder). Record review of Resident #145's Comprehensive Care Plan initiated: 08/15/2024 documented, Problem: [Resident #145] is dependent on staff for meeting emotional, intellectual, physical and social needs related to physical limitations. Interventions: functional performance with personal care: the resident requires partial/moderate assistance for personal hygiene. Record review of Resident #145's MDS dated [DATE] documented a Brief Interview of Mental Status score of 12/moderately impaired cognition, as well as extensive dependency of staff to assist in activities of daily living. An indwelling urninary catheter was used. During an observation on 03/25/2025 at 11: 09AM, observed Resident #145 had an indwelling urinary catheter. CNA O commenced catheter care of Resident #145. CNA O entered Resident #145's room after knocking. CNA O began with washing hands for 30 seconds, gloved up, and prepared the table of needed supplies. CNA O continued by raising the bed and then discarded gloves. After discarding the gloves, CNA O continued with applying hand sanitizer and she did apply new gloves. CNA proceeded with catheter care and proceeded to clean bowel movement. Once bowel movement was cleaned, using the same pair of gloves, she removed the brief, and applied a new brief. During an interview on 03/25/2025 at 11: 28AM, CNA O stated that they should have changed those gloves after cleaning the foley catheter, to minimize contraction of infection. CNA O stated they should have washed hands/used hand sanitizer and changed gloves, before, during, and after care to minimize chance of infection. CNA O stated their recognition of error and proceeded to state it was noted as a standard of practice. CNA O stated that Resident #145 could get an infection because she did not change gloves when changing from one area to another area. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/25/25 at 4:40PM with the DON, the DON stated that after perineum care, hand hygiene should have been performed prior to moving to the second part of cleaning of the bowel movement. The DON stressed the importance of infection prevention and stated that personnel were educated and observed by her performing specific care during checkoffs, before being allowed to work on the floor independently. The DON stated this practice could put Resident #145 at risk for urinary tract infection. Record review of the facility's Hand Hygiene Policy dated 10/24/2022 revealed Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Definitions: Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub. Record Review of the facility's Infection Prevention and Control Program Policy dated 05/13/23 revealed Policy: This facility has established and maintains 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 as per accepted national standards and guidelines. Policy Explanation and Compliance Guidelines: 2. All staff are responsible for following all policies and procedures related to the program. Standard Precautions: b. Hand Hygiene shall be performed in accordance with our facility's established hand hygiene procedures. d. Licensed staff shall adhere to safe injection and medication administration practices as described in relevant facility policies. 50487