STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675185	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longmeadow Healthcare Center	120 Meadowview Dr Justin, TX 76247

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one (Resident #76) of six residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Residents #76's rooms was in a position that was accessible to the resident. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Review of Resident #76's Face Sheet dated 03/27/2024 reflected that resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included muscle wasting and atrophy (decrease in size of a body part), unsteadiness of feet, and abnormalities of gait and mobility. Review of Resident #76's Quarterly MDS assessment dated [DATE] reflected that Resident #76 had a moderate cognitive impairment with a BIMS score of 11. Resident #76 required supervision for oral hygiene, toileting, lower body dressing, and transfer. The Quarterly MDS also indicated that the primary reason for admission was medically complex conditions such as muscle wasting, unsteadiness of feet, and abnormalities of gait. Review of Resident #76's Comprehensive Care Plan dated 02/22/2024 reflected that Resident #76 was at risk for falls related to unsteady gait and one of the interventions was to be sure the resident's call light is within reach and encourage the resident to use it for assistance. The Comprehensive Care Plan also reflected that resident had an ADL (activities of daily living) self-care performance deficit related to limited mobility and one of the interventions was to encourage to use bell to call for assistance. Observation on 03/26/2024 at 9:21 AM, revealed Resident #76 was sleeping on her bed. the resident was facing the wall. It was observed that Resident #76's call light was hanging on the wall near the privacy curtain. The resident then rolled to the other side and opened her eyes. When asked where her call light was, resident only shrugged her shoulders. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with LVN A on 03/26/2024 at 9:46 AM, LVN A went inside the resident room when advised that the resident's call light was hanging by the wall. LVN A then said that the resident's roommate was the one hanging the call light on the wall. LVN A then left the room and did not put the residents call light within the reach of the resident. Interview of Resident #76's roommate on 03/26/2024 at 9:51 AM, room mate stated she did not need the call light that was why she was putting it at the foot of her bed. She said she does not mess with anybody else's call light. Interview and observation with CNA A on 03/26/2024 at 9:58 AM, CNA A stated call light should always be within reach of the resident because the call light was the resident's means of communication. The resident used the call light to call for assistance and ask the staff if the resident needed something. CNA A went inside Resident #76's room and took the call light hanging on the wall and placed it where the resident could reach it. CNA A continued if the call light was not with the resident, the resident might try to stand up and eventually fall on the process. CNA A continued that the needs of the resident would not be known and met if she did not have her means to call the staff. Interview with ADON B on 03/27/2024 at 12:27 PM, ADON B stated that the call light was the resident's source of help. ADON B said the call light should always be within the reach of the resident because it was their lifeline. If the call light was not with the resident, the resident will not be able to call for help in cases of emergency. If the call light was not with the resident, the resident's needs will not be addressed. ADON B added that call lights were for dependent and independent residents. ADON B said the staff should monitor if the call lights were with the residents during shift reports and during rounds. ADON B added she would remind the staff to ensure the call lights was within the residents reach at all times. Observation and interview with Resident #76 on 03/28/2024 at 8:51 AM, revealed resident's call light was on the floor beside the bed. When asked where was her call light, resident just shrugged her shoulders. Interview with HA A on 03/28/2024 at 8:59 AM, HA A stated that call lights were important for the residents because it is what the residents use to call the staff when they needed assistance or even for just a glass of water. HA A said that the call lights should be in a place where the residents could reach it and press the red button. If the call light was not with the residents, they will not be able to call the staff for assistance or help. HA A added if the call light was not with the resident, the resident might to stand up and this could result in falls, skin tears and frustration. HA A went to Resident #76's room and put the call light within the reach of the resident. Interview with the DON on 03/28/2024 at 9:15 AM, the DON stated that residents' call lights must always be within reach because the call lights would the residents' way of calling the staff if they needed or wanted something. The DON said without the call lights, the residents' needs will not be addressed. The DON said that the expectation was for the staff to ensure the call lights were within reach of the residents. The DON concluded that moving forward, she will monitor and continue to remind the staff to observe if the call lights were within reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 03/28/2024 at 10:07 AM, the Administrator stated the call lights should always be with the residents because the call lights were what the residents use to request for assistance or to call for help. Without the call light the needs of the residents would not be addressed. The Administrator said everybody was responsible for the call lights. The Administrator concluded that the expectation is that the staff would do their due diligence and check the residents if the call lights were within reach more often. Record review of facility's policy Resident Rights on 03/28/2024 revealed The resident has a right to a . and communication with and access to persons and services inside and outside the facility . Respect and dignity . 3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Policy for call light, specifically for call lights within reach requested on 03/28/2024. The DON stated they do not have a policy particular for call light within reach.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on interview and record review, the facility failed to ensure the resident had a right to manage his or her financial affairs for one (Resident#87) of three residents reviewed for trust funds. The facility failed to provide Resident #87 with money from her trust fund when she requested. Resident #87 was required to provide receipts for items purchased with her own money. This failure could place residents whose personal funds were managed by the facility at risk for not receiving their funds when they request. Findings included: Review of Resident #87's quarterly MDS assessment, dated 02/28/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE]. The resident was cognitively intact. Her diagnoses included diabetes and cerebral ischemia (brain injury related to impaired blood flow to the brain) An interview on 03/27/24 at 10:00 AM with Resident #87 revealed there were times when she had to wait for days at a time to obtain money from her trust fund. She said if she asked for more than $100 the facility would write her a check, but she did not have any way to cash it. Resident #87 said her privacy was violated because if she did spend her money, she had to provide the facility with the receipts of items she purchased. Resident #87 said the BOM told her she could only take out $75 per month, so that all of the other residents had the opportunity to pull out money. An interview on 03/27/24 at 1:53 PM with the BOM revealed in order for a resident to take out money from their trust fund, they had to ask for it and sign it out. The BOM said the facility would write a check to the resident for amounts requested over $100. The BOM said the resident could have a family member go cash the check, or the resident could have a staff member cash the check for them. The BOM said the residents had to show receipts for funds spent over $100. She said the facility only kept $500 at a time so if a resident asked more than once to take out money, she would ask them to wait so other residents could pull out money. The BOM said the facility usually replaced the $500 every other day. She said that she did receive complaints regarding the issue. An interview on 03/27/24 at 2:21 PM with the Administrator revealed money could be given to residents if they had money in their account. The Administrator said residents had to show receipts if more than $100 was spent. The Administrator said there were instances when facility staff asked residents to wait to get their money until they went to the store. The Administrator said he heard the complaint before because multiple residents were able to pull out money. Review of the facility policy, Resident Rights, not dated, reflected: The resident has a right to manage his or her financial affairs .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 37028 Based on observation, interview, and record review the facility failed to ensure each resident had a right to a safe, clean, comfortable and homelike environment for 2 (Resident #40 and Resident #14) of 8 residents reviewed for safe and homelike environment. 1. The facility failed to ensure Resident #14 who resided on the secure unit had a homelike environment in her room. 2. The facility failed to ensure Resident #40 who resided on the secure unit had a homelike environment in her room. This failure could place residents at risk of living in an unsafe, unsanitary, and uncomfortable environment. Findings included: 1. Record Review of Resident #14's quarterly MDS assessment dated [DATE], reflected she was a [AGE] year-old female admitted to the facility 02/02/18. Her cognitive status was severely impaired. Her diagnoses included non-Alzheimer's dementia. 2. Record Review of Resident #40's quarterly MDS assessment dated [DATE], reflected she was a [AGE] year-old female admitted to the facility 10/21/16. Her cognitive status was moderately impaired. Her diagnoses included non-Alzheimer's dementia. An interview on 03/27/24 at 12:06 PM with a family member of Resident #14 revealed staff told her she was not allowed to bring any personal items to the facility for the resident. The family member said she was not allowed to bring personal items because other residents would steal her stuff. She said the resident's room was very bare. An observation and interview on 03/28/24 at 1:45 PM revealed Resident #14 had a comforter and 2 baby dolls in her room. There were no personal affects or pictures on the wall. The resident was confused, but said she liked her room. An observation and interview on 03/28/24 at 11:48 AM revealed Resident #40 was lying on her bed. There were no pictures, personal affects, decorations, or a TV in her room. The resident said she wished she had decorations in her room. An interview on 03/28/24 at 2:27 PM with the DON revealed she was not aware that Resident #40 wanted decorations in her room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 03/28/24 at 10:18 AM with the DON and Corporate Nurse revealed they were not aware of any complaints about rooms in the secure unit not being home-like. The DON said families were encouraged to bring in comforters for the residents. The DON said many of the residents in the secure unit had guardians and she did not see them coming to the facility to put items up. The DON said residents could not have breakable items. The Corporate nurse said the facility deterred family from bringing in items that other residents might want to take or put on. The DON said the facility tried to make sure that residents who took items and clothes were returned to the resident. The DON said the residents wandered into each other's rooms and would take their stuff. The Corporate Nurse said some of the residents liked to go shopping into other resident's rooms and take their stuff. The Corporate nurse said the residents did not have locks on their closets. Review of the facility policy, Resident Rights, not dated, reflected: 2. The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents .

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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** 47743 Based on observation, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for 3 of (Resident #100, Resident #30 and Resident #49) 7 residents reviewed for Care Plans. 1. The facility failed to ensure Resident #100 was care planned for oxygen administration. 2. The facility failed to ensure Resident #30 was care planned for dialysis. 3. The facility failed to ensure Resident #49 was care planned for his behavior concerns towards female residents. These failures could place residents at risk of not receiving necessary care and services. Findings included: 1. Review of Resident #100's Face Sheet dated 03/27/2024 reflected that resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included cerebral infarction (impaired blood flow to the brain) and anemia (deficiency of red blood cells) that carry oxygen to all parts of the body). Review of Resident #100's Quarterly MDS assessment dated [DATE] reflected that Resident #27 was cognitively intact with a BIMS score of 13. The Quarterly MDS also indicated that the primary reason for admission was anemia. Review of Resident #100's Comprehensive Care Plan dated 03/07/2024 reflected no care plan for oxygen administration. Review of Resident #100's Progress Notes dated 02/06/2024 indicated, this nurse called to resident room for SOB (shortness of breath), labored breathing VS BP 76/53 RR 24 O288% 2L NC (nasal cannula). Review of Resident #100's Progress Notes dated 02/06/2024 indicated, resident was transferred to a Hospital on 02/06/2024 8:35 AM related to SOB wheezing labored breathing with gurgling . Review of Resident #100's Progress Notes dated 02/14/2024 indicated, resident arrived via care flight transport accompanied by 2 EMS techs that transferred resident to his bed using sheet VS BP 108/62 T 97.4 RR 16 O2 89% ra (room air) with oxygen being applied at 1L (liter) via nc . Review of Resident #100's Progress Notes dated 02/15/2024 indicated, resident readmitted to . on 02/14/2024 after being hospitalized and treated for acute respiratory failure with hypoxemia (low level of oxygen in the blood) . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #100's Progress Notes dated 02/15/2024 indicated, . Plan: . 4. Continue O2 (oxygen) via nasal cannula to keep O2 saturation greater that 92%. Review of Resident #100's Progress Notes dated 02/25/2024 indicated, resident O2 sats were at 88% oxygen applied at 2L via nc. will continue to monitor. Review of Resident #100's Progress Notes dated 02/25/2024 indicated, resident O2 sats at 94% with 2L via nc. will continue to monitor. Review of Resident #100's Progress Notes dated 03/06/2024 indicated, resident has open wound to right posterior ear r/t oxygen tubing. O2 sats at 98%at this time and oxygen removed to relieve pressure on sore behind ear. order entered to apply mupirocin cream to right ear for 14 days then reassess. cushion applied to oxygen tubing to prevent further injury. will continue to monitor. Review of resident #100's Progress Notes on 03/27/2024, this nurse notified Dr of wound to right ear r/t oxygen tubing . Review of resident #100's Progress Notes on 03/27/2024 indicated no order for oxygen supplement discontinuation. Observation and interview on 03/26/2024 at 09:18 AM revealed Resident #30 was on his bed awake. It was also observed that Resident #30 was on oxygen supplement with 2 liters per minute via nasal cannula. According to the resident, he had been on oxygen for a long time but cannot specifically remember the date he had oxygen. Observation on 03/27/2024 at 08:52 AM revealed resident was on his bed awake and was still with oxygen supplement at 2 liters per minute via nasal cannula. Interview and observation on 03/27/2024 starting at 9:37 AM with ADON B. ADON B stated Resident #100 was on oxygen because his oxygen saturation would drop. ADON B said the resident was hospitalized last month because of his oxygen saturation dropped to a low level of 88%, shortness of breath, and wheezing. ADON B added as far as she knows, the order for the resident's oxygen supplement was as needed. ADON B clicked the care plan button and started to look for the plan of care for Resident #100's oxygen supplementation. ADON B said there was no care plan for the resident's oxygen. 2. Review of Resident #30's Face Sheet dated 03/27/2024 reflected that resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included end stage renal disease (kidneys permanently failed to work) and acute kidney failure (loss of function of the kidneys). Resident #30 was also dependent on dialysis (treatment that helps the body remove extra fluid and waste products). Review of Resident #30's Quarterly MDS assessment dated [DATE] reflected that Resident #39 was cognitively intact with a BIMS score of 13. The Quarterly MDS also indicated that the primary reason for admission was medically complex conditions such as renal failure (kidney failure) and end-stage renal disease. Resident #30 was undergoing dialysis while a resident of the facility. The Quarterly MDS Assessment specified that resident was undergoing dialysis while a resident of the facility. Review of Resident #30's Comprehensive Care Plan dated 02/05/2024 reflected no plan of care for dialysis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #30's Progress Note dated 01/26/2024 indicated, hemodialysis initiated JAN24 . Review of Resident #30's Progress Note dated 03/20/2024 indicated, hemodialysis initiated JAN24 . Observation and interview with Resident #30 on 03/26/2024 at 8:28 AM, resident was on his bed awake. Resident stated he had been undergoing dialysis for a couple of months. Resident #30 showed the old fistula on his left arm and then pulled the neckline of his shirt to show the port on the right of his chest. Interview and observation on 03/27/2024 at 10:05 AM with ADON B, ADON B stated Resident #30 was not in his room because he was having dialysis. ADON B said resident was receiving hemodialysis for a while. ADON B added resident had a port on the right chest and an old fistula on the left arm. ADON B further said since he was on dialysis, there should be a care plan for dialysis. ADON B went to Resident #30's profile and searched for Resident #30's care plan. ADON B said there was no care plan for Resident #30's dialysis. Interview with ADON B on 03/27/2024 at 10:21 AM, ADON B stated it was important that residents have a care plan to fully provide the care and services the residents needed. ADON B said that for these cases, there should be a care plan for oxygen supplement for Resident #100 since one of the reasons he was hospitalized was his oxygen saturation was dipping and because the resident was still using oxygen. ADON B added that it was the same thing with Resident #30's dialysis. ADON B stated there should be care plan for dialysis to know the goals as well as the interventions. She said the care plan would tell the staff what care were needed for the residents' medical issues. She added if without the care plan, the current health status of the resident will not be addressed. If the medical issues were not addressed, the resident will not attain the quality of care needed and appropriate for them. She said the MDS Nurse and the DON were responsible in making the care plan. She said since she was an ADON, it was her responsibility as well to help oversee if the care plan were done. For these two medical issues, ADON B said the care plans were not done. Interview and observation with MDS Nurse A on 03/28/2024 at 8:50 AM. MDS Nurse A stated care plans were important to ensure the residents were getting the care needed. MDS Nurse said care plans served as a guidebook on how to manage the medical issues of the residents. MDS Nurse A said care plans were comprised of the problem lists, the goals, and the interventions appropriate for the needs of the residents. MDS Nurse A added that without the care plans, the staff could miss out significant interventions needed by the residents. MDS Nurse A said Resident # 100 had a care plan for oxygen and Resident #30 had a care plan for dialysis. MDS Nurse A then added the care plans for Resident #100 oxygen and Resident #30's dialysis was only added the day before. MDS Nurse A said he did the care plan for the dialysis when a nurse told him to do the care plan for dialysis the day before and then said somebody else did the care plan for the oxygen. MDS Nurse A said he was not aware the Resident #100 was still using oxygen and that resident #30 was on dialysis. MDS Nurse A there was an oversight and a break in communication with regards to the Resident 100's oxygen supplement and Resident #30's dialysis. MDS Nurse A said he would check on the residents' care plans to see if they summarized the residents' health conditions and to see if they have the current treatment needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with MDS Nurse B on 03/28/2024 at 8:50 AM stated they were not the only ones doing the care plan. MDS Nurse B said the nurses could also do the care plan. MDS Nurse B said that all staff were responsible in assessing the residents and to see if the care being given were appropriate. MDS Nurse B added that if there were no care plan, the specific needs and care of the residents will not be met. MDS Nurse B said they usually were included in the interdisciplinary team but they were not advised that Resident #100 was using oxygen and that Resident #30 was in dialysis. Interview with DON on 03/28/2024 at 9:15 AM, the DON stated that care planning was absolutely important so that the staff would know the residents' health conditions as well as the treatments needed by the resident. The DON said care planning was a team approach and a collaboration of the interdisciplinary team composed of the resident, family, nurses, rehab team, and social worker. The DON said the MDS Nurses and the DON were responsible in overseeing if the residents had their appropriate care plans. The DON added that without a care plan, the current health issues would not be addressed and managed accordingly. The DON further stated that the care plan should be accurate and up to date. The DON said if the resident was using oxygen, there should be a care plan for oxygen supplement, if the resident was in dialysis, there should be care plan for dialysis. The DON said that the expectation is for the staff to ensure that every health issues are care planned. The DON concluded that moving forward, she will monitor staff's adherence to the policy care planning to ensure the best possible care. Interview with Administrator on 03/28/2024 at 10:07 AM, the Administrator stated every medical necessity of the residents should be care planned. The Administrator said that without a care plan, the resident would not have care needed. The Administrator concluded that the expectation is that the staff will ensure that every issue of the residents are care planned. 3. Review of Resident #49's admission record reflected the resident was a [AGE] year-old male with an admitted [DATE]. Resident had a diagnosis of Cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain), unspecified dementia (impaired ability to remember, think or make decisions), personal history of other mental and behavioral disorders (Disruptive behaviors). Review of Resident #49's MDS dated [DATE] reflected a BIMS score of 04 indicated a moderate cognitive impairment. Review of Resident #49's Care Plan from 11/01/2023 to 03/27/2024 reflected no care plan for his behavior issues towards female residents. Review of Resident #49's progress notes from 11/01/2023 to 03/27/2024 reflected no notes regarding his behavior issues towards female residents. Review of Resident #49's Psychiatric Subsequent assessment dated [DATE] reflected Resident behavioral concerns including inappropriate touching of female residents reported by staff. An interview on 03/26/2024 at 11:26 AM with Resident #87 revealed Resident #49 reached out to her and touched her buttocks several times in the past few months, while she was passing by Resident #49 who was sitting in his wheelchair in the dining area or hallway. Resident #87 stated she felt Resident #49's behavior was inappropriate, and she felt unsafe. Resident #87 stated she had reported this to the nurses and the nurses responded to her that Resident #49 did not know what he was doing. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator 03/27/24 02:56 PM revealed that he was not aware of Resident #87's compliant about Resident #49 touching her butt while she pass by the dining or hall way. Resident reported this happened 1-2 times a week. Administrator stated he did not know about this and he was going to conduct an investigation about this incident. Observation and interview on 03/27/2024 at 03:10 PM revealed Resident #49 was sitting in his wheelchair in the hall way. Resident did not provide a response when asked about his behavior of touching female residents inappropriately. Interview on 03/28/2024 at 10:32 AM, CNA C stated she was able to recognize abuse, she received in service on abuse 2 weeks ago. She stated there were several types of abuse and sexual abuse was one of them. CNA C stated she would first make sure the victim was safe and report any type of abuse to the administrator, her nurse and DON immediately. CNA C stated Resident #49 reaches out and touches everybody, he tries to grab such as a wheelchair when someone passes by him in the common areas such as dining, hallways. CNA C stated a resident had called police on Resident #49 when he grabbed her wheelchair and touched her body. CNA C stated she had reported this incident to the Administrator. Interview on 03/28/2024 at 10:45 AM, ADON B stated she received in service on abuse a week ago and she was able to identify sexual abuse and other types of abuse such as physical and emotional abuse. She stated touching someone without their consent was an example for sexual abuse and she would immediately report to the abuse coordinator who is the Administrator, if she had heard about abuse. ADON B stated she had heard from other staff that a female resident had complained about Resident #49 of inappropriately touching her. ADON B stated she did not think Resident #49 was inappropriately touching or intentionally trying to hurt any female residents and that he holds him arm out when people pass by his wheelchair, this was part of his attention seeking behavior. Interview with LVN E on 03/28/2024 at 11:02 AM,. She stated there were several types of abuse such as financial, physical, emotional, and sexual. She stated any unwanted sexual behaviors or advancements made towards a resident was considered as sexual abuse and if she had the knowledge of abuse taken place, she would immediately report to the administrator who is the abuse coordinator. LVN E stated she was not aware of any male resident inappropriately touching female residents. When asked about Resident #49, she stated Resident #49 try to grab people and touch them when someone pass by him while he is at the hallway. LVN E stated she heard about a resident calling police on him and few other residents yelling at him for touching them. LVN E stated none of the residents reported to her that Resident #49 touched them inappropriately or sexually abused but she thinks Resident #49 was touching females with sexual intention, otherwise he would touch male residents too. Interview on 03/28/2024 at 11:14 AM, CNA D, stated she received in service on abuse a week ago and she was able to identify different types of abuses such as sexual, verbal, physical, mental and financial. CNA D stated she would immediately report to the abuse coordinator who is the administrator, if she came to know about abuse. CNA D stated she was not aware of any male resident inappropriately touching female residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/28/2024 at 11:29 AM, LVN E, who was the MDS nurse, stated she had received in service on abuse, and she was able to identify abuse. LVN E stated Resident #49 may grab your arm to get attention if you pass by him. She stated there was an incident when a female resident called police on him for touching her, LVN E stated she did not think that incident had anything to do with sexual abuse. LVN E stated she searched but she could not find Resident #49's inappropriate behavior with female residents was care planned. LVN E stated the whole team including the DON, ADON, MDS nurse, Social Worker were responsible to do the care plan. LVN E stated care planning Resident #49's inappropriate behavior was important because by care planning, all the staff were able to monitor his behavior towards female residents and try to control his inappropriate behavior. LVN E stated she did not know the reason for not care planning Resident #49's inappropriate behavior and the female residents could feel violated because of Resident #49's repeated inappropriate behaviors. Interview on 03/28/2024 at 02:08 PM, the DON stated she received in services on abuse and the staff were given in services on abuse on a regular basis. She stated touching a female can be perceived as sexual abuse and she expect her staff to immediately report any abuse concerns to the abuse coordinator which is the administrator. The DON stated if there was a sexual abuse concern, she expects her staff to separate the residents and ensure the victim was safe, notify the doctor, responsible party. She stated the facility will investigate and find the cause of the abuse, care plan the behavior and try to prevent it from happening again. The DON stated Resident #49 was childlike and he thought it was funny to touch other residents and staff. The DON stated a female resident had called police on Resident #49 when he touched her arm. The DON stated Resident #49's behavior was care planned on 03/28/2024 and that it was not care planned prior to that date. The DON stated she did not know the reason for not care planning Resident #49's behavior and the MDS nurse, DON, nursing staff- all were responsible to do the care plan for the residents. The DON stated not care planning Resident #49's inappropriate behavior towards female residents would result in female residents feeling intimidated and not safe at the facility. Interview on 02/28/2024 at 02:19 PM, the Administrator stated he was not aware of Resident #49's behavior issues. He stated Resident #49 was a severely demented individual who was not able to make decisions. The administrator stated he expects all the staff to immediately report any type of abuse to him so that the abuse can be investigated. The Administrator stated he did not know the reason for Resident #49's behavior not care planned, the Inter Disciplinary Team was responsible to do the care plan. He stated the risk for other residents were that other residents may have felt bad about Resident #49's behavior. Administrator stated Resident #49's behavior was supposed to be documented and all the staff were trained on abuse/neglect recently. Record review of facility's policy, Comprehensive Care Planning, Nursing Policy & Procedure Manual, The facility will develop and implement a comprehensive person-centered care plan for each resident . the resident's goals for admission and desired outcome . address the resident's medical . needs . the resident's care plan will be reviewed after Admission, Quarterly, Annual, and/or Significant Change. 48235

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding for one (Resident #100) of one resident reviewed for feeding tubes. The facility failed to ensure Resident #100's medications were administered one by one via G-tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach) as per policy. The facility failed to ensure Resident #100's feeding formula tubing was capped when detached from the G-tube port. The facility failed to ensure Resident #100's medications were fully dissolved before administering the medications. The facility failed to ensure Resident #100's syringe used for medication administration via G-tube was cleaned after use. These failures could place residents with G-tubes at risk of infection, at risk for medication-to-medication interaction, and at risk of not receiving the full benefit of the medications administered. Findings included: Review of Resident #100's Face Sheet dated 03/27/2024 reflected that resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included gastrostomy (medical procedure where a tube is inserted into the stomach) status and dysphagia (difficulty in swallowing). Review of Resident #100's Quarterly MDS assessment dated [DATE] reflected that Resident #100 was cognitively intact with a BIMS score of 13. The Quarterly MDS also indicated resident was on tube feeding while a resident of the facility. Observation and interview on 03/27/2024 at 08:52 AM, revealed Resident #100 was on his bed awake. Resident #100 had an IV pole at bedside with a formula for tube feeding hanging on it. The formula was connected to Resident #100's g-tube. The resident's head was elevated to 30 degrees. Resident said he was on tube feeding because he had difficulty swallowing. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/27/2024 at 8:52 AM, revealed ADON B was about to administer Resident #100's medications. ADON B prepared the medications by putting the medications in a small white cup. After placing all the medications needed in a small cup, ADON B then transferred the medications to a pill crusher pouche and crushed the medications. After crushing the medications, ADON B transferred the crushed medication to a plastic cup. ADON B then prepared Resident 100's Miralax in a different plastic cup. ADON B brought both plastic cups inside Resident #100's room along with two cups of water. Inside the room, ADON B put some water in the Miralax and in the crushed medications. ADON B did not mix the medications. ADON B put on gloves and then disconnected the tube of the feeding formula from the g-tube and hung it on the IV pole. The end of the tube touched the enteral feeding pump. ADON B took the syringe and extracted some air. ADON B connected the syringe to the g-tube and placed a stethoscope on the resident's diaphragm. ADON B pushed the plunger to check on placement. ADON B removed the plunger and connected it on the g-tube. ADON B then ADON B poured 30 ml of water in the syringe. ADON B then took the cup of the crushed medications and poured it in the syringe. ADON B put some water in the cup of crushed medications and poured it in the syringe. Remnants of the medications were noted to be still in the bottom of the cup. ADON B discarded the cup. ADON B took the cup of Miralax and poured it in the syringe. Remnants of the Miralax was noted at the bottom of the cup. The cup was discarded. ADON B then put the syringed used inside the plastic. The syringe was not cleaned before placing it back inside the plastic. ADON B then connected the tube for the feeding formula to the g-tube. Interview with ADON B on 03/28/2024 at 12:10 PM, ADON B stated they usually had an order for a cocktail medication for residents with g-tube. ADON B turned on the computer and searched for the order for a cocktail medication. She said there was no order for a cocktail medication. ADON B said if there was no order for the medication to given all at the same time, she should had given it one-by-one. She said medications were given one-by-one to ensure the medications administered were compatible with each other. ADON B said she should had made sure the end of the feeding tube did not touch the pump because it could cause infection. She added she should had made sure the tube was free hanging. ADON B said she should had diluted the medications thoroughly so the resident could acquire the full benefit of the medications. ADON B acknowledged that she placed the syringe back to the plastic without washing it. ADON B said the syringe should be cleaned before using it again because it could cause infection. She said she would get a new one to replace the syringe that was not washed. Interview with the DON on 03/28/2024 at 9:15 AM, the DON stated medications for tube feeding should be administered one-by-one unless there was an order that it could be cocktailed or given all together. The DON said this procedure was done to prevent problems with drug compatibility. The DON said if the tube for the feeding formula was disconnected from the g-tube, the end of the tube should be capped to prevent it from touching any surface. The DON added if the end of the tube could be contaminated and could cause infection. The DON said the medications should be dissolved fully to ensure that there would be blockage when the medications were poured on the syringed. She added a tongue depressor or a wooden spoon could be used to dilute the medications. She said the medications should be dissolved completely so the resident could have the full benefit of the medications. The DON said the syringe should had been washed and dried after each use to prevent infection. She said not cleaning the syringe could attract bacteria and other harmful organisms to dwell on the syringe. The DON said the expectation was the staff providing enteral feeding to practice the right procedure in doing tube feeding so that the residents with g-tube could receive quality care. She added she would remind the staff of the proper procedure of tube feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 03/28/2024 at 10:07 AM, he stated he was not aware of the procedure for tube feeding. He said whatever the policy and procedure for tube feeding should be followed to address the medical necessities of the residents. Record review of facility's policy Enteral Medication Administration, Pharmacy policy & Procedure Manual rev. 1/25/2013 revealed, . 5 . When separating the tube from a pump, avoid contamination of the open end . 8. Administer one medication at a time with a flush of 5-10 ml water or the amount ordered by the physician, between each medication and after the final medication is administered. Verify that medication cups are clear of any remnants of crushed pills or liquid medication . 12. Change the medication syringe as directed by the manufacturer's label. If the syringe is used for 24 hours, clean after each use.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 48560 Based on observation, interview and record review the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice for 4 of 8 (Residents #15, #68, #58 and #30) residents reviewed for respiratory care, in that: 1- The facility failed to ensure Resident #15, and Resident #68 nasal cannula tubing and humidity bottle were labeled or dated. 2- The facility failed to ensure Resident #58, and Resident #30 nasal cannula was properly stored. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. The findings were: Review of Resident # 15's Quarterly MDS assessment dated [DATE] reflected resident was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included stroke (blood supply to brain is interrupted), hypertension (high blood pressure), Peripheral vascular disease (circulation disorder caused by narrowing of blood vessels), Diabetes Mellitus (high blood sugar), hemiplegia (paralysis of one side of the body) and was on oxygen therapy in the facility. Review of Resident #15's care plan dated 2/1/2024 reflected Resident #15 has Oxygen Therapy at bedtime and one of the interventions included Oxygen at 2 lpm per nasal canula at bedtime. Review of Resident #15's Physician order dated 10/18/2023 reflected Change Oxygen tubing every Wednesday night, rinse filter. Place change Wednesday sticker on tubing with date and initials on Every night shift every Wednesday. Review of Resident #15's Physician order dated 9/20/2023 reflected oxygen 2 Liter via Nasal Cannula at bedtime. Observation on 03/26/24 at 01:01 PM, revealed that Resident #15 was in his wheelchair with oxygen concentrator on via nasal cannula and oxygen humidity bottle and nasal cannula tubing was not dated or labeled. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with ADON B on 3/26/2024 at 1:04 PM, revealed she was working the floor today. She stated that nurses were responsible for dating and labeling oxygen supplies including nasal cannula and humidity bottle. She stated that night shift nurses were to change and date oxygen tubing and humidity bottle every Wednesday and oxygen supplies can be changed and dated on as needed basis. ADON B revealed that dating and labeling oxygen supplies was a part of nursing protocol and should be reflected on resident's physician orders. She stated risk to resident of not dating or labeling oxygen supplies was infection control. She stated as an ADON, she had a weekly checklist and checking oxygen tubing for dates and labels was a part of it. She stated that her last weekly check was on 3/21/2024. Resident #68 Review of Resident # 68's Quarterly MDS dated [DATE] reflected a [AGE] year-old male readmitted to the facility on [DATE]. Relevant diagnoses include heart failure (condition that develops when heart does not pump adequate blood), hypertension (high blood pressure), pneumonia (infection in lungs), Diabetes Mellitus (high blood glucose), Respiratory failure (condition that makes it difficult to breathe on your own) and was on oxygen therapy in the facility. Review of Resident #68's comprehensive care plan revised 10/24/2023 reflected Resident #68 had Oxygen therapy and one of the interventions included OXYGEN SETTINGS: PRN Oxygen 2-4 LPM via Nasal Cannula to keep saturation above 92%. Review of Resident #68's Physician order dated 10/18/2023 reflected Change Oxygen tubing every Wednesday night and rinse filter. Place a change Wednesday sticker on tubing with date and Initials, every nightshift every Wednesday. Review of Resident #68 Physician order dated 8/25/2023 reflected Check Oxygen saturation every 8 hours and apply Oxygen at 2-4 Liter to keep Oxygen saturation more than 92% every 8 hours. Observation on 03/26/24 at 11:17 AM revealed resident resting in bed, oxygen not running, and oxygen humidity bottle and nasal cannula tubing was not dated or labeled. In an observation and interview with LVN A on 03/26/24 at 11:22 AM, revealed she was not sure when the nasal cannula and humidity bottle was last changed since she could not see a label or date on it. She stated that Resident #68 was on her list to change nasal cannula tubing and humidity bottle today; was usually changed on the night shift nurses. LVN A checked Resident #68's oxygen saturation, which was 98%. LVN A added risk to resident for not dating and labeling Oxygen supplies was major risk of infection. In an interview with DON on 3/28/24 at 11:14 AM, revealed her expectation was that all oxygen tubing and supplies should be dated and labeled. It should be changed weekly and on as needed basis. the DON added it was the responsibility of night nursing staff every Wednesday to change and date all oxygen supplies. She stated that the risk to residents for not following procedures for respiratory care was infection control. She started as a DON, she ensured that she conducted floor rounds at least bi-weekly to address any concerns with quality of care was not compromised. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #58's Face Sheet dated 03/27/2024 reflected resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included neoplasm (abnormal growth in the tissue) of the breast and history of COVID-19. Review of Resident #58's Comprehensive MDS assessment dated [DATE] reflected Resident #58 was cognitively intact with a BIMS score of 14. Resident #58 was on oxygen therapy while a resident of the facility. Review of Resident #58's Care Plan dated 02/01/2024 reflected resident had oxygen therapy related to long COVID and one of the interventions was O2 via nasal cannula at 2 liters per minute as needed to maintain O2 saturation at or above 92%. Review of Resident #58's Physician Order dated 12/13/2023 reflected, May use oxygen @ 2 L/M via nasal cannula every shift for O2 sats below 92%. Observation on 03/26/2024 at 10:46 AM, revealed Resident #58 was on her bed, sleeping. Resident #58 had an oxygen concentrator at bedside with a nasal cannula attached to it. There was a plastic bag behind the oxygen concentrator. The nasal cannula was not bagged and was hanging on top of the oxygen concentrator. Resident #58 also had a nasal cannula at the back of her wheelchair attached to an oxygen tank. The nasal cannula not bagged and was hanging on top of the oxygen tank. Observation and interview with LVN A on 03/26/2024 starting at 2:23 PM, LVN A stated Resident #58 had been on oxygen for a while. LVN A said she not aware the resident was back in her room, so she was not able to put back the oxygen. When she was about to get the nasal cannula, LVN A noticed the nasal cannula was hanging on top of the oxygen concentrator. LVN A said she needed to get a new nasal cannula because it was just lying on top of the oxygen concentrator. She said it should be bagged when not in use. LVN A disconnected the nasal cannula from the oxygen concentrator. When LVN A was about to leave the room, she also disconnected the nasal cannula connected on the oxygen tank behind the wheelchair. She said she would also replace it because it was lying on top of the oxygen tank. LVN A left the room and returned with two nasal cannulas. LVN A connected one of the nasal cannulas on the oxygen concentrator and put the prongs of the nasal cannula on the resident's nostril. The other nasal cannula was also connected to the oxygen tank at the back of the wheelchair. Only the part to be connected to the oxygen tank was taken out of the plastic while the rest of the tubing remained inside the plastic. LVN A stated the nasal cannula should be bagged when not in use because it could cause contamination and eventually infection. LVN A said she must make sure the nasal cannula was bagged if the residents were not using them. Review of Resident #30's Face Sheet dated 03/27/2024 reflected that resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included acute respiratory failure with hypercapnia (higher than normal level of carbon dioxide in the blood) and hypoxia (low blood oxygen). Review of Resident #30's Quarterly MDS assessment dated [DATE] reflected that Resident #30 was cognitively intact with a BIMS score of 13. The Quarterly MDS also indicated that the primary reason for admission was medically complex conditions such as chronic lung disease and respiratory failure. Resident #30 was on oxygen therapy while a resident of the facility. Review of Resident #30's Comprehensive Care Plan dated 02/05/2024 reflected resident had oxygen therapy and one of the interventions was oxygen at 2 LPM per nasal cannula as needed for O2 < 92%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/27/2024 at 8:28 AM, revealed Resident #30 was not inside the room. Resident had an oxygen concentrator at bedside and a nasal cannula was connected to the oxygen concentrator while the prongs of the nasal cannula were on the trash. A plastic bag was attached at the back of the oxygen concentrator. Interview with ADON B on 03/27/2024 at 10:05 AM, ADON B stated the nasal cannula should had not been exposed nor touching anything because it could cause infections. ADON B said the nasal cannula should had been bagged when not in use to ensure cleanliness. ADON B said she would disconnect the nasal cannula and connect a new one to make sure Resident #30 would use a clean one when he returned to his room. Interview with the DON on 03/28/2024 at 9:15 AM, the DON stated the nasal cannula should be bagged when not in use. The DON said it was the proper way to store the nasal cannula. The DON added if those nasal cannulas was not bagged and touching surfaces that were not sure clean, the oxygen administration could be compromised. The DON said the staff, including her, were responsible in monitoring that the equipment used in oxygen therapy were bagged when not in use. She said the expectation was the nasal cannula would be stored properly if the residents were not using them. The DON said she would continually remind the staff to be diligent in making sure the procedures for respiratory care were followed. Interview with the Administrator on 03/28/2024 at 10:07 AM, the Administrator stated he was not familiar with the clinical policies but said that whatever the residents were using should maintained clean. He said that for this concern, the nasal cannula should be stored properly to prevent more respiratory issues. The Administrator said the expectation is for the staff to be diligent in order to provide the highest level of care. Policy for Respiratory Care, specifically for nasal cannula being bagged and dating and labeling Oxygen supplies was requested on 03/28/2024. The DON stated they do not have a policy about nasal cannula being bagged or dating and labeling oxygen supplies.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview, and record review, the facility failed to ensure residents who required dialysis received such services, consistent with professional standards of practice for one (Resident #30) of one resident undergoing dialysis. The facility failed to ensure Resident #30 had orders pertaining to dialysis. This failure could place the residents undergoing dialysis not receiving proper care and treatment to meet their dialysis needs and place them at risk for complications. Findings included: Review of Resident #30's Face Sheet dated 03/27/2024 reflected that resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included end stage renal disease (kidneys permanently failed to work) and acute kidney failure (loss of function of the kidneys). Resident #30 was also dependent on dialysis (treatment that helps the body remove extra fluid and waste products). Review of Resident #30's Quarterly MDS assessment dated [DATE] reflected that Resident #30 was cognitively intact with a BIMS score of 13. The Quarterly MDS also indicated that the primary reason for admission was medically complex conditions such as renal failure (kidney failure) and end-stage renal disease. Resident #30 was undergoing dialysis while a resident of the facility. The Quarterly MDS Assessment specified that resident was undergoing dialysis while a resident of the facility. Review of Resident #30's Care Plan dated 02/05/2024 reflected resident was on hemodialysis and one of the interventions was to encourage resident to go to the scheduled dialysis. Review of Resident #30's Progress Note dated 03/20/2024 indicated, hemodialysis initiated JAN24 . Review of Resident #30's Progress Note on 03/27/2024 indicated no documentation that resident went out for dialysis. Review of Resident #30' Physician Order on 03/27/2024 showed no order for dialysis nor what type of dialysis. Review of Resident #30' Physician Order on 03/27/2024 showed no order for when the dialysis was scheduled. Review of Resident #30' Physician Order on 03/27/2024 showed no order for no needle stick, blood pressure, and blood draw to left arm. Review of Resident #30' Physician Order on 03/27/2024 showed no order to assess the port to right chest for infection. Review of Resident #30' Physician Order on 03/27/2024 showed no order to check for bruits and thrill. (continued on next page)

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Longmeadow Healthcare Center	120 Meadowview Dr Justin, TX 76247

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #30' Physician Order on 03/27/2024 showed no order to weigh before and after dialysis. Review of Resident #30' Physician Order on 03/27/2024 showed no order to assess for bleeding on the dialysis site. Observation and interview with Resident #30 on 03/26/2024 at 8:28 AM, resident was on his bed awake. Resident #30 stated he had been undergoing dialysis for a couple of months. Resident #30 showed the old fistula on his left arm and then pulled the neckline of his shirt to show the port on the right of his chest. Resident said the facility was taking care of his transportation. Interview and observation on 03/27/2024 at 10:05 AM, ADON B stated Resident #30 was not in his room because he was having dialysis. When asked, what was the order for his dialysis, ADON B said she would check Resident #30's profile. ADON B said there were no orders for Resident #30's dialysis. She said there should be an order for the days the resident was out for dialysis, an order to assess the dialysis site for bleeding, an order to check for bruits to ensure the shunt was intact, and an order to weigh the resident before and after dialysis to ensure there was no fluid retainment. ADON B said these orders were important to fully assess the effectiveness of the dialysis. She said without the orders, the staff would not know what to assess before and after dialysis. She said the resident was in and out of the hospital but said it was not an excuse that the orders for dialysis was not entered in the system. Interview with the DON on 03/28/2024 at 9:15 AM, the DON stated the staff should not only be familiar that Resident #30 was receiving dialysis. She said the staff should ensure that orders for dialysis were entered in the system and could be viewed by staff caring for the resident. She added if there were no orders on the system, a staff not familiar with his care would not know that the resident needed dialysis and what to assess before and after dialysis. She said dialysis care was important to see if dialysis was effective, if the blood pressure was managed, and if there was no fluid retention. The DON said the expectation was the staff would have a conscious effort to enter the order for dialysis to provide quality care for the resident. She said she would remind the staff to enter the needed order for dialysis. Interview with the Administrator on 03/28/2024 at 10:07 AM, he said he was not aware of the procedure for dialysis. He said whatever the policy and procedure in providing care for residents undergoing dialysis should be followed to address the medical necessities of the residents. Record review of facility's policy Dialysis Nursing Policy & procedure manual 2013, rev. November 2013 revealed, Dialysis: Dialysis is a process used to remove fluid and waste products from the body when the kidneys are unable to do so . The purposes of dialysis are to maintain the life and well-being of the patient . Procedure . 1. Review and confirm the physician's order for dialysis . 7. The site will be assessed for bleeding, bruising . The nurse will palpate the access from the distal anastomosis to the proximal anastomosis . Record the results of the examination.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49459 Based on observation, interview and record review, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to ensure that an account of all controlled drugs were maintained and reconciled for one (Resident #16) for three residents reviewed for controlled drug records. The facility failed to account for Resident #16's Fentanyl patches (pain medication) on 11/30/23. This failure placed residents at risk for decreased quality of life, unrelieved pain, and misappropriation of property. Findings included: Record review of Resident #16's face sheet dated 01/13/2023, reflected Resident #16 was a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included neurocognitive disorder with Lewy Bodies, hydrocephalus, Parkinson's disease with dyskinesia, hyperlipidemia, opioid dependence, unspecified dementia, lack of coordination, muscle weakness, abnormal gait and mobility, prediabetes, and chronic pain. Record review of Resident #16's quarterly MDS assessment dated [DATE] reflected he had severe cognitive impairment. Record review of Resident #16 's Narcotic Count Record, dated November 2023, reflected: The narcotic count sheet and box of 5 Fentanyl patches was missing on 11/20/23. Record review of the facility's Provider Investigation Report, dated 12/07/23, reflected: On 11/30/23, when MA Y went to change Resident #16's fentanyl patch, she found that the box of 5 patches was not in the narcotic box. MA Y did not remove the resident's current patch and notified LVN Z of the missing fentanyl patches. LVN Z confirmed that hospice delivered a box of 5 fentanyl patches the night of 11/30/23. A patch was placed on Resident #16 early on 12/01/23. LVN Z confirmed that the quantity on hand matched the count sheet and the one applied was indeed signed out. An interview with MA Y on 03/28/24 at 11:05 AM, revealed facility staff counted to make sure the medication count matched the count on the Narcotic Count Record at the beginning of each shift. MA Y said the staff used to also make note if the resident had multiple Narcotic Count Records and multiple medication cards of the same medication. MA Y said the staff no longer counted the number of medication cards. MA Y said on the day of the incident, she counted the narcotics when she got to work. MA Y said when she went to apply a new Fentanyl patch to Resident #16, she identified that a box of Fentanyl patches (5 in the box) was missing. MA Y said she notified LVN Z, MA Y said, she also counted the medication cart the day before and the Fentanyl patches and narcotic count record was on the cart. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with LVN E on 03/28/24 at 11:15 AM, revealed during narcotic counts, the staff no longer counted the number of medication cards during medication count. She said she would not know if a card of medications was missing. She said the narcotic count sheet would have been with the card of medication. An interview with LVN Z on 03/28/24 at 11:25 AM, revealed she was working the day shift when the incident occurred. She said MA N brought the narcotic discrepancy to her attention. LVN Z said the Fentanyl patches was in the medication cart the previous day. LVN Z said she notified the medical director, DON, Administrator, and police department. The medication carts was checked, and no other medications were found to be missing. LVN Z said all staff who worked on the day of the incident was interviewed, but the alleged perpetrator was not found. LVN Z said following the incident, the facility switched to a new form for counting narcotics. The new form did not contain an area to put the number of medication cards. It only had a space to the staff name that the cart was counted. LVN Z said that there was no way to determine if a medication card and narcotic count sheet might be missing. An interview with the DON on 11/28/24 at 1:45 PM, revealed there was not a system in place to account for the number of medication cards and narcotic count sheets per shift. A copy of the November 2023 Narcotic Count Record for Resident #16's Fentanyl was requested from the Administrator. The document was not provided prior to exit. Record review of the facility's policy Medication Administration: Documentation of Controlled Substance dated 12/04/23, reflected: 16. There shall be a narcotic audit at each change of shift to ensure against any discrepancy. Upon a correct audit, the nurses involved will sign the Narcotic Check List.at the time of the audit, the nurses are to observe for correct count and correct medication.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview, and record review, the facility failed to ensure, based on the comprehensive assessment of a resident, residents who had not used psychotropic drugs were not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 of 5 residents (Resident #84) reviewed for unnecessary psychotropic medications. The facility failed to provide an appropriate diagnosis for Resident #84's use of Paliperidone ER (Antipsychotic used to treat schizophrenia and schizoaffective disorder). These failures could put residents at risk of receiving unnecessary psychotropic medications. Findings included: 1. Record review of Resident #84's admission MDS assessment, dated 01/26/24, revealed the resident was a [AGE] year-old male who admitted to the facility on [DATE]. The resident's cognition was severely impaired. The resident had diagnoses including bipolar disorder and non-Alzheimer's disease. The MDS indicate the resident took an antipsychotic. The resident did not have a diagnosis of schizophrenia. Record review of Resident #84's care plan revealed he did not have a care plan for the antipsychotic medication for schizophrenia. Record review of Resident #84's Order Summary Report, dated March 2024, reflected: 1. Admit to secure unit due to history of elopement with active exit seeking behavior 2. Paliperidone ER Oral Tablet Extended Release 3 mg one time a day for Schizophrenia related to bipolar disorder. Record review of Resident #84's Pharmacy Consultant Nursing Summary Report, dated 03/15/24, reflected: Please clarify the following indication . 1. Paliperidone ER tablet 3 mg. Give one tablet by mouth once a day for Schizophrenia . An interview on 03/26/24 at 11:15 AM with Resident #84 revealed he resided on the secure unit. The resident was not interviewable, but said he was doing well. The resident was sitting in a chair reading a book. An interview on 03/27/24 at 3:26 PM with LVN J revealed Resident #84 did not have any behaviors. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 03/27/24 at 3:50 PM with LVN Z revealed Resident #84 resided on the secure unit and did not have any behaviors other than wandering. An interview on 03/28/24 at 9:59 AM with the DON and Corporate Nurse revealed Resident #84 did not have a diagnosis for schizophrenia. They said he had a diagnosis of bipolar disorder. The DON said paliperidone treated mental health issues and she did not know why the order said to administer for schizophrenia. The DON said the resident did not have signs or symptoms of schizophrenia. The DON said she did not know why the March Pharmacy Consultant Nursing Summary Report was not addressed. The DON said the Report said to clarify the diagnosis. Review of the facility policy and procedure, Psychotropic Medications, revised 10/25/17, reflected: The facility must will ensure that- 1. Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41211 Based on observation, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food storage, labeling, dating, and kitchen sanitation. The facility failed to properly store scoops for the ice machine. The facility failed to ensure that food stored in the dry goods pantry as dated and closed/sealed properly. The facility failed to ensure that only non-expired foods were stored in the dry goods panty. These failures could place residents at risk for cross contamination, other air-borne illnesses, and food-borne illnesses. Findings included: Observations on [DATE] from 09:40 AM to 10:21 AM in the facility's only kitchen reflected: o One of two scoops used for the ice machine was lying inside the ice machine and the other one was lying on top of plastic wrap on a shelf next to the ice machine. o Two bags of opened potato chips, of which one was not dated. Neither bag was dated with an opened date. They were stored on the top shelf, upon entry to the dry goods pantry. They were folded down, but not tightly, which exposed the food to air-borne contaminants and possibly compromised the freshness of the chips. o 1 package of tortillas opened and not sealed, was lying in a box with six other sealed packages of tortillas. o One opened bag of cornbread mix dated ,d+[DATE]; however, there was no date to indicate when it was opened. o One open bag of grits dated ,d+[DATE]; however, there was no date to indicate when it was opened. o One 7-pound 8-ounces container of chocolate syrup dated ,d+[DATE], which had dried chocolate syrup around the lid and on the side of the container. o One bottle of red food coloring with no visible date. And there was dried red liquid on the lid and around the top area of the bottle. o One half-gallon container of pan coating oil blend was opened, half-full, dated ,d+[DATE]. There was no date opened, no use by date, no best by, and no expiration date were visible. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o One 11-pound container of chocolate fudge icing dated ,d+[DATE], with dried icing around the rim of the, sides and on the lid of the container. o One 11-pound container of vanilla creme frosting opened on [DATE], there is no date to show when this item was received. o One 1-gallon of Worcestershire sauce dated ,d+[DATE], there were no date opened, no use by, best by, or expiration dates visible. There were dried drip stains of the sauce on the container. o One 1-gallon of apple cider vinegar was opened dated ,d+[DATE]; however, there were no use by, best by, or expiration dates visible. o Two 1-gallon containers of cooking wine dated ,d+[DATE], were opened and no opened dated, use by, best by, or expiration dates were visit. o One 1-gallon container of 40-grain while distilled vinegar dated ,d+[DATE] was opened. There were no use, by best by, or expiration dates visible. o One 1-gallon of pancake and waffle syrup dated ,d+[DATE] was opened. There were no use by, best by, or expiration date visible. o One 1-gallon jar of sliced pepperoncini peppers dated ,d+[DATE] was opened. The expiration date was [DATE]. o Three unopened 1-gallon jars of sliced pepperoncini peppers dated ,d+[DATE], with an expiration date of [DATE]. In an interview on [DATE] at 10:08 AM, the Dietary Manager, stated the scoops are not to be left inside of the machine because the handle touching the ice could contaminate the ice. She stated she would have to check with the food manufactures about the expiration dates of their products. She stated it was not good for the containers to have dried product on them because it would attract insects and it was important to maintain cleanliness. She stated having complete dates documented on the food containers was important because they have to provide safe, fresh foods to the residents. She stated expired foods and foods not properly closed or sealed could cause the food to lose its taste could make the residents sick. In an interview on [DATE] at 1:55 PM, the Administrator stated its necessary to ensure the food containers are kept clean because the food substances on the containers could attract insects. He stated it was unacceptable to have foods which have expired in the kitchen because it would affect the taste of the food and it could make the residents ill. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of the Facility's policy on Food Storage and Supplies dated 2012, revealed All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. 4. Open packages of food are stored in closed containers with covers or in sealed bags, and dated as to when opened. 6. When items are received from the vendor, they should be first examined for expiration date, and if an expiration dated is present, it is beneficial to mark it by circling it so it is readily visible and noticeable. If an item does not have a date designated by the manufacturer as an expiration date, then the item should be dated as to when it is received, and shelf-stable items will be stored in a 'first in, first out' manner, to be used within one year. After one year, any product that is shelf-stable will be inspected by the dietary manager to ensure that it is good quality before it is used. Any product with a stamped expiration date will be discarded once the date passes. Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S ,d+[DATE].18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts ,d+[DATE] - ,d+[DATE].

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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** 42824 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 #6 and Resident #32) of 6 residents observed for infection control. 1. The facility failed to ensure that CNA F changed her gloves and performed hand hygiene while providing incontinence care to Resident #6. 2. The facility failed to ensure CNA W changed his gloves and performed hand hygiene while providing incontinence care to Resident #32. These failures could place the residents at risk of cross-contamination and the development of infection. Findings included: Resident #6 Review of Resident #6's Face Sheet dated 03/28/2024 reflected resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included chronic lymphocytic leukemia (a type of cancer of the blood and bone marrow) and need for assistance with personal care. Review of Resident #6's Comprehensive MDS assessment dated [DATE] reflected Resident #6 had a severe impairment in cognition with a BIMS score of 1. Resident #6's primary reason for admission to the facility was debility. Resident #6 required maximal assistance in toileting hygiene and was frequently incontinent for bladder and bowel. Review of Resident #6's Care Plan dated 03/21/2024 reflected resident had occasional bladder incontinence and the interventions were clean peri-area with each incontinent care and wash hands before and after delivery of care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 03/28/2024 at 1:23 PM, revealed Resident #6 was on her bed awake. CNA F then told Resident #6 that he would be doing incontinent care. CNA F donned a pair of gloves and then proceeded with incontinent care. CNA F did not wash his hands before putting on the gloves. CNA F unfastened the tape on both sides of the soiled brief, rolled the front portion and pushed it downward on the center. CNA F cleaned Resident #6's front part. CNA F then instructed and assisted Resident #6 to roll towards the wall. CNA F continued to clean the resident's buttocks. CNA F pulled the soiled brief and threw it on the trash can. CNA F then went ahead and took the clean brief without changing his gloves or performing hand hygiene. CNA F placed the new brief on resident's buttocks and instructed the resident to roll back. CNA F fastened the tape on both sides. CNA F then pulled Resident #6's blanket to her chest. CNA F removed his gloves, threw the soiled gloves to the thrash can, tied the plastic bag on the trash can and proceeded to throw the plastic bag. CNA F acknowledged he did not wash his hands before and after incontinent care. CNA F also said he did wash his hands and did not change his gloves after he pulled the soiled brief and before he touched the new brief. CNA F said it was important to wash hands and change gloves before touching the clean brief because the dirty gloves could contaminate the clean brief, and this could result to infection. Resident #32 Review of Resident #32's Face Sheet dated 03/28/2024 revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included Alzheimer's Disease (brain disorder that leads to memory loss,) Vascular Dementia (lack of blood to the brain that causes problems with reasoning, planning, judgement and memory,) Transient Ischemic Attacks (brief blockage of blood flow to the brain,) Cerebral Infarction (lack of blood flow to brain that causes cellular death,) Schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior,) and contractures (chronic loss of mobility due to shortening of muscles, tendons, skin, and soft tissues.) Review of Resident #32's Quarterly MDS assessment dated [DATE] revealed Resident #32 was unable to complete a BIMS assessment, but she was assessed as having short and long-term memory problems that severely impaired her cognitive skills for daily decision making. Resident #32 required total dependence on staff with toileting, hygiene, and was incontinent of bowel and bladder. Review of Resident #32's Care Plan dated 01/29/2024 revealed she had functional bowel/bladder incontinence related to Alzheimer's disease process and interventions included to clean peri-area with each incontinent episode . and hand washing before and after delivery of care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 03/28/2024 at 12:43 PM, revealed Resident #32 was in her bed awake. CNA W then told Resident #32 that he would be doing incontinent care. CNA W performed hand hygiene in the resident's sink then donned clean gloves, removed residents clothing and unfastened the tape on both sides of her soiled brief and rolled down the front portion and pushed it downward between resident's legs. CNA W removed his gloves, performed hand hygiene in resident's sink then donned clean gloves. CNA W then cleaned Resident #32's front groin area then log rolled the resident towards the wall. CNA W continued to clean the resident's buttocks after removing the soiled brief and discarding it in the trash can. CNA W then obtained a clean brief with his soiled gloved hands and positioned the brief under the resident. CNA W then fastened the tape on both sides after log rolling Resident #32 to her back. CNA W touched Resident #32's right hip and shoulder with his left and right soiled gloved hands and then obtained a clean gown with his soiled gloved hands. CNA W then repositioned the resident in her bed and pulled her sheets up with his soiled gloved hands. CNA W then removed his gloves and failed to perform hand hygiene. With soiled hands, he gathered up Resident #32's soiled trash in bag and obtained Resident #32's tethered bed controller to lower her bed. CNA W then placed her call light near the resident with his soiled hands. CNA W failed to sanitize the resident's bed controller and call light after contaminating it. CNA W then exited Resident #32's room, walked down the hallway and discarded the trash in the soiled utility room after using the door handle with his soiled hands. CNA W failed to perform hand hygiene upon exiting Resident #32's room and prior to opening the soiled utility door. CNA W acknowledged he did not change gloves and perform hand hygiene after cleaning resident's buttocks and prior to the application of Resident #32's new brief, gown, before touching resident's body, touching her bedsheets, bed controller and call light. Additionally, he acknowledged he should have performed hand hygiene upon exiting resident's room and touching anything else in the hallway like a door handle. CNA W stated he was not sure why he failed to perform hand hygiene at these times; but stated it was important to perform proper hand hygiene to prevent contamination and for infection control purposes. In interview with ADON B on 03/28/2024 at 2:58 PM, she stated she expected staff to perform hand hygiene upon entering and exiting resident rooms, before and after the application of gloves, and after moving from a soiled to clean area during incontinence care. She stated it was important for infection control purposes. In interview with the DON on 03/28/2024 at 3:05 PM, she stated she expected staff to perform hand hygiene properly and adhere to facility policy as it was the best way for infection control and prevention. In interview with the Administrator on 03/28/2024 at 3:15 PM, he stated he expected staff to perform hand hygiene per facility policy for infection control reasons. Record review of facility policy Hand Hygiene, provided electronically 03/28/2024 at 3:30 PM by the Administrator it stated You may use alcohol based hand cleaner or soap/water for the following: . Before and after assisting a resident with personal care . Upon after coming in contact with a resident's intact skin . After contact with a residents . body fluids or secretions . After handling soiled or used linens, dressings, bedpans . equipment or utensils . After removing gloves or aprons . After completing duty . You must use soap/water for the following: . Before and after assisting a resident with toileting . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longmeadow Healthcare Center	120 Meadowview Dr Justin, TX 76247

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy Nursing: Personal Care . Perineal Care effective 05/11/2022 stated Purpose . This procedure aims to . prevent infections and skin irritation . Start . 10) Perform Hand Hygiene 11) Don gloves . 21) Gently perform care . working front to back without contaminating the perineal area . 24) Doff gloves . 25) Perform hand hygiene . Conclude 26) Provide resident comfort and safety by re-clothing (if applicable - incontinence pad(s) and briefs), straightening bedding, adjusting bed and/or side rails, and placing call light within resident's reach . 30) Tie off the disposable plastic bag of trash and/or linen 31) Perform hand hygiene . Important Points . Always perform hand hygiene before and after glove use .