STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House Nursing and Rehabilitation	407 N College St Rosebud, TX 76570

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49065 Based on interview and record review, the facility failed to refer all level I residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment for 3 of 3 residents (Resident #3, #24 and #29) assessments reviewed for PASARR evaluations. The facility failed to demonstrate a PASRR I was completed on Resident #03 and failed to refer her to the appropriate, State-designated authority when she was diagnosed with bipolar disorder. The facility failed to refer Resident #24 to the appropriate, State-designated authority when he was diagnosed with Major Depressive Disorder and Unspecified Psychosis. The facility failed to refer Resident #29 to the appropriate, State-designated authority when she was diagnosed with schizoaffective disorder and Bipolar disorder. This failure could place residents at risk for missing services that could improve their quality of life and maintain their highest level of practicability. Findings include: Record review of Resident 3's undated face sheet, revealed she was an [AGE] year-old female admitted [DATE] with diagnoses of Epilepsy (seizures), Anemia in Chronic Kidney Disease, and Depression. Diagnoses of Suicidal Ideations was added 9/28/2021 and bipolar disorder was added on 9/29/2021. A diagnosis of stroke was also added on 10/12/2024. Record review of Resident 3's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 10, which indicated the resident's cognitive ability was moderately impaired. Record review of Resident 3's Care Plan, reflected a Focus area was initiated on 9/10/2021 for a Behavior problem related to suicidal behavior. Resident 03's interventions included a geri-psychiatric evaluation. Record review of Resident 3's Orders, reflected she had an 8/14/2024 active order for Prozac capsule 20 mg by mouth daily for Major Depressive Disorder, Recurrent which she was receiving. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 3's undated electronic medical chart reflected there was no PASRR level I or level II form for this resident. Record review of Resident 24's undated face sheet, revealed he was a [AGE] year-old male admitted [DATE] with diagnoses of Hypertension, Parkinsonism (Neurological Disorder), Major Depressive Disorder, and Unspecified Psychosis not due to a substance or known physiological condition. A diagnosis of Anxiety was added on 8/5/2024. Record review of Resident 24's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 12, which indicated the resident's cognitive ability was moderately impaired. Record review of Resident 24's Care Plan, reflected a Focus area was initiated for Requires anti-depressant medications for diagnosis of Major Depressive Disorder on 3/7/2023 with a goal for resident to remain free from adverse reactions related to medications. Resident 24's interventions included to Administer medications as ordered. Record review of Resident 24's orders, reflected an 8/6/2024 active order for Sertraline HCL Tablets 100 mg by mouth daily related to Major Depressive Disorder which he was receiving. Record review of Resident 24's undated electronic chart reflected a 3/5/2023 PASRR I screen form that was marked negative. Record review of Resident 29's undated face sheet, revealed she was an [AGE] year-old female admitted [DATE] with diagnoses of Hypertension (high blood pressure), Heart Failure, Asthma, Anxiety Disorder and Major Depressive Disorder. On 3/3/2024 diagnoses of schizoaffective disorder (psychiatric disorder) and Bipolar disorder (severe mood disorder) were added for the resident. Record review of Resident 29's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 04, which indicated the resident's cognitive ability was severely impaired. Record review of Resident 29's Care Plan, reflected a Focus area was initiated on 3/20/2024 for mood problem related to Mood disorder, Bipolar disorder and Schizoaffective Disorder and requires anticonvulsant medication Depakote with a goal to improve the resident's mood. Resident 29's interventions included to take medications, Behavioral Health consults (psycho-geriatric team, psychiatrist, etc.). Record review of Resident 29's orders, reflected a 8/26/24 active order for Depakote Oral Tablet Delayed Release 125 mg-Give 1 tablet by mouth two times a day related to UNSPECIFIED MOOD (AFFECTIVE) DISORDER. Resident was receiving this medication. Record review of Resident 29's undated electronic medical chart reflected there were negative PASRR I forms on 10/13/2023, 1/3/2024, and 5/2/2024. PASRR I screening form on 6/14/2024 was positive for mental illness but no PASRR II form was located in the chart. In an interview on 10/17/2024 at 1:55 PM the RRN stated that there were no PASRR II forms for Residents #3, Resident #24 and Resident #29. She said Depakote for Resident 29 would not be coded as a PASRR related medication as it was an anticonvulsant. The RRN did acknowledge that the Depakote was ordered specifically for Mood (Affective) Disorder and not for seizures. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/18/2024 at 2:10 PM the DON stated, all residents needed PASRR screening on admission. She was unaware if a new diagnosis would require the resident to be screened. She stated she does not work with the PASRR forms or processes. In an interview on 10/18/2024 at 2:13 PM the CRN stated, every resident was PASRR screened on admission. She stated that if an existing resident gets a new psychiatric diagnosis that was coded on the MDS, then they need to be PASRR screened. She also stated that if the PASRR I form was positive, then the next step would be to alert the local authority for them to complete the PASRR II form. The CRN stated, it was important to do PASRR screening, so residents get services they need. She stated the negative outcome if screening was not done would be residents missing services that would improve quality of life. A record review of the facility policy titled, PASRR Level 1 Screen Policy and Procedure with a revision date of 3/6/2019 (no original date on policy) reflected the following: . It is the policy to obtain a PASRR Level 1 screening form from the referring entity prior to admission to the Nursing Facility. PASRR Program goal is to ensure individual receive the required services for their mental illness. For positive Preadmissions a PASRR 1 is entered into the portal and this becomes the notification to complete the PASRR Evaluation (PASRR II).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47795 Based on interviews, and record review, the facility failed to ensure each resident's person-centered comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 2 (Resident #4, Resident # 28) of 8 residents reviewed for care plans. The facility failed to ensure Resident #4)comprehensive care plan was updated when he quit smoking. The facility failed to ensure Resident # 28's comprehensive care plan reflected current physician orders for weights . These failures could place residents at risk of receiving inadequate or unnecessary interventions not individualized to their health care needs. The Findings included: Review of Resident # 4 Face sheet printed 10/18/20244 reflected a [AGE] year-old male originally admitted [DATE] with a readmission on 3/29/2024. Diagnoses included Congestive Heart Failure (CHF) (a chronic condition in which the heart does not pump blood as well as it should), Type2 Diabetes Mellitus (a chronic condition that happens when you have a persistently high blood sugars effecting your body use of insulin) Chronic Obstructive Pulmonary disease (COPD)(a group of lung diseases that block airflow to the lungs and make it difficult to breath). Review of Resident # 4's annual MDS dated [DATE] reflected a BIMS score of 15 (which indicate cognitively intact). Section J revealed Current Tobacco use as 1 which indicates yes. Review of Resident # 4's Care plan revised 8/13/2024 reflected. Focus: Resident # 4 is a smoker Date Initiated: 05/16/2023 Revision on: 06/29/2023 Goal: Resident # 4 will smoke in designated area without any occurrence of injury over the next 92 days. Date Initiated: 12/06/2021 Revision on: 06/01/2023 Target Date: 11/11/2024. Interventions/ Task: 1. Perform smoking assessments according to facility policy. Date Initiated: 12/06/2021 2. Explain/show where designated area are and repeat prn Date Initiated: 12/06/2021 4. Keep all lighting materials at the nurses station, may have tobacco products on him. Date Initiated: 12/06/2021 Ensure that the resident and/or responsible is made aware of the facility smoking policy Date Initiated: 05/16/2023 Staff to provide direct supervision during scheduled smoke breaks. Date Initiated: 07/29/2023 Revision on: 08/01/2023 Staff will ensure that no oxygen is located in the designated smoking area Date Initiated 05/16/2023 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident # 28's Face sheet dated 10/18/2024 reflected a [AGE] year-old female originally admitted on [DATE] with a readmitted [DATE] with diagnosis that included Unspecified protein-calorie malnutrition (an imbalances between the nutrients our body needs and the nutrients it gets) and CHF (a chronic condition in which the heart does not pump blood as well as it should). Review of Resident # 28's Quarterly MDS July 23,2024 reflected a BIMS score of 2 (Severe cognitive impairment). Review of Resident # 28's Physician orders printed 10/18/2024 reflected: Regular diet Regular texture, Regular consistency, RED GLASS. Super Cereal w/Breakfast, shake on lunch and dinner trays Written 9/11/2024. Readycare 2.0 three times a day for weight maintenance for 60 Days Ready Care 2.0 -90 mls PO TID x 60 days written 9/9/2024. Super Cereal one time a day for weight maintenance written 9/9/2024. Admit to]Hospice for comfort measures Hospice Dx: GI Bleed Hospice Medical Physician every shift. Written 6/22/2024. No orders for weights noted. Review of Resident # 28' care plan reflected: Focus: Potential risk for Malnutrition Date initiated 7/11/2024 Goal: Maintain stable weight and nutritional parameters Date Initiated: 07/11/2024 Target Date: 12/29/2024 Interventions/Task: Monitor and document meal intake Date Initiated: 07/11/2024 Monitor resident weights Date Initiated: 07/11/2024 Focus: The resident has a significant unplanned/unexpected weight loss. Date Initiated: 07/11/2024 Revision on: 07/11/2024 Goal: The resident's weight will stabilize within 4 weeks Date Initiated: 07/11/2024 Target Date: 12/29/2024 Revision on: 09/20/2024 Target Date: 12/29/2024 Intervention/task: 2 cal/cc supplement with med pass Date Initiated: 09/09/2024 Administer dietary stimulant as ordered.(Mirtazapine 7.5 at HS) Date Initiated: 09/12/2024 Revision on: 09/20/2024 Notify the dietician of the weight loss upon their next visit Date Initiated: 07/11/2024 Notify the physician, resident and family of the weight loss Date Initiated: 07/11/2024 Weigh the resident weekly for at least 4 weeks or until weight has stabilized Date Initiated: 09/09/2024 Weight watchers assessment Date Initiated: 09/20/2024 Interview with Resident #4 on 10/17/2024 at 11:00 am stated that he had quit smoking in July 2024 and has not had any issues since then. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DON on 10/18/2024 at 12:30 PM revealed her expectations were that the care plan reflects an accurate picture of the resident and was updated in real time. She stated that she or the ADON were responsible for updating the care plan. The care plan should be updated when the residents condition changes She stated the care plan should be reviewed as part of the quarterly care plan meeting. The DON stated that Resident # 3 stopped smoking in July of 2024. She stated care plans not updated can lead to inappropriate care. Interview with MDS nurse on 10/18/2024 at 1:18 PM revealed that she was not responsible for the care plans, the IDT which consist of Nursing, therapy, the social worker and the activities director team was and she was not sure how they were updated. Interview with the ADM on 10/18/2024 at 2:00 PM revealed his expectation was that care plans be current and updated timely. He stated they had several methods to communicate the needs of the residents to the Interdisciplinary team such as morning meeting and order review. He stated that the IDT team was responsible for updating the care plan and that a care plan not updated can lead to the residents not receiving the care they need. Review of the Policy Care Plan Process, Person-centered care Revision May 5, 2023, revealed 9. Thru ongoing assessment, the facility will initiate person-centered care plans when the resident's clinical status or change of condition dictate the need such as but not limited to falls and pressure ulcer/development.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47795 Based on observation, interviews and record review the facility failed to ensure a resident maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise for 8 (Residents # 4,8,9,13,25,27,28 and 30) of 31 residents reviewed for consistent review of weight variances. The facility failed to ensure accurate resident weights for 8 (Residents # 4,8,9,13,25,27,28 and 30) of 31 Residents reviewed which resulted in significant weight variance. The facility failed to consistently monitor that effective interventions were put in place for residents with significant and/ or severe weight loss which resulted in weight variances. This failure resulted in resident with unidentified significant weight variance in resident with medical conditions being at risk for change in physical status. Findings Included: Review of Resident # 4's Face sheet printed 10/18/2024 reflected a [AGE] year-old male originally admitted [DATE] with a readmission on 3/29/2024. Diagnoses included CHF (a chronic condition in which the heart does not pump blood as well as it should), Type2 Diabetes Mellitus (a chronic condition that happens when you have a persistently high blood sugars effecting your body use of insulin) and COPD (a group of lung diseases that block airflow to the lungs and make it difficult to breath). Review of Resident # 4's annual MDS dated [DATE] reflected a BIMS score of 15 (which indicate cognitively intact). Section K reflected no weight loss or gain of 5% in the last month or more than 10% in the 6 months Nutritional approaches reflected a Therapeutic diet. Review of Resident # 4's medical orders printed 10/18/2024 reflected no order for weights or parameters on when to notify MD of weight loss/gain. Order for monitor for edema was written 10/11/2024. Review of Resident's # 4 Care plan revised 11/26/2021, 5/20/2024, 8/13/2024 reflected: Focus Resident #4 has nutritional problem or potential nutritional problem r/t obesity (BMI 37.3) Goal none stated. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions/Task: Coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat. Appears concerned during meals. Monitor/record/report to MD s/sx of malnutrition: Emaciation (the state of being abnormally thin or weak) (Cachexia) (a metabolic syndrome that causes a loss of muscle and body weight, often due to an underlying illness) , Muscles wasting, significant weight loss: 3 lb. is 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Provide, serve diet as ordered, monitor intake and record every meal. RD to evaluate and make diet change recommendations as needed. Focus: Resident is on diuretic therapy r/t CHF (bumex) Goal: Resident will be free of any discomfort or adverse side effects of diuretic therapy through the next review date. Intervention/tasks Administer medication as ordered, monitor vital signs as ordered and report to the physician if abnormal for this resident. Report any increased swelling of legs, arms, or face to the charge nurse, Report any increased swelling to the physician, report ordered labs to physician, resident could experience, dizziness, postural hypotension, fatigue, and an in increased risk for fall. Observe of possible side effects. Review of Resident's # 4's Weight summary report printed 10/18/2024 reflected weight on 7/30/2024 of 278.0. 8/2/2024 of 275.4 reflecting a 3 lb. weight loss in one week. Weight on 10/10/2024 was 276.6, Resident # 4's weight on 10/17/2024 witnessed by the surveyor was 274.8 weight. Resident #4's on 4/5/2024 documented as 295.0 which represents a 7.12% loss in 6 months. Review of resident's medical records shows emergency room visit on 3/2024 with shortness of breath and admitted , discharge diagnosis CHF. Resident went to the emergency roiagnom on [DATE] with abnormal labs and shortness of breath, admitted to the hospital, discharge diagnosis on 3/31/2024 was Respiratory Failure. Review of Resident # 4's Dietary note written by the RD dated 4/5/2024 reflected a 7.7% weight gain in 30 days. No new orders or progress notes indicating that the doctor was notified. Review of Resident's # 8 face sheet printed on 10/18/2024 reflected a [AGE] year-old female admitted on [DATE] and readmitted [DATE] with diagnoses that include Cerebral Palsy (a neurological disorder),and Unspecified Protein-calorie Malnutrition (an imbalances between the nutrients our body needs and the nutrients it gets). Review of Resident's # 8 Quarterly MDS dated [DATE] reflected a BIMS score of 8 (Moderate Cognitive Impairment). Per documentation the resident is Dependent (helper does ALL of the effort. Resident does none of the effort to complete the activity,) for eating. Section K reflected a loss of liquids/solids from mouth when eating or drinking, weight loss of 5% or more in the last month or loss of 10% or more is last 6 months coded as yes, not on a physician-prescribed weight loss regimen. Nutritional approaches reflected a mechanically altered diet. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident's # 8 medical orders printed 10/18/2024 Admit to [name of hospice] Hospice written 7/18/2024. Regular diet/consistency chocolate shake on lunch tray. Super cereal with breakfast per please feed order from hospice written 9/26/2024. Ready care 2.0 two times a day for weight maintenance/weight loss written 1/8/2024. No order for weight monitor/ or reporting variance to hospice. Intervention also include Red Glass program which places a red glass on the residents tray to notify staff the resident may need assistance or encouragement during meal time. Review of Resident's # 8 Care plan dated 8/6/2024 reflected. Focus Resident # 8 has a ADL self-care performance deficit Goal the goal section is blank. Interventions/Tasks staff with personal hygiene and oral care. Date Initiated: 11/10/2020 Revision on: 11/10/2020, EATING: Resident #8 requires (x)1 staff participation to eat. Date Initiated: 07/17/2024 Revision on: 07/18/2024, Resident # 8 has contractures of the of bilateral upper and lower extremities. (Knees and hands) Date Initiated: 10/29/2020 Revision on: 06/07/2024. TRANSFER: Resident # 8 requires total assistance with transfers. Date Initiated: 11/10/2020. TOILET USE: Resident # 8 is not toileted. Requires total assistance with incontinent care. Date Initiated: 05/03/2024, Revision on: 05/03/2024 Focus: Resident # 8 has a significant unplanned/unexpected weight loss due to recent hospitalization and diet changed to clear liquids per hospital on 7/17/24. Recent upgrade per speech therapy to pureed foods on 7/23/24. Further upgrade of diet to mechanical soft as pleasure feed per Hospice. Last diet upgrade 9/26/24 to REGULAR TEXTURE, regular consistency due to resident's refusal to eat if diet was not changed. Date Initiated: 07/25/2024 Revision on: 09/26/2024 Goal: Resident # 8 's weight will stabilize or improve through the next review date. Date Initiated: 07/25/2024 Target Date: 11/03/2024. Interventions/ Task Administer medications as ordered. (Remeron) Date Initiated: 09/09/2024 Chocolate shake on lunch tray Date Initiated: 08/06/2024 Initiate Red Glass Program Date Initiated: 07/24/2024 Monitor and document meal intake. Monitor Resident # 8 weights. Monitor Resident # 8's labs. Notify the physician for any negative findings, abnormal labs, or Resident # 8 noncompliance. Offer diet as ordered by the physician. Update food preferences as needed. Date Initiated: 07/25/2024 Refer to speech therapy for evaluation. Date Initiated: 07/25/2024. Super Cereal w/ breakfast Date Initiated: 09/12/2024 Review of Resident # 8's Weight Summary printed 10/18/2024 reflect weight on 8/2/2024 of 124.0. Resident # 8's weight on 8/15/2024 reflected a weight of 115.8 lb. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident # 8's weight on 10/10/2024 was 104. Resident # 8's weight as observed by the surveyor on 10/17/2024 was 103.4 lb. Weight on 4/18/2024 was 116 lb, this reflects a 17.59% weight loss in 3 months which is a significant weight loss. Review of Resident # 9's Face Sheet printed revealed a [AGE] year-old male admitted on [DATE] with a readmission on 10/4/2024 with diagnoses that include CHF (A chronic condition in which the heart does not pump blood as well as it should), malignant neoplasm of the transverse colon(cancerous tumor of the colon) and unspecified protein-calorie malnutrition (an imbalances between the nutrients our body needs and the nutrients it gets). Review of Resident # 9's Quarterly MDS dated [DATE] reflected a BIMS score of 10 (Moderate Impairment). Section K reflected no swallowing disorder, weight gain of 5% or month in the last month or 10% or more in last 6 months coded as on a physician-prescribed weight gain program nutritional approaches included Therapeutic diet. Review of Resident # 9's medical orders revealed Regular texture, Regular consistency, Red Glass, Allergic to Chocolate, NSOT, Cardiac/diabetic (has NRA for diabetic diet) written 10/9/2024, Ensure three times a day give 10 am, 2 PM, and 7 PM- family provides. Written 10/9/2024. Weekly weights every Thru for weight maintenance written 9/26/2024. Review of Resident # 9's Care Plan dated 10/17/2024 reflected : Focus: Resident # 9 has a diet order other than Regular and is at risk for unplanned weight loss or gain. RCS/LCS/NSOT Regular diet Allergic to Chocolate Date Initiated: 06/26/2024 Revision on: 10/17/2024. Goal: Resident # 9 will maintain ideal weight and receive proper nutrition daily x 90 days. Date Initiated: 06/26/2024 Target Date: 01/11/2025. Intervention/Task: 16 oz fluids with all meals 09/06/2024, Administer supplement (Prostat AWC) as ordered Date Initiated: 09/09/2024 Determine food preferences and provide within dietary limitations. Date Initiated: 06/26/2024. Encourage meal completion and document amount consumed. Date Initiated: 06/26/2024. Monitor weight per facility protocol Date Initiated: 06/26/2024, Offer sub, if resident eats less than 50% or dislikes meal and offer supplement if resident continues to eat less than 50%. Date Initiated: 06/26/2024. Praise resident for eating well. Date Initiated: 06/26/2024, RD assess per facility protocol Date Initiated: 06/26/2024, Red Glass Program Date Initiated: 09/09/2024,Serve diet and snacks as ordered Date Initiated: 06/26/2024 ST eval and TX per Physicians orders Date initiated: 6/26/2024. Focus: Resident # 9 has a significant unplanned/unexpected weight loss Date Initiated: 06/28/2024. Goal: The resident will consume __x__50% of two of three meals/day through the review date. Date Initiated: 06/28/2024 Revision on: 6/28/2024 Target Date: 01/11/2025. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions: Administer dietary stimulant as ordered. Mirtazapine Date Initiated: 06/28/2024 Revision on: 06/28/2024. Alert DON if consumption is poor for more than 48 hours. Date Initiated: 06/28/2024, Encourage food related activities Date Initiated: 06/28/2024, Give the resident supplements as ordered. Alert nurse if not consuming on a routine basis. Supplements initiated are: Prostat AWC Date Initiated: 09/09/2024 Revision on: 09/09/2024, Labs as ordered. Report results to physician and ensure dietician is aware. Date Initiated: 06/28/2024, Monitor and encourage PO intake, meals, fluids and supplements Date Initiated: 09/09/2024, Monitor and record food intake at each meal. Date Initiated: 06/28/2024 Monitor and report any changes in the residents eating habits to the Date Initiated: 06/28/2024, Notify the dietician of the weight loss upon their next visit Date Initiated: 06/28/2024, notify the physician, Resident# 9 and family of the weight loss Date Initiated: 06/28/2024, Offer substitutes as requested or indicated. Date Initiated: 06/28/2024, Place a Red Glass on the Resident's meal tray to identify the resident to staff as possibly needing assistance, encouragement, and substitutes. Date Initiated: 09/09/2024 Revision on: 09/09/2024, Provide hands on assistance with Resident # 9 during meals. Date Initiated: 06/28/2024 Revision on: 06/28/2024, Social Service Consult as needed Date Initiated: 06/28/2024, Weigh the resident weekly for at least 4 weeks or until weight has stabilized Date Initiated: 06/28/2024 Review of Resident # 9's Weight summary printed 10/18/2024 reflected a weight of 140.4 on 6/26/2024, weight on 10/10/2024 153, reweigh with surveyor observing on 10/17/2024 was 164.6. which is a 17.57% weight gain in 3 months. Review of Resident # 13's Face sheet printed on 10/18/2024 reflected a [AGE] year-old male original admitted [DATE] with a readmitted [DATE] with diagnoses that included Unspecified protein-calorie malnutrition(an imbalances between the nutrients our body needs and the nutrients it gets). Review of Resident # 13's Quarterly MDS dated [DATE] reflected a BIMS score of 11 (moderate Impairment). Section K reflected no swallowing issues, No weight gain or loss. No nutritional approached coded. Review of Resident # 13's physician orders printed on 10/18/2024 reflected Regular texture, Regular consistency, Red Glass, Resident to use covered cup for all hot liquids. No Pork products: Fluid restriction 1500 ml daily: intolerance to milk/milk products. HS Snacks. Written 6/23/2023. Weekly weights x 4 or until stabilized written 10/9/2024. Review of Resident # 13's Care Plan dated 7/23/2024 reflected: Focus: The resident has a significant unplanned/unexpected weight loss. Date Initiated: 10/04/2024 Revision on: 10/04/2024 Goal : The resident's weight will stabilize within 4 weeks. Date Initiated: 10/04/2024 Revision on: 10/04/2024 Target Date: 10/21/2024 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675210	A. Building B. Wing	10/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House Nursing and Rehabilitation	407 N College St Rosebud, TX 76570

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions/Task: Monitor and record food intake at each meal. Date Initiated: 10/04/2024 Revision on: 10/04/2024 Monitor and report any changes in the residents' eating habits to the DON. Date Initiated: 10/04/2024 Revision on: 10/04/2024 Notify the physician, resident and family of the weight loss. Date Initiated: 10/04/2024 Revision on: 10/04/2024 Place a Red Glass on the resident's meal tray to identify the resident to staff as possibly needing assistance, encouragement, and substitutes Date Initiated: 10/04/2024 Revision on: 10/04/2024. Provide hands on assistance with resident during meals. Date Initiated: 10/04/2024 Provide verbal assistance and cues during meals. Date Initiated: 10/04/2024 Revision on: 10/04/2024 Weigh the resident weekly for at least 4 weeks or until weight has stabilized. Date Initiated: 10/04/2024 Revision on: 10/04/2024 Weight Watcher Program (the facility weight monitoring plan) Date Initiated: 10/04/2024. Review of Resident # 13's Weight watcher program note dated 10/14/2024 reflected that the resident did have 0.7 weight gain. Red Glass program initiated, Provide physical hands-on assistance at meals, Encourage food related activities, and physician ordered Medication for appetite stimulant (Remeron 7.5 mg daily ordered 10/10/2024). Review of Resident # 13's Weight Summary report reflected weights on 4/30/2024 180 weight 10/4/2024 of 161.4 reweighs observed by surveyor on 10/17/2024 was 164.8 which reflected a 10.33% weight loss in 6 months. Review of Resident # 25's Face sheet dated 10/18/2024 reflected a [AGE] year-old male originally admitted on [DATE] with readmitted [DATE] with diagnoses that included Unspecified Protein-calorie malnutrition (an imbalances between the nutrients our body needs and the nutrients it gets) and Dementia long-term brain disorder causing personality changes and impaired memory, reasoning and social functioning. Review of Resident #25's Quarterly MDS dated [DATE].2024 reflected a BIMS score of 06 Severe cognitive Impairment). Section K reflected no swallowing disorder, No weight gain or loss, Nutritional Approaches reflected a mechanically altered diet. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #25's Physician Orders printed on 10/18/2024 reflected: Renal diet Regular texture, Regular consistency, NRA for regular diet. large portions. PM snack. Apple, grape or cranberry juice w/ each meal written 10/09/2024. Weekly weights x 4 one time a day every Thru written 9/19/2024. Mirtazapine Oral Tablet 7.5 MG (Mirtazapine) Give 1 tablet by mouth one time a day for APPETITE STIMULANT written 3/25/2024. Review of Resident # 25's Care Plan dated 9/6/2024 reflected: Focus: Resident # 25 t has a diet order Regular and is at risk for unplanned weight loss or gain. Regular texture, Regular consistency, for weight maintenance NRA for regular diet. large portions. PM snack. Apple, grape or cranberry juice w/ each meal. Serve minimum 16 oz fluid each meal. Monitor and encourage PO intake meals, fluids and supplements. Date Initiated: 05/27/2024 Revision on: 06/14/2024. Goal: Resident # 25 will have no significant weight loss through the next review date. Date Initiated: 05/27/2024 Target Date: 09/03/2024. Focus: Monitor and record percentage of meal consumed. Report to DON if resident continues to eat less than 50% of meals. Date Initiated: 05/27/2024 Offer substitutes if resident does not like meal being served. Date Initiated: 05/27/2024. Provide hands on assistance with meals and feeding if needed. Date Initiated: 05/27/2024. Resident# 25 to be weighed according to facility protocol, typically at least once monthly. Date Initiated: 05/27/2024 Resident # 25 was prescribed Renal diet related to CKD stage 3 but refused meals which would contribute to further weight loss. Resident # 25's wishes were to remain on a regular diet. Resident has a Negotiated Risk Agreement on file completed 6/13/24. Date Initiated: 06/14/2024. Revision on: 06/14/2024 Serve diet as ordered. Date Initiated: 05/27/2024. Focus: Resident # 25 has a nutritional problem or potential nutritional problem r/t unspecified protein calorie malnutrition. Date Initiated: 02/23/2024 Revision on: 02/23/2024 Goal: The Resident # 25 will maintain adequate nutritional status as evidenced by maintaining weight within normal parameters), no s/sx of malnutrition, and consuming at least 50% of at least 2 meals daily through review date. Date Initiated: 02/23/2024 Revision on: 02/23/2024. Target Date: 09/03/2024 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions/Task : Administer medications as ordered. Monitor/Document for side effects and effectiveness. (MIRTAZAPINE) Date Initiated: 02/23/2024 Revision on: 02/23/2024. Discuss the Resident 25's feelings about weight and commitment to weight loss/gain as needed. Allow the resident to express feelings. Discuss positive coping behaviors, alternatives to overeating/under eating, feelings related to food, environmental issues, relationship and self-image concerns. Date Initiated: 02/23/2024 Revision on: 02/23/2024. Explain and reinforce to the Resident # 25 , the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors. Date Initiated: 02/23/2024 Revision on: 02/23/2024 Invite the resident to activities that promote additional intake Date Initiated: 02/23/2024 Revision on: 02/23/202 Large portions at each meal. Date Initiated: 06/05/2024 Mirtazapine 7.5 mg for appetite stimulant. Date Initiated: 06/05/2024 Monitor/document/report to MD PRN for s/sx of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Date Initiated: 02/23/2024 Monitor/record/report to MD PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3 lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Date Initiated: 02/23/2024 Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Date Initiated: 02/23/2024 OT to screen and provide adaptive equipment for feeding as needed. Date Initiated: 02/23/2024 Provide and serve diet as ordered. Date Initiated: 02/23/2024 Provide, serve diet as ordered. Monitor intake and record q meal. Date Initiated: 02/23/2024 RD to evaluate and make diet change recommendation PRN. Date initiated 02/23/2024. Review of Resident # 25's weight summary printed 10/18/2024 reflected a weight on 6/10/2024 was 123.4. 10/3/2024 of 121.1 10/17/2024 weight as observed by surveyor was 128.6. which reflect a 6.1% Weight gain in 30 days Review of Resident # 27's Face Sheet dated 10/18/2024 reflected a [AGE] year-old female originally admitted [DATE] with diagnosis that include Paraplegia (a type of paralysis that affect the movement of the lower limbs). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident # 27's Admission MDS dated [DATE] reflected Cognitive patterns: resident has a short term memory problem with long term memory okay. No BIMS assessment conducted as resident is rarely/never understood). Eating requires Partial/moderate assistance (helper does less than half the effort). Section K reflected with no swallowing disorders Nutritional approaches coded at Mechanically altered diet. This was an admission assessment no weight loss or gain information was available. Review of Resident #27's care plan dated 9/28/2024 reflected: Focus: Resident # 27 has a significant unplanned/unexpected weight loss Date Initiated: 10/04/2024 Goal: The resident's weight will stabilize within 4 weeks Date Initiated: 10/04/2024 Target Date: 12/27/2024 Interventions/ Task : Administer dietary stimulant as ordered. Remeron 7.5 mg daily, Date initiated: 10/24/2024 , revision on: 10/04/2024 Monitor and record food intake at each meal. Date Initiated: 10/04/2024. Monitor and report any changes in Residents' # 27 eating habits to the DON Date Initiated: 10/04/2024 Notify the physician, resident and family of the weight loss Date Initiated: 10/04/2024 Place a Red Glass on the residents meal tray to identify the resident to staff as possibly needing assistance, encouragement, and substitutes Date Initiated: 10/04/2024 Provide hands on assistance with Resident # 27 during meals. Date Initiated: 10/04/2024 Weigh the resident weekly for at least 4 weeks or until weight has stabilized Date Initiated: 10/04/2024 Weight Watcher Program Date Initiated 10/04/2024. Focus: Resident # 27 has a diet order other than Regular and is at risk for unplanned weight loss or gain. Regular with Mechanical Ground Meat texture and intolerance to lactose. Date Initiated: 09/14/2024 Revision on: 09/17/2024. Goal: Resident # 27 will maintain ideal weight and receive proper nutrition daily x 90 days. Date Initiated: 09/14/2024 Target Date: 12/27/2024. Intervention/Task: Advise dietary of resident's intolerance to lactose. Date Initiated: 09/17/2024 Determine food preferences and provide within dietary limitations. Date Initiated: 09/14/2024 Encourage meal completion and document amount consumed. Date Initiated: 09/14/2024 Monitor weight per facility protocol Date Initiated: 09/14/2024 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	offer sub, if resident eats less than 50% or dislikes meal and offer supplement if Resident continues to eat less than 50%. Date Initiated: 09/14/2024 Praise resident for eating well. Date Initiated: 09/14/2024 RD assess per facility protocol Date Initiated: 09/14/2024 Serve diet and snacks as ordered Date Initiated: 09/14/2024 ST eval and TX per Physicians orders as condition warrants. Date Initiated: 09/14/2024 The resident has mechanically altered diet Date Initiated: 09/14/2024. Review of Resident # 27's Weight-watchers program dated 10/11/2024 reflected Nurse Practitioner was notified on about weight variance on 10/14/2024. Review of Resident # 27's weight summary reflected 9/13/2024 weight was 178.4. 10/10/2024 weight was 167.6. weight on 10/17/2024 observed by the surveyor 164.8 which is a 7.62% weight loss in less than 60 days. Review of Resident # 28's face sheet dated 10/18/2024 reflected a [AGE] year-old female originally admitted on [DATE] with a readmitted [DATE] with diagnoses that include Unspecified protein-calorie malnutrition (an imbalances between the nutrients our body needs and the nutrients it gets) and CHF (a chronic condition in which the heart does not pump blood as well as it should). Review of Resident # 28's Quarterly MDS July 23,2024 reflected a BIMS score of 2 (Severe cognitive impairment). Section K revealed Swallowing disorder coded as loss of liquids/solids from mouth when eating or drinking. Weight loss coded are yes, not on a physician-prescribed weight-loss regimen. No Nutritional approaches coded. Review of Resident # 28's Physician orders printed 10/18/2024 reflected: Regular diet Regular texture, Regular consistency, RED GLASS. Super Cereal w/Breakfast, shake on lunch and dinner trays Written 9/11/2024. Readycare 2.0 three times a day for weight maintenance for 60 Days Ready Care 2.0 -90 mls PO TID x 60 days written 9/9/2024. Super Cereal one time a day for weight maintenance written 9/9/2024. Admit to [name of hospice] Hospice for comfort measures Hospice Dx: GI Bleed Hospice Medical Physician: [name of physician] every shift. Written 6/22/2024. No orders for weights noted. Review of Resident # 28' care plan reflected: Focus: Potential risk for Malnutrition Date initiated 7/11/2024 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goal: Maintain stable weight and nutritional parameters Date Initiated: 07/11/2024 Target Date: 12/29/2024 Interventions/Task: Monitor and document meal intake Date Initiated: 07/11/2024 Monitor resident weights Date Initiated: 07/11/2024 Monitor resident's labs Date Initiated: 07/11/2024 Notify the physician for any negative findings, abnormal labs, or resident noncompliance Date Initiated: 07/11/2024 Offer diet as ordered by the physician Date Initiated: 07/11/2024 Update food preferences as needed Date Initiated: 07/11/2024 Focus: Resident # 28 has a significant unplanned/unexpected weight loss. Date Initiated: 07/11/2024 Revision on: 07/11/2024 Goal: The resident's weight will stabilize within 4 weeks Date Initiated: 07/11/2024 Target Date: 12/29/2024 Resident # 28 will consume ___50% ___ two of three meals/day through the review date Initiated: 09/20/2024 Revision on: 09/20/2024 Target Date: 12/29/2024 Intervention/task: 2 cal/cc supplement with med pass Date Initiated: 09/09/2024 Administer dietary stimulant as ordered.(Mirtazapine 7.5 at HS) Date Initiated: 09/12/2024 Revision on: 09/20/2024 Alert DON if consumption is poor for more than 48 hours. Date Initiated: 07/11/2024 Dental Consult as needed Date Initiated: 07/11/2024 Encourage food related activities Date Initiated: 07/11/2024 Give the resident supplements as ordered. Alert nurse if not consuming on a routine basis. Readycare 2.0 Date Initiated: 07/11/2024 Revision on: 09/09/2024 Labs as ordered. Report results to physician and ensure dietician is aware. Date Initiated: 07/11/2024 Monitor and record food intake at each meal. Date Initiated: 07/11/2024 Monitor and report any changes in the residents eating habits to the DON Date Initiated: 07/11/2024 Notify the dietician of the weight loss upon their next visit Date Initiated: 07/11/2024 Notify the physician, resident and family of the weight loss Date Initiated: 07/11/2024 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Offer substitutes as requested or indicated. Date Initiated: 07/11/2024 Place a Red Glass on the resident # 28 's meal tray to identify the resident to staff as possibly needing assistance, encouragement, and substitutes. Date Initiated: 09/09/2024 Revision on: 09/20/2024 Provide hands on assistance with resident during meals. Date Initiated: 07/11/2024 Provide resident the diet as ordered by the physician. Regular, super cereal, shake with lunch/dinner Date Initiated: 09/12/2024 Revision on: 09/12/2024 Provide verbal assistance and cues during meals Date Initiated: 07/11/2024 Refer the resident to therapy for screen Date Initiated: 07/11/2024 Social Service Consult as needed Date Initiated: 07/11/2024 Super cereal at breakfast. Date Initiated: 09/09/2024 Revision on: 09/09/2024. Weigh the resident weekly for at least 4 weeks or until weight has stabilized Date Initiated: 09/09/2024 Weight watchers assessment Date Initiated: 09/20/2024 Review of Resident # 28's weight watchers program in the medical record dated 10/14/2024 revealed notification of weight variance to Nurse practitioner . No new orders received due to decline in condition. Review of Resident # 28's weight summary report reflected weight on 6/7/2024 197, 10/4/2024 weighted 161.2 10/17/2024 with surveyor observing weight was 155.4. Which represented a weight loss of 21.32% in 3 months. Review of Resident # 30's face sheet dated 10/18/2024 reflected a [AGE] year-old female admitted on [DATE] with diagnoses that included Type 2 diabetes Mellitus with unspecified complications (a chronic condition that happens when you have a persistently high blood sugars effecting your body use of insulin) and Chronic Obstructive Pulmonary disease (COPD)(a group of lung diseases that block airflow to the lungs and make it difficult to breath). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident # 30's Quarterly MDS dated [DATE], reflected a BIMS score of 13 (cognitively intact). Review of Resident # 30's Physician Orders printed 10/18/2024 revealed Regular diet Regular texture, Regular consistency written 3/6/2024, Weekly weights x 4 one time a day every Thru for weight maintenance until 10/31/2024 written 10/9/2024. Review of Resident # 30's Care Plan dated 7/23/2024 reflected: Focus: Resident# 30 has a significant unplanned/unexpected weight gain r/t Overeating Date Initiated: 10/09/2024. Goal : Resident will not develop complications from weight gain such as skin breakdown, ineffective breathing pattern, altered cardiac output, diabetes, impaired mobility through review date Date Initiated: 10/09/2024 Revision on: 10/09/2024 Target Date: 10/21/2024 Interventions/ Task: Monitor/record the resident's eating habits, and patterns to assist in determining cause of overeating Date Initiated: 10/09/2024 Revision on: 10/09/2024 Notify MD if: Increasing shortness of breath; escalating edema; increased anxiety; inability to lie flat; change in baseline level of orientation/alertness. Date Initiated: 10/09/2024 Notify nurse if: Increasing shortness of breath; escalating edema; increased anxiety; inability to lie flat; change in baseline level of orientation/alertness. Date Initiated: 10/09/2024 Weigh the resident weekly for at least 4 weeks or until weight has stabilized. Date Initiated: 10/09/2024 Revision on: 10/09/2024 Review of Resident #30's Weight Summary printed 10/18/2024 reflected 4/01/2024 weight was 133.8 10/10/2024 weight was 150. Weight on 10/18/2024 observed by surveyor resident weight was 150.4 which reflected a weight gain of 12.11 in 6 months. Review of Resident# 30's medical record from 10/10/2024 to present revealed no progress note or weight watchers indicating MD was notified of weight variance. Observation on 10/17/2024 Observation of weights by surveyor on 6 (2,4,6,8,25 and 26) Residents revealed , the facility final weights and the surveyors did not match on 3 (2,6, and 6) of the residents weighted. 10/18/2024 surveyor observation of weights on all 31 residents at the facility. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/15/2024 in the dining room of Resident # 8 being assisted to eat her meal. Observation on 10/16/2024 of breakfast meal in the dining room Resident # 8 is being assisted to eat. Interview on 10/17/2024 at 1 PM with Resident # 4 he stated that he is okay living here, he states they take good care of him and he feels safe. He stated they weight him once a month, he was no aware of weight gain and says he does not pay attention to his weight. Interview on 10/16/2024 with Resident # 8 she stat

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47795 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the transmission of communicable diseases and infections for 4 of 4 resident (Residents# 8, 14, 26, and 186) reviewed for infection control. The facility failed to ensure MA performed proper hand hygiene and sanitized equipment properly during medication pass on 4 residents (Residents# 8, 14, 26, and 186). This failure could place residents at risk for development of communicable diseases and infections. Findings include: Record review of Resident 8's undated face sheet, revealed she was an [AGE] year-old female admitted [DATE] with diagnoses of Epilepsy (seizures), Depression, Heart Failure, and Hypertension (high blood pressure). Record review of Resident 8's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, which indicated the resident's cognitive ability was not impaired. Record review of Resident 8's Care Plan, reflected a Focus area was initiated for hypertension on 1/28/2015 with a goal to remain symptom free of high blood pressure. Resident 08's interventions included to take residents. Record review of Resident 14's undated face sheet, revealed he was an [AGE] year-old male admitted [DATE] with diagnoses of Malnutrition, Hypertension (high blood pressure) and Atrial Fibrillation (abnormal heart rhythm). Record review of Resident 14's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 14, which indicated the resident's cognitive ability was not impaired. Record review of Resident 14's Care Plan, reflected a Focus area was initiated for hypertension on 8/8/24 with a goal for resident to remain free of complications related to hypertension. Resident 14's interventions included giving the resident hypertensive medications. Record review of Resident 26's undated face sheet, revealed he was a [AGE] year-old male admitted [DATE] with diagnoses of Right-side paralysis, Depression, and stroke. Record review of Resident 26's Quarterly MDS assessment dated [DATE] revealed a BIMS score could not be determined on this resident. Record review of Resident 26's Care Plan, reflected a Focus area was initiated for depression on 9/20/23 with a goal to show decreased episodes of depression. Resident 26's interventions included to take anti-depressant medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675210	A. Building B. Wing	10/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House Nursing and Rehabilitation	407 N College St Rosebud, TX 76570

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 - Some	Record review of Resident 186's undated face sheet, revealed she was an [AGE] year-old female admitted [DATE] with diagnoses of Heart Disease, Anemia, Depression, and Hypertension. Record review of Resident 186's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, which indicated the resident's cognitive ability was not impaired. Record review of Resident 186's Care Plan, reflected a Focus area was initiated for hypertension on 1/3/24 with a goal to remain free of complications related to hypertension. Resident 186's interventions included to take anti-hypertensive medications. Observation on 10/16/24 at 8:49 a.m. revealed MA at her medication cart with a blood pressure (BP) cuff laying on the top of the cart. She took the BP cuff into room and took Resident #26's blood pressure. Afterwards, she returned the blood pressure cuff to the top of the medication cart without cleaning the equipment. She then prepared the medications on the cart. No hand hygiene was performed between getting the residents BP and preparing medications at the cart. Many areas of the cart were touched while preparing medications. She returned inside the room and administered the medications to Resident #26. MA washed her hands after all medications were given to him. Observation on 10/16/24 at 9:06 a.m. revealed MA left Resident #26's room and moved to Resident #14's room. The blood pressure (BP) cuff was still laying on the top of the cart un-sanitized. She took the BP cuff into room and took Resident #14's blood pressure. Afterwards, she returned the blood pressure cuff to the top of the medication cart without cleaning the equipment. She then prepared the medications on the cart. No hand hygiene was performed between getting the residents BP and preparing medications at the cart. Many areas of the cart were touched while preparing medications. She returned inside the room and administered the medications to Resident #14. Afterwards she returned to the medication cart without performing any hand hygiene. MA proceeded to touch multiple areas of the medication cart and the computer on the cart. She then moved the medication cart to the next room. Observation on 10/16/24 at 9:14 am revealed MA left Resident #14's room and moved to Resident #186's room. The blood pressure (BP) cuff was still laying on the top of the cart un-sanitized as she worked on the top of the cart and on the computer. MA performed hand hygiene but did not sanitize the BP before she took the BP cuff into the room and took Resident #186's blood pressure. Direct contact with the resident's bare skin was observed while the MA was taking the blood pressure. Afterwards, she returned the blood pressure cuff to the top of the medication cart without cleaning the equipment. She then prepared the medications on the cart. No hand hygiene was performed between getting the residents BP and preparing medications at the cart. Many areas of the cart were touched while preparing medications. She returned inside the room and administered the medications to Resident #186. No hand hygiene performed after leaving the room. MA then moved the medication cart to Resident #08's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/16/24 at 9:40 am. revealed MA left Resident #186's room and moved to Resident #08's room. The blood pressure (BP) cuff was still laying on the top of the cart un-sanitized. She took the BP cuff into room and took Resident #0'8's blood pressure. No hand hygiene was done before entering the room. Afterwards, she returned the blood pressure cuff to the top of the medication cart without cleaning the equipment. She then prepared the medications on the cart. No hand hygiene was performed between getting the residents BP and preparing medications at the cart. Many areas of the cart were touched while preparing medications. She returned inside the room and administered the medications to Resident #08. Afterwards, she returned to work at the medication cart without performing hand hygiene. In an interview on 10/18/24 at 1:50 PM CNA-E stated, the policy was to wash hands or sanitize hands between residents. She stated the policy on cleaning equipment between residents was to use sanitizer wipes to clean BP cuffs. CNA-E stated it was important to clean hands and equipment between residents to keep down infections. She stated the negative outcome to residents if this was not done would be residents getting sick. In an interview on 10/18/24 at 2:04 PM the ADM stated, the policy was to remove gloves and wash hands thoroughly or use hand sanitizer if appropriate between residents. She stated the policy on cleaning equipment between residents was to use proper cleaning material between resident's blood pressures. The ADM stated it was important to clean hands and equipment between residents to prevent infectious bacteria transferring from one resident to another. She stated the negative outcome to residents if this was not done would be residents would get an infection. In an interview on 10/18/24 at 2:10 PM the DON stated, the policy was to clean hands with alcohol base gel, wash hands with soap and water if resident was on isolation and use gel when gloves were removed. She stated the policy on cleaning equipment between residents was to wipe with wipes and let it dry between each resident use. The DON stated it was important to clean hands and equipment between residents for infection control and to not pass anything between residents. She stated the negative outcome to residents if this was not done would be to spread germs or infectious diseases to residents. In an interview on 10/18/24 at 2:13 PM CRN stated, the policy was to complete hand hygiene between residents, usually with alcohol-based-hand gel. She stated the policy on cleaning equipment between residents was to wipe with purple wipes between each resident use. RN-E stated it was important to clean hands and equipment between residents to cut down on the spread of infections. She stated the negative outcome to residents if this is not done, would be to spread infections. A record review of the facility policy titled, Fundamentals of Infection Control Precautions dated 2019 and with a last revision date of 3/2023 reflected the following: Hand hygiene continues to be the primary means of preventing the transmission of infection. Situations listed that require hand hygiene include: Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure). Non-invasive resident care equipment is cleaned daily or as needed between use by the nursing assistant.