STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675271	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Oaks Nursing & Rehabilitation	901 Seven Oaks Rd Bonham, TX 75418

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interviews and record reviews the facility failed to ensure assessments accurately reflected the resident status for 1 of 15 residents (Resident #34) reviewed for MDS assessment accuracy. The facility failed to ensure Resident #34's anticoagulant (blood thinner) use was accurately coded on his quarterly MDS assessment dated [DATE]. This failure could place residents at risk for not receiving care and services to meet their needs. Findings included: Record review of Resident #34's face sheet dated 06/18/24, indicated a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #34 had diagnoses of psychosis (collection of symptoms that affect the mind, where there has been some loss of contact with reality), intermittent explosive disorder (impulsive, aggressive, violent behavior or angry verbal outburst), recurrent severe major depression (mood disorder that causes persistent sadness and loss of interest), chronic kidney disease (a gradual loss of kidney function that can lead to kidney failure), and anxiety. Record review of Resident #34's quarterly MDS assessment dated [DATE], indicated Resident #34 usually understood others and was able to make himself understood. The MDS assessment indicated Resident #34 had a BIMS score of 07, which indicated his cognition was severely impaired. The MDS assessment did not indicate Resident #34 had received an anticoagulant medication within the 7-day look back period. Record review of Resident #34's medication administration record dated 04/01/24-04/30/24, indicated Resident #34 had received rivaroxaban (anticoagulant medication used to prevent blood clots) 10mg daily with no documented missed or refused doses. Record review of Resident #34's comprehensive care plan dated 05/02/23, indicated Resident #34 was on anticoagulant therapy. The care plan interventions included to take medication at the same time each day and monitor for signs and symptoms of anticoagulant complications such as blood-tinged urine, sudden severe headache, or bruising. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #34's order summary report dated 06/18/24, indicated Resident #34 had an order for Rivaroxaban 10mg one time a day related to chronic kidney disease with an order start date of 05/02/23. During an interview on 06/18/24 at 09:51 AM, the MDS Coordinator said Resident #34's anticoagulant medication, rivaroxaban, should have been coded on his quarterly MDS assessment as having received it. The MDS Coordinator said failure to code Resident #34's anticoagulant medication would not indicate Resident #34 was at risk for bleeding or skin issues. The MDS Coordinator said she was responsible for ensuring the MDS assessments were accurate. The MDS Coordinator said when coding medications on the MDS assessment she looked at the resident's medication administration record and must have missed it. The MDS Coordinator said she made a mistake of not coding Resident #34's anticoagulant medication. During an interview on 06/18/24 at 10:20 AM, the DON said rivaroxaban was an anticoagulant medication. The DON said if there was a question on the MDS assessment asking if a resident received an anticoagulant medication, then it should have been marked that he received it. The DON said not coding the anticoagulant medication was an in accurate MDS assessment. The DON said the MDS Coordinator was responsible for ensuring the MDS assessments were accurate. During an interview on 06/18/24 at 10:41 AM, the Administrator said she expected the MDS assessments to be accurate. The Administrator said if a resident was receiving an anticoagulant medication, then she expected the MDS assessment to be coded that resident received it. The Administrator said not coding the anticoagulant could cause a mistake when completing the resident's care plan. The Administrator said the MDS Coordinator was responsible for ensuring the MDS assessments were accurate. Record review of the Resident Assessment Instrument 3.0 User's Manual, last revised October 2023, indicated Coding Instructions . N0415E1. Anticoagulant: Check if an anticoagulant medication was taken by the resident at any time during the 7- day look-back period (or since admission/entry or reentry if less than 7 days).

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46928 Based on interview, and record review, the facility failed to ensure individuals with mental health disorders were provided an accurate Preadmission Screening and Resident Review (PASRR) Screenings for 1 of 4 residents (Resident #34) reviewed for PASRR. The facility failed to refer Resident #34 for PASRR review following new mental illness diagnosis of severe major depression (mood disorder that causes persistent sadness and loss of interest) on 07/17/23. This failure could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs. Findings included: Record review of Resident #34's face sheet dated 06/18/24, indicated a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #34 had diagnoses of psychosis (collection of symptoms that affect the mind, where there has been some loss of contact with reality), intermittent explosive disorder (impulsive, aggressive, violent behavior or angry verbal outburst), recurrent severe major depression (mood disorder that causes persistent sadness and loss of interest), and anxiety. Resident #34's face sheet indicated the onset of the severe major depression diagnosis was 07/17/23. Record review of Resident #34's PASRR Level 1 screening dated 05/01/23, indicated there was no evidence Resident #34 had a mental illness, intellectual disability, or developmental disability. Record review of Resident #34's comprehensive care plan dated 05/02/23, indicated Resident #34 required antidepressant medication with interventions to give antidepressant medication as ordered and to monitor for signs and symptoms of depression which include sadness, irritability, crying, suicidal ideations and negative mood/comments. Record review of Resident #34's comprehensive care plan dated 07/17/23, indicated Resident had a history of making false accusations. Resident #34 alleged the facility was holding him against his will and holding him hostage and calling 911. The care plan interventions included to review medications with in-house psych services and primary care physician for any medication changes. Record review of Resident #34's comprehensive care plan dated 08/11/23, indicated Resident #34 had a current and past history of having auditory and visual hallucinations, hearing and seeing people and objects that were not there. The care plan interventions included to continue with in-house psychiatric services, adjusting medications as necessary, and to educate the patient and their family about auditory/visual hallucinations, their nature, and strategies to cope with them effectively. The care plan also indicated Resident #34 had a behavior problem related to having a history of calling 911 prior to admission to facility as reported by the sheriff's office to investigate seeing people on his property/inside his house. The care plan interventions included to monitor behavior episodes and attempt to determine underlying cause. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #34's psychiatric progress note dated 01/03/24, indicated Resident #34 had diagnoses of Major Depressive Disorder, recurrent episode, severe and Intermittent Explosive Disorder. Record review of Resident #34's quarterly MDS assessment dated [DATE], indicated Resident #34 usually understood others and was able to make himself understood. The MDS assessment indicated Resident #34 had a BIMS score of 07, which indicated his cognition was severely impaired. The MDS assessment indicated resident had little interest or pleasure in doing things and feeling down, depressed, or hopeless 2-6 days out of the 2-week look back period. The MDS assessment indicated Resident #34 had no behaviors and sometimes felt lonely or isolated from others. The MDS assessment indicated Resident #34 had anxiety, depression, psychotic disorder, and intermittent explosive disorder as active diagnoses. Record review of Resident #34's order summary report dated 06/18/24, indicated Resident #34 had the following orders being given for major depression: *Lexapro 5mg one tablet at bedtime with an order start date of 07/17/23. *Mirtazapine 15mg one tablet at bedtime with an order start date of 05/01/23. Record review of Resident #34's medication administration record dated 06/01/24-06/30/24, indicated Resident #34 received Lexapro 5mg and mirtazapine 15 mg daily at bedtime. During an interview on 06/18/24 at 09:51 AM, the MDS Coordinator said major depression constituted a mental illness and a Form 1012 (a form used to determine if a previously negative PASRR level 1 form needs to be changed to a positive PASRR level 1 for Mental Illness) should have been completed on Resident #34 when he was diagnosed with major depression. The MDS Coordinator said in October 2023, corporate sent a list of all residents that needed to be looked at to ensure all proper documentation was completed for residents that were considered PASRR positive. The MDS Coordinator said Resident #34 was not on that list. The MDS Coordinator said Resident #34 was missed. The MDS Coordinator said failure to complete a form 1012 on Resident #34 resulted in him not receiving the proper evaluation from PASRR services or receiving additional services. The MDS Coordinator said she was responsible for ensuring all PASRR level 1 were completed and completing the Form 1012 when a resident had a new mental illness. During an interview on 06/18/24 at 10:20 AM, the DON said Major Depression was a mood disorder and fell under the category of mental illness. The DON said the MDS Coordinator was responsible for ensuring the PASRRs were updated. The DON said failure to complete a positive PASRR for Resident #34 could have resulted in missed PASRR services. During an interview on 06/18/24 at 10:41 AM, the Administrator said Resident #34 had long-term issues with mental illness that they were not aware of when he admitted to the facility. The Administrator said after Resident #34 admitted , he started randomly calling the police and they referred him to psychiatric services. The Administrator said after speaking with Resident #34's family regarding his behaviors, they were notified of Resident #34 mental illness and requiring treatment. The Administrator said she was unsure if a positive PASRR had to be completed and not completing one he could have missed some of the psychiatric services. The Administrator said the MDS Coordinator was responsible for updating the PASRRs. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy PASRR PCSP/IDT Policy and Procedure revised 03/06/2019, did not address updating the PASRR level one after a new mental illness diagnosis.

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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** 45810 Based on interview and record review the facility failed to facilitate resident and family participation in the care planning process for 4 of 15 residents (Resident #15, Resident #17, Resident #21, and Resident #28) reviewed for care plans. The facility failed to notify and invite Resident # 17's responsible party to care plan meetings. The facility failed to ensure Resident # 15, Resident #21, Resident #28 and their representatives were invited to their care plan meetings. These failures could place residents at risk of not having needs met by depriving them the opportunity to participate in the decision making regarding their care. Findings included: 1. Record review of Resident #15's face sheet dated 06/24/24 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses chronic obstructive pulmonary disease (disease causing restricted airflow and breathing problems), major depression (mood disorder that causes persistent sadness and loss of interest), heart failure (a condition in which the heart does not pump blood as well as it should), diabetes mellitus (a group of diseases that result in too much sugar in the blood stream), and high blood pressure. Record review of Resident #15's quarterly MDS date 06/09/24 indicated she was able to make herself understood and understood others. The MDS assessment indicated Resident #15 had a BIMS score of 15, which indicated she was cognitively intact. Record review of Resident #15's Care plan conference dated 05/16/24, indicated NO on the question if the resident had attended the meeting. The section to indicate why the resident did not attend was left blank. The care plan conference indicated NO on the question if the resident representative attended the meeting. The section on why the resident representative did not attend was left blank. The care plan conference indicated the staff that attended the meeting were the RN, the MDS Coordinator, the Food Service staff, the Physician, the Activity Director, the Social Service Director, and the Director of Rehab. During an interview on 06/18/24 at 03:29 PM Resident #15 said she had never been invited to her care plan meetings, but she would like to be invited and included in her care. 2. Record review of Resident #17's face sheet dated 06/18/24 indicated she was an [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses Alzheimer's (a progressive disease that destroys memory and other important mental functions), psychosis (collection of symptoms that affect the mind, where there has been some loss of contact with reality), major depressive disorder (mood disorder that causes persistent sadness and loss of interest), and chronic pain. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #17's quarterly MDS assessment dated [DATE] indicated she was sometimes able to make herself understood and sometimes understood others. The MDS indicated Resident #17 had a BIMS of 1 which indicated she had severe cognitive impairments. Record review of Resident #17's care plan meeting summary dated 02/29/24 did not indicate any documentation regrading having a care plan meeting with Resident #17. Resident #17's care plan meeting summary had the signatures of the Director of Rehab, MDS Coordinator, Activity Director, and the Director of Nursing. The summary did not indicate Resident #17 or Resident 17's representative attended the meeting. Record review of Resident #17's Care plan conference dated 05/23/24, indicated NO on the question if the resident had attended the meeting. The section to indicate why the resident did not attend was left blank. The care plan conference indicated NO on the question if the resident representative attended the meeting. The section on why the resident representative did not attend was left blank. The care plan conference indicated the staff that attended the meeting were the RN, the MDS Coordinator, the Food Service staff, the Physician, the Activity Director, and the Social Service Director. During an interview 06/18/24 at 02:14 PM a responsible party said she had not been invited nor had she had a care plan meeting in over a year. 46928 3. Record review Resident #21's face sheet dated 06/18/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #21 had diagnoses of chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs), hypertension (high blood pressure), Alzheimer's (brain disorder that causes problems with memory, thinking, and behavior) and heart failure (when the heart muscle does not pump blood as well as it should). Record review of Resident #21's quarterly MDS assessment dated [DATE], indicated she was able to make herself understood and understood others. The MDS assessment indicated Resident #21 had a BIMS score of 14, which indicated her cognition was intact. Record review of Resident #21's care plan meeting summary dated 10/26/23 did not indicate any documentation regrading having a care plan meeting with Resident #21. Resident #21's care plan meeting summary had the signatures of the Director of Rehab and MDS Coordinator. The summary did not indicate Resident #21 or Resident 21's representative had attended the meeting. Record review of Resident #21's care plan meeting summary dated 01/25/24 did not indicate any documentation regrading having a care plan meeting with Resident #21. Resident #21's care plan meeting summary had the signatures of the Director of Rehab, MDS Coordinator, Activity Director, and Dietary Manager. The summary did not indicate Resident #21 or Resident 21's representative attended the meeting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #21's Care plan conference dated 04/25/24, indicated NO on the question if the resident had attended the meeting. The section to indicate why the resident did not attend was left blank. The care plan conference indicated NO on the question if the resident representative attended the meeting. The section on why the resident representative did not attend was left blank. The care plan conference indicated the staff that attended the meeting were the RN, the MDS Coordinator, the Food Service staff, the Physician, the Activity Director, and the Social Service Director. During an interview on 06/18/24 at 02:43 PM, Resident #21 said she had been at the facility for over a year. Resident #21 said she had not attended or been invited to a care plan meeting. Resident #21 said if she had been invited to the care plan meetings, she would have attended them. Resident #21 said she liked to know what was going on and be involved in her care. 4. Record review of Resident #28's face sheet dated 06/18/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included congestive heart failure (condition when the heart cannot pump blood well enough to meet the body's needs), atrial fibrillation (abnormal heart rhythm characterized by rapid irregular beating), old myocardial infarction (heart attack), and shortness of breath. Record review of Resident #28's annual MDS assessment dated [DATE], indicated Resident #28 was able to make herself understood and understood others. The MDS assessment indicated Resident #28 had a BIMS score of 15, which indicated her cognition was intact. Record review of Resident #28's care plan meeting summary dated 12/07/23 did not indicate any documentation regarding having a care plan meeting with Resident #28. Resident #28's care plan meeting summary had the signatures of the Director of Rehab, MDS Coordinator, Activity Director, and Dietary Manager. The summary did not indicate Resident #28 or Resident 28's representative attended the meeting. Record review of Resident #28's care plan meeting summary dated 03/21/24 did not indicate any documentation regarding having a care plan meeting with Resident #28. Resident #28's care plan meeting summary had the signatures of the MDS Coordinator, Physical Therapy Assistant, and Dietary Manager. The summary did not indicate Resident #28 or Resident 28's representative attended the meeting. During an interview on 06/18/24 at 02:38 PM, Resident #28 said she had been in the facility a little over a year. Resident #28 said she had not been invited or attended a care plan meeting that she could recall. Resident #28 said she liked to be involved in her stuff so she would have attended one if she had known. During an interview on 06/18/24 at 03:25 PM the Director of Rehab said the families used to attend the meetings regularly but recently the facility had not had very many residents' families show up. She said she was unsure if they were being invited to attend the care plan meetings. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/18/24 at 03:40 PM the Activity Director said the social worker was responsible for sending out the care plan invitations. She said the Social Worker had been at the facility about 6 weeks and before that she would call to notify the families about the care plan meetings. The Activity Director said she did not make a note about the calls, and she was not aware that she needed to document the information. She said she invited the residents as well but could not remember when the last resident attended a care plan meeting. The Activity Director said her way of notifying the residents for care plan meetings was by telling them on the day of the care plan meeting, but she had never notified them prior to the meetings. The Activity Director said the failure placed the families of residents and residents at risk of not knowing what was going on with their care and not having input into their care. During an interview on 06/18/24 at 03:50 PM the Social Worker said she had been working at the facility for 2 days a week Tuesdays and Thursdays for about 2 months. She said when she began working at the facility, she was not sure who was responsible for sending out care plan meeting invites to the residents and families. The Social Worker said she began the process of filling out the paperwork for invitations to care plan meetings and started sending them out to residents' families because she was accustomed to completing them. She said she was not aware of the issue with the invites not being sent out to residents and families. The Social Worker said she was unsure who was responsible. She said the importance of inviting the family and residents to care plan meetings was to make sure the family knows what is going on with their loved ones and ensure resident were aware of their care. During an interview on 06/18/24 at 04:08 PM the DON said she believed the social worker was now responsible for providing invitations for care plan meetings to residents and families, and prior to the Social Worker starting the Activity Director was responsible and completing them. She said she was unaware if the Activity Director had provided letters to the residents or families. The DON said she expected the families should have been invited and notified of the care plan meetings, and residents should have been notified of meetings as well. She said it was the right of the resident to be notified of the care plan meeting prior to meeting as well as the family, and placed a risk is for family and resident not being involved in care. During an interview on 06/18/24 at 04:21 PM the Administrator said the Social Worker had been completing the care plan invitation letters and sending them out since she began to work at the facility. She said prior to the social worker, the Activity Director and MDS nurse was responsible. The Administrator said the failure of not inviting residents and families to care plan meetings placed the resident or family at risk for miscommunications or lack of coordination of care. Record review of the undated facility's Comprehensive Care Planning policy indicated . The facility will provide the resident and resident representative, if applicable with advance notice if care planning conferences to enable resident/resident representative participation. Resident and resident representative in care planning can be accomplished in many forms such as holding care planning conferences at a time the resident representative is available to participate, holding conference calls or video conferencing .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45810 Based on observation, interview, and record review, the facility failed store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 3 medication carts (nurse medication cart) reviewed for medication storage. LVN C failed to ensure the facility nurse medication cart was locked when it was left unattended when she went in Resident #31's room to check her blood sugar for insulin administration. This failure could place residents at risk of injury and drug diversion. Findings included: During an observation and interview on 06/17/24 at 04:25 PM LVN C prepared supplies to check Resident #31's blood sugar, went into Resident #31's room, closed the door, and left the nurse medication cart unlocked and unsupervised. When LVN C returned to the cart she said she was not supposed to have left the medication cart unlocked while being unsupervised. She said the failure placed a risk for residents or staff to get into the cart and take medications. During an interview on 06/18/24 at 03:58 PM the DON said she expected the nurses to lock the carts when unattended. The DON said the failure placed the risk is for anyone getting into the cart. She said nursing administration (DON and ADON) were responsible for ensuring the nurse were locking carts when not attended. The DON said the administrative nurses made rounds to ensure the nurses were locking carts. During an interview on 06/18/24 at 04:19 PM the Administrator said her expectation was for the nurses to lock the medication carts when they were not attending the cart. She said the DON and ADON was responsible for ensuring the nurses know to keep carts lock and they complete check offs upon hire and annually or if the facility had issues. The Administrator said the failure placed a risk for residents or anyone passing to be able to get into the cart and get medications out. Record review of the facility Recommended Medication Storage policy revised 07/2012 did not indicate when the facility should be locking medication carts.

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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** 47708 Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for dietary services, in that: 1) The facility failed to label and date all food items. 2) Dietary staff failed to dispose of expired foods items. 3) Dietary Staff failed to effectively reseal, label and date frozen food items. 4) Dietary staff failed to store thawed raw meat below ready to eat foods. These failures could place residents at risk for food contamination and foodborne illness. The findings included: During observations with [NAME] B on [DATE] at 10:05 am, the following observations were made in the kitchen walk-in refrigerator (1 of 1): - (1) large bowl of chicken salad with no preparation (prep) date and no use by date; located underneath 10 pounds of thawed ground beef. - (1) prepared bagged ham sandwich with no prep date and no expiration date; located underneath 10 pounds of ground beef. (label was unreadable on the sandwich bag). - (3) single purple onions and (1) single yellow onion had no open date, a use by date of [DATE], received on [DATE]. -(1) five-pound bag of golden harvest mild cheddar shredded cheese with no open date, and no receive date. -(1) zip lock bag of sliced ham not in original packaging had an open date of [DATE], no receive date, no expiration date and was not labeled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-(1) zip lock bag of Golden harvest Yellow slice cheese of about 50 slices had open date of [DATE], no receive date and no expiration date. -(1) zip lock bag of tomatoes had a preparation date of [DATE] and had no expiration date. -(1) two quart container of pineapples had a preparation date of [DATE] and no expiration date. -(1) container of Cranberry Juice had a preparation date of [DATE] and no expiration date. -(1) sixteen ounce container of beef base had an open date of [DATE], no receive date and no expiration date. -(1) zip lock bag of BBQ sausages had a preparation date of [DATE] and no expiration date. -(1) four quart container of ranch dressing had a preparation date of [DATE] and expiration date of [DATE]. -(1) two quart container of strawberry glaze had a preparation date of [DATE] and no expiration date. -(1) half quart of yogurt had a preparation date of [DATE], not labeled, and no expiration date. -(1) zip lock bag of cooked pork meat had a preparation date of [DATE] and an expiration date of [DATE]. -(1) gallon of 1 percent milk had no receive date, no open date and expired on [DATE]. -(1) gallon of 1 percent milk unopened had no receive date and expired on [DATE]. During observations on [DATE] beginning at 10:25 am, the following observations were made in the kitchen freezer: -(1) empty container of butter pecan ice cream had no open date and an expiration date of [DATE] . -(3) 4 fluid ounces of sherbet ice cream cups had no receive date, no expiration date. -(1) zip lock bag of turkey breast had no receive date. -(1) 24 pack of hotdogs received on [DATE] had no expiration date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-(1) bag of about 10 frozen dinner rolls opened on [DATE], had no receive date and no expiration date. -(1) open box of hamburger meat patties open to air was received on [DATE], had no open date, no expiration date. -(1) open box of popsicles opened on [DATE], had no receive date and no expiration date. During observations with [NAME] B on [DATE] beginning at 10:46 a.m., the following observations were made in the kitchen dry storage: -(1) container of brown sugar had a preparation date of [DATE] and no expiration date. -(1) 16 ounces of chicken base seasoning had a receive date of [DATE], and no open date. -(1) container of [NAME] seasoning had a receive date of [DATE] and no open date. -(1) 16 ounces of cooking spray oil had a no receive date, no open and no expiration date. -(1) 26 ounce of salt seasoning had no receive date and no open. -(1) 4.5 ounce of seasoning salt had no open date and no receive date. -(1) package of mini dinner rolls open to air held 3 rolls; there was no open date. -(1) container of beef base seasoning received on [DATE], opened on [DATE] and no expiration date. During an interview on [DATE] at 10:05 a.m., [NAME] B stated, she was the acting Dietary Manger when the Dietary Manager was not in the facility. [NAME] B stated the ready to eat foods were not supposed to be below the thawing ground beef in the refrigerator. [NAME] B stated she would throw away the sandwich and chicken salad found underneath the thawing hamburger meat. [NAME] B stated she believed the prepared foods was good for 5 days. [NAME] B stated she did not know some of the items found in the walk in freezer and kitchen was not labeled, dated and expired foods thrown away. [NAME] B stated the expired and empty box of ice cream found in the kitchen freezer belonged to a staff member at the facility. [NAME] B stated she did not know the ice cream was expired and empty container was in the kitchen freezer. [NAME] B stated the frozen ground beef hamburger patties bag should have had an open date, expiration date and bag should have been closed and sealed. [NAME] B did not know why the bag of hamburger patties was not sealed closed. [NAME] B stated she would inform the Dietary Manager of the findings located in the kitchen and freezers. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:22 a.m., [NAME] A stated she had been working at the facility for a few months as a cook but had been employed at the facility for a year. [NAME] A stated she worked the 5am to 1 pm shift at the facility. [NAME] A stated prepared food items should be discarded after 5 days. [NAME] A stated all food items should be labeled, dated with the received date or preparation date and the expiration date [NAME] A stated all freezer food items should be properly closed and sealed. [NAME] A stated the Dietary Manager oversaw her. [NAME] A stated in-services on labeling and dating was completed last week. [NAME] A stated the Dietary Manager conducted daily walk-thru in the kitchen every morning. [NAME] A stated she was not aware of expired food items in the kitchen. [NAME] A stated the Dietary Manager would normally discard expired food items during her daily walk-thru. [NAME] A stated the dietary staff was expected to ensure all food items were labeled, dated and discarded if expired. [NAME] A stated thawed meats should not be above the ready to eat foods. [NAME] A stated the risks to the residents for having thawed meat above the ready to eat foods was food contamination. [NAME] A stated it was important to ensure all food items were labeled, dated and discarded to prevent food borne illnesses. During an interview on [DATE] at 10:40 a.m., the Dietary Manager stated she had been the Dietary Manager for 4 years. The Dietary Manager stated she worked Monday thru Friday from early mornings to about 1:30 p. m. The Dietary Manager stated she thought it was 5 days that prepared foods should have been discarded but when she checked the FDA site she realized it was 7 days instead of 5 days. The Dietary Manager stated freezer food items should be properly closed and sealed. The Dietary Manager stated she oversaw the Dietary staff, and the Administrator oversaw her at the facility. The Dietary Manager stated in-services on labeling, dating and discarding expired food items was last completed on [DATE]. The Dietary Manager stated her last walk thru in the kitchen was last completed on Saturday on [DATE]. The Dietary Manager stated, I normally completed daily walk-thru on my days I work. The Dietary Manager stated she was not made aware of the expired refrigerated food items and food items not labeled. The Dietary Manager stated she did expect staff to ensure they were labeling, dating and discarding expire food items. The Dietary Manager stated, I coached to them every day and ask, What's wrong with this picture? The Dietary Manager stated it was important to ensure staff were labeling and dating food items to prevent residents from getting sick, infection control and cross contamination. The Dietary Manager stated thawed meats should not be above the ready to eat foods. The Dietary Manager stated the thawed meats should be stored on the bottom shelf. The Dietary Manager stated the risk to the residents for having the thawed meats stored above the ready to eat foods was cross contamination, food borne illnesses and bacteria. During an interview on [DATE] at 1:54 pm., the Administrator stated, she had been the Administrator for 3 years at the facility. The Administrator stated, Yes, all food items should have a receive date, prep date and expiration date. The Administrator stated all freezer food items should be properly sealed and closed. The Administrator stated she oversaw the Dietary staff. The Administrator stated she could not answer the question regarding in-services, but the Dietary Manager did in-services a lot. The Administrator stated, Yes she did walk-thrus in the kitchen. The Administrator stated, She conducted weekly rounds in the kitchen. The Administrator stated she expected staff to ensure they were labeling, dating and discarding expired food items. The Administrator stated expired food items should have been discarded in the kitchen. The Dietary Manager stated it was important to ensure staff were labeling, dating and discarding expired food items so the residents did not get food borne illnesses. The Administrator stated ready to eat foods should not have been underneath the thawing hamburger meat to prevent the residents from getting sick. (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 Dietary policy titled, Left-over Foods, dated 2012 indicated, (1) Left-over foods shall be refrigerated, dated, labeled and properly covered promptly after meal service; (5) Food that is spoiled, contaminated, or suspect shall not be served and shall be discarded immediately Record Review of the facility's Dietary policy titled Food Storage and Supplies dated 2012, indicated (6) When items are received from the vendor, they should be first examined for expiration date, and if an expiration date is present, it is beneficial to mark it by circling it, so it is readily visible and noticeable. It is important to distinguish between an expiration date and a production date, or a best by or use by date. Production dates indicate-when the product-was manufactured, not when it expires, and should not be interpreted as a best by date. best by or use by dates indicate when a product will have best flavor or quality and are not an indicator of the product s safety. As the quality may deteriorate after the date passes, the dietary manager should closely inspect any products that are past the best by date to determine if they are still good quality. If in doubt, discard the product. If any stamped date is unclear, contact the food vendor for clarification. 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 that date passes.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 2 of 3 residents (Resident #'s 34 and 27) reviewed for hospice services. The facility failed to obtain Resident #34's and Resident #27's most recent updated hospice plan of care. This deficient practice could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. Findings included: 1. Record review of Resident #34's face sheet dated 06/18/24, indicated a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #34 had diagnoses of psychosis (collection of symptoms that affect the mind, where there has been some loss of contact with reality), intermittent explosive disorder (impulsive, aggressive, violent behavior or angry verbal outburst), recurrent severe major depression (mood disorder that causes persistent sadness and loss of interest), chronic kidney disease (a gradual loss of kidney function that can lead to kidney failure), and anxiety. Record review of Resident #34's comprehensive care plan dated 03/19/24, indicated Resident #34 had a terminal prognosis and/or was receiving hospice services. The care plan interventions indicated if receiving hospice services, work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. Record review of Resident #34's quarterly MDS assessment dated [DATE], indicated Resident #34 usually understood others and was able to make himself understood. The MDS assessment indicated Resident #34 had a BIMS score of 07, which indicated his cognition was severely impaired. The MDS assessment indicated Resident #34 received hospice care. Record review of Resident #34's Hospice IDG Comprehensive Assessment and Plan of Care Updated Report dated 05/22/24, indicated Resident #34 had the following orders on his hospice plan of care update that were not on his facility's order summary report: *Abilify 5mg two tablets by mouth at bedtime for psychosis *Vitamin C 500mg one tablet by mouth daily as a supplement *Gabapentin 100mg one capsule twice a day for pain (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Santyl 250 unit/Gram apply 1 cm to wound topically one time a day There was not a recent Hospice Plan of Care Update noted in Resident #34's electronic medical record or his hospice binder. Record review of Resident #34's order summary report dated 06/18/24, indicated Resident #34 had the following orders: *Call hospice nurse with any changes or concerns with an order date of 01/02/24. *May admit to [hospice company] with diagnosis of senile degeneration with an order date of 01/02/24. * Gabapentin 100mg two capsules by mouth twice a day for pain with an order start date of 03/07/24. Record review of Resident #34's electronic medical record on 06/18/24, indicated Resident #34's following orders were discontinued: *Abilify 5mg two tablets at bedtime- discontinued on 02/18/24 *Gabapentin 100mg one capsule twice a day- discontinued on 03/07/24 *Vitamin C 500mg one tablet daily- discontinued on 01/12/24 *Santyl 250 unit/gram- discontinued on 03/08/24. 45810 2. Record review of Resident #27's face sheet dated 06/18/24 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses senile degeneration of the brain (mental deterioration or loss of intellectual ability associated with old age), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), major depression (mood disorder that causes persistent sadness and loss of interest), and anxiety (a health disorder characterized by feelings of worry or fear that interfere with one's daily activities). Record review of Resident #27's care plan revised on 03/15/24 indicated she was receiving hospice services related to senile degeneration of the brain with interventions to work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. Record review of Resident #27's quarterly MDS dated [DATE] indicated she usually understood others and usually made herself understood. The MDS assessment indicated Resident #27 had a BIMS score of 03, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #27 received hospice care. Record review of Resident #27's Hospice IDG Comprehensive Assessment and Plan of Care Updated Report dated 05/22/24. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was not a recent Hospice Plan of Care Update noted in Resident #27's electronic medical record or her hospice binder. During an interview of 06/18/24 at 09:24 AM, the Hospice DON said they had IDG meetings every 2 weeks and once the meeting was completed, they would print out the IDG meeting for the case manage to take to the facility. The Hospice DON said there should been an updated hospice care plan at the facility for Resident #27 and Resident #34 dated 06/05/24. The Hospice DON said she expected the updated care plan to be at the facility with the medication list reconciled and reflecting what the resident was taking. The hospice DON said when a hospice nurse visit was made, the medications were to be reconciled, so there would not be a discrepancy. The Hospice DON said failure to reconcile the medications could cause a medication error. The Hospice DON said the Hospice Case Manager was responsible for providing the facility the most recent hospice care plan and reconciling the resident's medications. During an attempted telephone interview on 06/18/24 at 09:35 AM, the RN Hospice Case Manager did not answer. During an interview on 06/18/24 at 10:20 AM, the DON said she expected the hospice documents to be up to date all the time. The DON said she was unsure of when the hospice provider had to update them. The DON said she knew that the hospice medications should be on the hospice medication profile but unsure of the other medications the resident was taking. The DON said not having an updated medication list would not affect the resident as the hospice staff does not administer medication, so a medication error was unlikely. The DON said not having the most recent updated hospice plan of care was lack of coordination of care. The DON said the hospice provider was responsible for ensuring the most recent hospice plan of care was brought to the facility. During an interview on 06/18/24 at 10:41 AM, the Administrator said she expected the hospice documents to be updated as needed. The Administrator said she would assume the hospice medication list should match the medications the resident was receiving at the facility and not updating them could cause a medication error. The Administrator said the DON and the Hospice provider were responsible of ensuring the most recent hospice plan of care with the updated medication list was at the facility. The Administrator said failure to have the most recent updated hospice plan of care was lack of coordination of care. Record review of the facility's Nursing Facility Hospice Services Agreement with the hospice company dated 02/15/21, indicated . Review and Revision of Plan of Care. The IDT, in consultation with Nursing Facility representatives and the Nursing Facility Attending Physician, shall review and revise the individualized Plan of Care as frequently as the Resident Patient's condition requires but no less frequently than every fifteen (15) calendar days .Hospice shall provide the Nursing Facility Designee with the following: a copy of the most recent Plan of Care specific to each Resident Patient .Hospice will maintain adequate records of all physician orders communicated in connection with the Plan of Care . (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facilities policy Hospice Services revised 02/13/2007 indicated . The DON or designee will be responsible for ensuring that documentation is a part of the current clinical record. At a minimum, the documentation will include .Hospice Plan of Care. Current interdisciplinary notes to include nurse notes/summaries, physician orders and progress notes, and medications and treatment sheets during the hospice certification period .The plan of care must be revised and updated as necessary to reflect the resident's current status .