STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675306	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluebonnet Nursing and Rehabilitation	696 Fm 99 Karnes City, TX 78118

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform the resident in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment option to choose the alternative option he or she preferred for 1 of 4 residents (Resident #7) reviewed for consent for antipsychotic medications. The facility failed to obtain consent by the responsible party for Resident #7 that her risperidone dosage was being reduced from 0.75 mg to 0.5 mg. This failure could place residents at risk for not being informed about care and treatments that may affect the resident's well-being. Findings included:Record review of Resident #7's admission Record dated 08/22/25, documented an [AGE] year-old female who was initially admitted to the facility 07/16/21 with the last admission date of 03/02/24. Her diagnosis included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), unspecified dementia, severe, with other behavioral disturbance (severe dementia of an unknown cause that includes mood disorders, psychotic symptoms and agitation), generalized anxiety disorder (a chronic mental health condition characterized by excessive, persistent, and uncontrollable worry), and psychotic disorder with delusions due to known physiological condition (a condition where delusions, or false beliefs, are caused by the effects of a specific medical or neurological illness, rather than a primary mental health disorder like schizophrenia). Record review of Resident #7's Quarterly MDS dated [DATE] documented a BIMS score of 7, which indicated severe cognitive impairment. Record review of Resident #7's medical chart documented a Form 3713 (Nursing Facility Consent for Antipsychotic or Neuroleptic Medication Treatment) which indicated the physician and responsible party signed the form for 0.75 mg of risperidone to be administered at night on 01/21/25. Record review of Resident #7's current physician's orders as of 08/22/25 indicated she received 0.5 mg of risperidone as of a start date of 07/11/25. Record review of Resident #7's medical chart did not contain a revised Form 3713 to indicate the risperidone dosage had been changed. During an interview with the MDS Coordinator on 08/22/25 at 2:23 pm, the MDS Coordinator stated she was not aware that a new Form 3713 was needed so one had not been completed. Record review of the facility's policy titled Psychotropic Medications dated 02/12/25 documented: Residents have the right to be informed of and participate in their treatment. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative will be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. The resident has the right to accept or decline the initiation or increase of a psychotropic medication. The resident's medical record will include documentation that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and was able to choose the options he or she preferred. A written consent form may serve as evidence of a resident's consent to psychotropic medication, but other types of documentation are also appropriate.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and time frames to meet a resident's medical, nursing and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 2 residents (Resident #44) reviewed for comprehensive care plans. 1. The facility failed to ensure Resident #44's dialysis port was correctly identified as a dialysis port rather than a central IV line. 2. The facility failed to develop an activity care plan for Resident #44. 3. The facility failed to identify that Resident #44's visual issue was not addressed in the resident's care plan. These deficient practices could place residents at risk of not being provided with the necessary care or services and having personalized plans developed to address their specific needs. Findings included: Record review of Resident #44's admission Record dated 08/19/25 documented a [AGE] year-old female who was admitted to the facility 08/05/25. Resident #44 had diagnoses that included metabolic encephalopathy (a condition where the brain's function is impaired due to an underlying metabolic disturbance), end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), diabetes mellitus due to underlying condition with diabetic mononeuropathy (a specific type of diabetes caused by an underlying medical issue leading to damage to a single nerve), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #44's admission MDS dated [DATE] revealed a BIMS score of 7, which indicated severe cognitive impairment. Record review of Resident #44's comprehensive care plan with a focus dated 08/08/25 stated The resident has intravenous (IV) access and the interventions included 1. Administer IV fluids as ordered, 2. Administer IV medications as ordered, and 3 flush the ports/lines as ordered. Another focus dated 08/08/25 stated Resident is on enhanced barrier precautions r/t (related to) have a peripheral central line in place and the interventions included 1. Gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high contact activity. This care plan did not address Resident #44's activity preferences nor did it address her concern about her eyesight. During an interview with Resident #44 on 08/19/2025 at 2:59 pm, the resident stated she does not attend activities because she could not see well. Resident #44 stated she needed to see an eye doctor since she felt her sight had deteriorated while she was in the hospital. Resident #44 was asked if she had an IV and she said she only had her dialysis port which was located in her right chest temporarily until the procedure could be done to put a dialysis fistula in her arm. During an interview with the Activity Director (AD) on 08/22/25 at 8:51 am, she stated she talked with Resident #44. The AD stated, she seems to talk more with family present. She says she wants to live here forever now. She also told me she wants to stay in her room and won't come to activities. I do the inventories for new residents - she likes shoes; likes to dress a certain way. The AD stated she would continue to encourage the resident to do some type of activity in her room and could provide materials according to her preferences.During an interview on 08/22/25 at 2:25 pm with the MDS Coordinator, she stated she was not aware of Resident #44's problem with her sight. The MDS Coordinator stated she would add this issue as well as an activity care plan which was important for the resident's overall well-being. The references to an IV line would also be corrected to reflect she only had a port for her dialysis treatment. During an interview with the DON on 08/22/25 at 2:41 pm, the DON stated Resident #44 never had an IV Line. The DON stated the reference to an IV should not be in the care plan. The DON also stated she was not aware the resident had a problem with her sight.Record review of the facility's, undated, policy titled Comprehensive Care Planning stated, the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Through the care planning process, facility staff will work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices and goals during their stay at the facility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, for 1 of 2 residents (Resident #35) reviewed for care plans. The facility failed to update the comprehensive care plan to reflect Resident #35 was receiving hospice services. This failure could have placed residents at risk of not having their needs identified and met. Findings included: Record review of Resident #35's admission Record documented an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #35 had diagnoses which included dementia in other diseases classified elsewhere, severe, with other behavioral disturbance (a medical diagnosis indicating severe dementia occurring in a patient whose dementia is caused by an underlying physiological condition), Parkinson's Disease with dyskinesia (the loss of dopamine-producing neurons in the brain in which the patient does not experience involuntary, repetitive movements that are often a side effect of Parkinson's medications), and dysphagia, pharyngeal stage (difficulty swallowing). Record review of Resident #35's physician's orders, as of 08/21/25, indicated an order for hospice on 06/26/25.Record review of Resident #35's care plan did not indicate the care plan had been updated to reflect the implementation of hospice.During an interview with the MDS Coordinator on 08/21/25 at 7:17 pm, she stated the initiation of hospice was not in Resident #35's care plan. The MDS Coordinator stated she was the only one to do care plans and it was important for everyone to know that someone was on hospice so there would be coordination of care.Record review of the facility's undated policy titled Comprehensive Care Planning documented the resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the observation, interview, and record review the facility failed to ensure that the resident's environment remained free of accidents and hazards as was possible and each resident received adequate supervision to prevent accidents for 2 of 3 residents (Resident #40 and #38) reviewed for accidents. The facility failed to ensure staff used the appropriate equipment for Resident #40 and Resident #38 during a transfer. This failure could place the resident at risk of falls and place them at risk for injury. The findings included: 1. Record review of Resident #40's face sheet dated 8/20/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included unsteadiness on feet, abnormalities of gait and mobility, muscle wasting and atrophy (decrease in the size of a body part, tissue, or organ due to a loss of cells), and lack of coordination. Record review of Resident #40's most recent quarterly MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and required partial/moderate assistance with transfers. Record review of Resident #40's comprehensive care plan with revision date 3/2/22 revealed the resident required 1-person assist with transferring and required the use of a wheelchair. Observation on 8/19/25 at 10:44 a.m. revealed Resident #40 sitting up in a recliner and the wheelchair in front of her. CNA A was observed assisting Resident #40 from the recliner to a standing position. Resident #40 placed both hands on the wheelchair armrests while CNA A assisted the resident by grabbing the back of the resident's pants and helping the resident to a standing position. During an interview on 8/20/25 at 12:24 p.m., CNA A stated, Resident #40 required staff assistance with transfers from 1 to 2-person. CNA A stated, she recalled assisting the resident from the recliner to a standing position and had not used a gait belt. CNA A stated for a 1-person or 2-person transfer, a gait belt was supposed to be used for extra support and to safely transfer a resident without causing injury to the resident and the staff. CNA A stated at the time she assisted Resident #40 to a standing position, she only helped her a little because the resident was able to transfer herself, and stated, if she had waited for a gait belt, Resident #40 would have gotten up by herself anyway. 2. Record review of Resident #38's face sheet dated 8/20/25 revealed an [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included fracture of shaft of right tibia (the long middle portion, shinbone, of the leg), joint pain, falls, legal blindness (a level of vision loss), bilateral osteoarthritis(a gradual breakdown and low of cartilage in the joints) of knee, low back pain, muscle wasting and atrophy (decrease in the size of a body part, tissue, or organ due to a loss of cells), difficulty in walking, lack of coordination, and age-related osteoporosis (bone disease in which the bones become weak, brittle, and more likely to break due to a loss of bone density and strength). Record review of Resident #38's Functional Ability Worksheet dated 8/8/25 revealed the resident required substantial/maximal assistance with transfers. Record review of Resident #38's comprehensive care plan dated 8/8/25 revealed the resident had an ADL self-care performance deficit and was at risk for falls with interventions that included 2-person staff assist with transfers. Observation on 8/20/25 at 11:27 a.m. revealed Resident #38 sitting on the bed wearing a full leg brace on the right leg, and CNA B and Student Aide C assisted the resident onto the wheelchair without using a gait belt. CNA B and Student Aide C placed their hands around the resident's armpit and lifted her onto the wheelchair. During an interview on 8/20/25 at 11:32 a.m., CNA B stated Resident #38 required 2-person assist with transfers and the CNA was trained by a former CNA. CNA B stated, it was acceptable to perform a 1-person transfer without a gait belt, and if the resident required 2-person assist, like Resident #38, I did not have to use a gait belt because I had a second person help me. You use a gait belt when you need extra help, and nobody is around to assist. During an observation and interview on 8/20/25 at 11:41 a.m., Student Aide C stated she had received training on transfers from multiple staff, including other CNA's, the DON and the ADON. Student Aide C stated she knew Resident #38 required 2-person assist with transfers but was not aware if Resident #38 had a gait belt. Student Aide C stated if Resident #38 had a gait belt it would have been hanging from a hook on the resident's bedroom door. Student Aide C returned with the State Surveyor to Resident #38's room and observed a gait belt hanging from the resident's bedroom door. Student Aide C stated the gait belt would have had the resident's name on it, but the gait belt seen on the resident's bedroom door did not have a name and was not sure if it belonged to Resident #38. Student Aide C stated the gait belt could have belonged to Resident #38's roommate but was not sure. Student Aide C stated she would get with the DON to determine if the gait belt belonged to Resident #38. Student Aide C stated

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections for 1 of 2 residents (Resident #46) reviewed for incontinent care: The facility failed to ensure CNA E provided incontinent care to Resident #46 in the order of cleanest to dirtiest, and CNA E and Student Aide C performed hand hygiene between glove changes. This deficient practice could place residents at-risk for infection and skin break down due to improper care practices. The findings included: Record review of Resident #46's face sheet dated 8/21/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included hemiplegia (complete paralysis on one side of the body) and hemiparesis (partial weakness or reduced strength to one side of the body) affecting the left non-dominant side, and gastrostomy status (a surgically created opening through the abdominal wall into the stomach). Record review of Resident #46's most recent comprehensive MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills and was always incontinent of bowel and bladder. Record review of Resident #46's comprehensive care plan initiated on 7/31/25 revealed the resident had bowel and bladder incontinence with interventions that included to provide incontinent care. Observation on 8/21/25 at 11:15 a.m. during incontinent care, CNA E, after cleaning Resident #46's buttock and anal area, took a clean brief using the same gloves used to clean the resident's buttock and anal area and placed the clean brief on the bed. CNA E and Student Aide C then assisted the resident onto her back and then to her right, removed their gloves, did not wash or sanitize their hands, and put on a new pair of gloves. Student Aide C then applied barrier cream to Resident #46's buttock area, removed her gloves, did not wash or sanitize her hands, and put on a new pair of gloves. During an interview on 8/21/25 at 12:36 p.m., Student Aide C stated she realized she had not washed or sanitized her hands between glove changes and had just forgotten. Student Aide C stated she usually carried a bottle of hand sanitizer with her and should have been used to sanitize her hands otherwise it was considered cross contamination and could results in the resident or the aide getting sick. Student Aide C stated, cross contamination could result in passing on an illness. During an interview on 8/21/25 at 12:48 p.m., CNA E stated she realized she had moved from a dirty area to a clean area and should not have done it and missed that step because she was probably nervous. CNA E stated moving from a dirty area to a clean area with the same gloves could cause an infection and was cross contamination. CNA E stated, taking the clean brief with soiled gloves made the clean brief dirty because it had been touched with dirty gloves. CNA E stated it was the same concept when changing gloves and we need to wash or sanitize our hands between gloves changes to prevent cross contamination. During an interview on 8/21/25 at 7:28 p.m., the DON stated it was her expectation staff were supposed to wash or sanitize their hands between glove changes because it was part of infection control practices and it not done could result in cross contamination and the staff or resident could pass an illness to each other, germs or bug. The DON stated, the aide should have changed her gloves when moving from a dirty area to a clean area because you have now actually done cross contamination. Record review CNA E's C.N.A. Proficiency Audit dated 8/16/25 revealed she had satisfied the requirement for performing hand washing skills and perineal care. Record review of Student Aide C's C.N.A. Proficiency Audit dated 7/5/25 revealed she had satisfied the requirement for performing hand washing skills and perineal care. Record review of the facility document titled, Nursing: Personal Care, Perineal Care dated 4/25/22 revealed in part, .An incontinent resident of urine and/or bowl (sic) should be identified, assessed, and provided appropriate treatment and services to restore as much normal bladder/bowel function as possible.Perform hand hygiene.Gently perform perineal care, wiping from clean, urethral area, to dirty, rectal area, to avoid contaminating the urethral area - CLEAN to DIRTY! .Doff gloves and PPE.Perform hand hygiene.Always perform hand hygiene before and after glove use.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice for 2 of 3 Residents (Resident #40 and Resident #8) reviewed for respiratory care. The facility failed to ensure Resident #40 and Resident #8's oxygen tubing was not touching the floor. This deficient practice could place residents who received oxygen therapy at risk for an increase in respiratory complications and/or infection. The findings included: 1. Record review of Resident# 40's face sheet dated 8/20/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (a long-term lung disease that makes it hard to breath), acute upper respiratory infection (short-term infection that affects the upper part of the respiratory system), pneumonia (infection of the lungs), and acute bronchitis (inflammation of the airways that carry air into the lungs). Record review of Resident #40's most recent quarterly MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and required oxygen therapy. Record review of Resident #40's Order Summary Report dated 8/20/25 revealed the following orders:- Change nebulizer mask and tubing every week on Sunday and clean filter every night shift every Sunday related to chronic obstructive pulmonary disease with order date 5/5/23 and no end date.- Change oxygen tubing and nasal cannula/mask as needed when visibly soiled with order date 7/21/25 and no end date.- Oxygen 2 to 4 liters per minute via nasal cannula every shift with order date 7/21/25 and no end date. Record review of Resident #40's comprehensive care plan with revision date 4/1/24 revealed the resident required oxygen therapy related to chronic obstructive pulmonary disease and interventions that included to give medications as ordered by the physician, monitor oxygen saturation every shift, and administer oxygen. Observation on 8/20/25 at 8:10 a.m. revealed Resident #40 sitting up in the wheelchair in her room and the oxygen concentrator operating via a nasal cannula and the tubing leading from the nasal cannula to the concentrator was touching the floor. During an observation and interview on 8/20/25 at 9:50 a.m., Resident #40 was observed sitting up in the wheelchair and the oxygen concentrator operating with the nasal cannula attached to the concentrator but not on the resident. Resident #40's nasal cannula was draped over the bedside table with the tubing touching the floor. Resident #40 stated she used the oxygen when she needed it and when she did not need it she would take it off. Resident #40 stated she could only take the nasal cannula off but could not put it back on. During an observation on 8/20/25 at 2:52 p.m., Resident #40 was observed sitting up in the wheelchair sleeping and the oxygen concentrator was operating via the nasal cannula and the tubing touching the floor. During an observation on 8/20/25 at 4:48 p.m., Resident #40 was observed sitting up in the recliner and the oxygen concentrator was operating and the nasal cannula was on the floor. During an observation and interview on 8/20/25 at 4:51 p.m., LVN D stated Resident #40 had a physician's order for continuous oxygen and there was an order to change the oxygen tubing and mask every Sunday because the tubing could get dirty with usage. LVN D stated, Resident #40 often removed her nasal cannula and stated she had been in the resident's room periodically often and was in the resident's room often, at least every 4 hours to administer pain medication. LVN D stated, during those times she would also check to see if the resident was using the oxygen. Observation with LVN D revealed Resident #40 with the nasal cannula on the floor while the oxygen concentrator was operating. LVN D stated, if the oxygen tubing was touching the floor, it's dirty and the tubing could pick up bacteria. LVN D stated, the oxygen concentrator tubing on the floor needed to be changed out. 2. Record review of Resident #8's face sheet dated 8/21/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] and 7/31/25 with diagnoses that included acute and chronic respiratory failure with hypoxia (a sudden onset of when the lungs cannot provide enough oxygen to the blood or cannot remove enough carbon dioxide), acute pulmonary edema (sudden buildup of fluid in the lungs' air sacs which makes it very difficult to breathe), heart failure, and chronic obstructive pulmonary disease (a long-term lung disease that makes it hard to breath). Record review of Resident #8's most recent comprehensive MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision- making skills and required oxygen therapy. Record review of Resident #8's Order Summary Report dated 8/21/25 revealed the following orders:- Oxygen 3 liters per minute via nasal cannula every shift with order date 8/1/25 and no end date. Record review of Resident #8's comprehensive care plan with revision date 8/13/25 revealed the resident used

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Bluebonnet Nursing and Rehabilitation	696 Fm 99 Karnes City, TX 78118

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and follow a policy to provide pharmacy services in accordance with State and Federal laws or rules of the Drug Enforcement Administration for 2 of 4 residents (Resident #33 and #35) reviewed for pharmacy services. The facility failed to ensure Medication Aide G documented she dispensed Resident #33's Xanax prescribed for major depressive disorder and Resident #35's Tramadol in the narcotic log for August 2025. This deficient practice could put residents at risk of misappropriation and drug diversion. The findings included: 1. Record review of Resident #33's face sheet dated 8/22/25 revealed an [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included dementia (general term for a group of symptoms that affect memory, thinking, reasoning, and the ability to perform daily activities), anxiety disorder (mental health condition characterized by excessive fear, worry, or nervousness), and major depressive disorder (mental health condition characterized by persistent and intense feelings of sadness, hopelessness, or a loss of interest or pleasure in most activities). Record review of Resident #33's Order Summary Report dated 8/22/25 revealed the following:- Xanax 5 mg tablet, give 1 tablet by mouth one time a day related to major depressive disorder with order date 5/21/25 and no end date. Record review of Resident #33's Medication Administration Record for August 2025 reflected the resident was administered Xanax 5 mg tablet on 8/22/25 by Medication Aide G. 2. Record review of Resident #35's face sheet dated 8/22/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included pain, fractures of the lower end of right radius (bone in the forearm located on the thumb side), lower end of right ulna (forearm bone located on the side of the little finger), and right femur (thigh bone). Record review of Resident #35's Order Summary Report dated 8/22/25 revealed the following:- Tramadol 50 mg, give 50 mg by mouth every 8 hours as needed for pain with order date 12/6/24 and no end date. Record review of Resident #35's Medication Administration Record for August 2025 reflected the resident was administered Tramadol 50 mg tablet on 8/22/25 by Medication Aide G. During an inspection of Medication Aide G's medication cart on 8/22/25 at 10:09 a.m. revealed the narcotic log for Resident #33's Xanax 5 mg did not reflect the resident's medication was signed out on 8/22/25. During the inspection of the same medication cart, Medication Aide G attempted to document in Resident #35's narcotic log to reflect she had signed out the resident's Tramadol 50 mg on 8/22/25. Medication Aide G stated she had administered Resident #33's Xanax 5 mg at approximately 7:00 a.m. and had administered Resident #35's Tramadol 50 mg at approximately 8:00 a.m. Medication Aide G stated she was supposed to document on Resident #33 and Resident #35's narcotic log immediately after the medication was administered to the resident to avoid a drug diversion. Medication Aide G stated she had forgotten to document in the narcotic logs for Resident #33 and Resident #35 and not doing so could result in an inaccurate narcotic count. During an interview on 8/22/5 at 2:39 p.m., the DON stated it was her expectation, when narcotics were being administered, nursing was supposed to document in the narcotic log immediately after the medication was administered. The DON stated an incident could occur if the staff assigned to the medication cart were called away and did not log out a narcotic, then the narcotic count could be inaccurate and result in a drug diversion. The DON stated, all narcotics should be signed out on the log when they are administered. Record review of the facility document titled Medication Administration and General Guidelines, dated 2025 revealed in part, .Medications are administered at the time they are prepared.In no case should the individual who administered the medications report off-duty without first recording the administration of any medications.Checklist for completing proper steps in the administration of medications.Adheres to the 6 Rights of Medication Administration.Right Medication.Right Documentation.Observed the resident take the medications. Documents the administration of each medication on the MAR & Controlled Medications on the Control Sheet.

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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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for 2 of 4 medication carts (C/D Hall cart and A/C Hall cart) reviewed for labeling and storage of drugs. 1. The facility failed to ensure the C/D Hall medication cart was not left unlocked and unattended.2. The facility failed to provide a change of direction label for Resident #6's Seroquel medication bottle from 50 mg at bedtime to 50 mg two times a day prescribed to treat depression on the A/D medication cart. These deficient practices could place residents at risk of medication misuse and diversion. The finding included: 1. During an observation on 8/21/25 at 9:42 a. m. revealed the C/D Hall medication cart was unlocked and unattended facing the hallway in front of the nurse's station. During an observation and interview on 8/21/25 at 9:47 a.m., the DON walked up to the C/D Hall medication cart and attempted to lock it. The DON stated the C/D Hall medication cart had been assigned to LVN D. The DON saw LVN D walking down the D Hall and summoned LVN D to the nurse's station. During an interview on 8/21/25 at 9:49 a.m., LVN D stated, she had gotten sidetracked and forgot to lock the C/D Hall medication cart. LVN D stated the C/D Hall medication cart should have been locked when not in use because people like you could get into it. LVN D stated, other people could get into the cart and take things they were not supposed to. 2. Record review of Resident #6's face sheet dated 8/21/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included dementia (general term for a group of symptoms that affect memory, thinking, reasoning, and the ability to perform daily activities) with agitation, depression (mental health disorder characterized by a persistent feeling of sadness, emptiness, or loss of interest or pleasure in activities once enjoyed), and anxiety disorder (mental health condition characterized by excessive fear, worry, or nervousness). Record review of Resident #6's Order Summary Report dated 8/21/25 revealed the following:- Seroquel 50 mg tablet, give 50 mg by mouth two times a day related to depression, with order date 8/18/25 and no end date. During observation and interview on 8/21/25 at 8:50 a.m., during the medication pass revealed Resident #6's Seroquel medication indicated 50 mg at bedtime on the pharmacy label. Medication Aide G stated the Seroquel pharmacy label for Resident #6 was incorrect because the physician's orders indicated Seroquel 50 mg was supposed to be given twice a day. Medication Aide G stated the directions on the pharmacy label was incorrect and should have been compared to the physician's orders for accuracy. Medication Aide G stated she was in a hurry and overlooked it. During an interview on 8/21/25 at 7:28 p.m., the DON stated the medication carts were not supposed to be left unlocked when unattended because it was a safety concern. The DON stated residents could get into the medication cart and take something that did not belong to them and could potentially make them sick. The DON stated it was her expectation when administering medications, the orders were supposed to be matched up to the physician's orders and if the pharmacy label did not match the physician's orders, then a change of direction sticker was supposed to be placed on the medication package. The DON stated, the pharmacy label not matching the physician's orders could result in a medication error or the resident missing a medication dose. Record review of the facility document titled Medication Storage in the Facility, dated 2025 revealed in part, .Medication and biologicals are stored safely, securely.The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.Medication rooms, carts, and medication supplies are locked or attended to by persons with authorized access. Record review of the facility document titled, Medication Administration and General Guidelines, dated 2025 revealed in part, .Medications are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and only by persons legally authorized to do so.Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions, or if there is any reason to question the dosage or directions, they physician's orders are checked for the correct dosage schedule.Checklist for completing proper steps in the administration of medications.Right dose.Right Medication.Right Time.Right Documentation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 3 of 4 residents (Resident #9, #51 and #46) reviewed for infection control: 1.The facility failed to ensure the nurse sanitized the blood pressure cuff between residents #9 and #51.2. Facility staff failed to wear PPE while doing pericare for Resident #46 and did not wash or sanitize their hands between glove changes.3. The treatment nurse and a CNA did not wear PPE during wound care treatment for Resident #46 and did not wash or sanitize hands between glove changes. These failures could place residents at-risk for infection due to improper care practices. The findings included: 1. Observation on 8/21/25 at 8:19 a.m., during the medication pass revealed LVN F took the blood pressure cuff and went into Resident #9's room to obtain the resident's blood pressure. LVN F then placed the blood pressure cuff on LVN D's medication cart counter, did not sanitize the blood pressure cuff after use, and relayed the results to LVN D. LVN D then took the same blood pressure cuff, did not sanitize it prior to use, and obtained Resident #51's blood pressure. During an interview on 8/21/25 at 8:34 a.m., LVN D stated, the blood pressure cuff used on the residents was provided by the facility. LVN D stated LVN F used the blood pressure cuff and obtained Resident #9's blood pressure and LVN F then took the blood pressure cuff and obtained Resident #51's blood pressure cuff without sanitizing it first. LVN D stated she had forgotten to sanitize the blood pressure cuff, and it was important because it helped to prevent cross contamination. LVN D stated, not cleaning the electronic blood pressure cuff was definitely an infection control issue and if cross contamination had occurred it could spread illness from one person to the other. During an interview on 8/21/25 at 8:41 a.m., LVN F stated she realized she had not sanitized the blood pressure cuff after obtaining Resident #9's blood pressure and should but didn't because she could not find any sanitizing wipes and did not want to get in LVN D's way. LVN F stated the blood pressure cuffs needed to be disinfected between residents because it was cross contamination and an infection control issue and to prevent passing illness from one person to the next. 2. Record review of Resident #46's face sheet dated 8/21/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy (wasting away, decrease in size, or weakening of a tissue, organ, or body part), and gastrostomy status (surgical procedure in which an opening is created directly into the stomach through the abdominal wall). Record review of Resident #46's most recent comprehensive MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills, required substantial/maximal assistance with mobility, was always incontinent of bowel and bladder, utilized a feeding tube, and was at risk of developing pressure ulcers/injuries. Record review of Resident #46's Order Summary Report dated 8/21/25 revealed the following:- (EBP) Enhanced Barrier Precautions every shift with order date 7/30/24 and no end date.- Clean left heel with wound cleaner, pat dry, Triad paste, apply adhesive bandage, and wrap with Kerlex (gauze) every day, one time a day for wound care with order date 8/20/25 and no end date. Record review of Resident #46's comprehensive care plan initiated on 7/31/25 revealed the resident had bowel and bladder incontinence with interventions to provide peri care after each incontinent episode, and the resident was on enhanced barrier precautions with interventions that included to wear gloves and gown if any of the following activities occurred: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity. Resident #46's comprehensive care plan revealed, perform hand sanitation before entering the room and prior to leaving the room. Resident #46's comprehensive care plan included the resident had a stage 2 pressure ulcer to the left heel with interventions that included to administer treatments as ordered. Observation on 8/21/25 at 11:15 a.m. revealed Student Aide C and CNA E assisted the resident during peri care without wearing a PPE gown when the resident was on enhanced barrier precautions. Student Aide C and CNA E did not wash or sanitize their hands between glove changes during peri care to Resident #46. After CNA E completed cleaning Resident #46's buttock and anal area, and Student Aide C assisted her, they removed their gloves, did not wash or sanitize their hands, and put on new gloves. Resident #46 was assisted to her left and CNA E took the resident's feeding tube and moved it over to the resident's left while Student Aide C adjusted the resident's incontinent brief. Student Aide C removed her gloves, did not wash or sanitize her hands and put on a new pair of gloves. Student Aide C then applied