STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675364	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Nursing and Rehabilitation of Baird	224 E 6th St Baird, TX 79504

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on interviews and record reviews, the facility failed to ensure a Minimum Data Set (MDS) assessment was electronically completed and transmitted to the CMS System within 14 days after completion for 1 of 3 residents (Resident #16) reviewed for MDS information. The facility failed to encode, complete, and submit a discharge MDS for Resident #16. This failure could place residents at risk of facilities have provided resident specific information for payment and quality measure purposes. Findings included: Closed record review of Resident #16's face sheet dated 04/03/2024 revealed a [AGE] year-old male that admitted into facility on 10/03/2023 and discharged on [DATE]. Closed record review of Resident #16's care plan dated 10/08/2023 revealed I will have access to necessary services to promote adjustment to my new living environment and or post discharge from facility. Closed record review of Resident #16's MDS assessment completion list did not reveal a Discharge MDS had been completed. During an interview on 04/03/2024 at 2:14 p.m., the ADON stated she was responsible for performing MDS assessments. She stated there should have been a discharge MDS assessment performed when a resident was discharged from facility. She stated she was unsure why the discharge MDS assessment was not performed. She stated corporate regional MDS consultant monitored assessments performed as the DON working during that time no longer worked for the corporation. During a phone interview on 04/03/2024 at 3:23 p.m., the [NAME] MDS Consultant stated discharge MDS assessments were to be performed with either return anticipated or return not anticipated when a resident was discharged . She stated discharge MDS assessment should be performed within 14 days of census change. She stated she did not know why discharge MDS assessment had not been performed. She did not state any negative effect not performing a MDS discharge assessment could have on the resident. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled Resident Assessment Instrument revised in September 2010 revealed: 1. The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews according to the following schedule: a. Within fourteen (14) days of the resident's admission to the facility; b. When there has been a significant change in the resident's condition; c. At least quarterly; and d. Once every twelve (12) months. 2. The Interdisciplinary Assessment Team must use the MDS form currently mandated by Federal and State regulations to conduct the resident assessment. Other assessment forms may be used in addition to the MDS form. 3. The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. 4. Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning. 5. Residents and/or their representatives (sponsors) will be encouraged to participate in the initial, quarterly and annual assessments. The Assessment Coordinator or designee will notify the resident and/or sponsor in advance of the scheduled assessment or review. 6. Within seven (7) days of the completion of the resident assessment, a comprehensive care plan will be developed. 7. All persons who have completed any portion of the MDS Resident Assessment Form MUST sign such document attesting to the accuracy of such information.

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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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45216 Based on interview and record review, the facility failed to develop and implement a person-centered, comprehensive care plan for each resident, consistent with resident rights, that included measurable objectives and timeframes to meet residents medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment for 5 (Resident #8, Resident #9, Resident #19, Resident #26, and Resident #31) of 5 residents reviewed for care plans. The facility failed to develop care plans based on assessed needs with measurable objectives in areas such as pain management, weight loss or gain, urinary control, psychotropic medications, difficulty sleeping, implanted pacemaker, high blood pressure medications, blood thinning medications, and seasonal allergies for Resident #8. The facility failed to develop care plans based on assessed needs with measurable objectives in areas such as infection control, behaviors, compliance with physician's orders, pain management, risk for malnutrition, mobility, and functional abilities for Resident #9. The facility failed to develop care plans based on assessed needs with measurable objectives in areas such as meal choices, activities of daily living, laboratory testing, dementia care, post-traumatic stress disorder, chronic pain, and vision impairment for Resident #19. The facility failed to develop care plans based on assessed needs with measurable objectives in areas such infection control, weight loss or gain, dementia care, pain management, and participation in activities for Resident #26. The facility failed to develop care plans based on assessed needs with measurable objectives in areas such as weight loss or gain, pain management, therapy services, mobility, allergies, and participation in activities for Resident #31. These failures could place residents at risk for not receiving care and services individualized to meet their specific physical, mental, and/or emotional needs. Findings included: Review of Resident #8's electronic face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with medical diagnoses of heart failure, difficulty communicating, difficulty walking, heart burn, constipation, swelling, heart pacemaker, kidney disease, obesity, high blood pressure and atrial fibrillation (an abnormal heart rhythm). Review of Resident #8's Brief Interview of Mental Status evaluation dated 02/21/2024, revealed Resident #8 scored 14 out of 15 indicating intact cognition. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #8's Comprehensive Care Plan reviewed/revised 02/21/2024 revealed the following problem care areas with objectives that were not measurable: Problem: [Resident] is at risk for alteration in comfort and or pain R/T: obesity Residents specific pain goal is: resident requires verbal numeric pain scale with in objective of resident will be able to verbalize pain and or discomfort at an acceptable level ., Problem: I have the Potential for weight fluctuations, loss and gain, related to resident having multiple comorbidities with an objective of Weight will either remain in a therapeutic range or reach a therapeutic range .:, Problem: Urge urinary incontinence R/T diuretics with an objective of Resident will establish a routine for urinary elimination, Problem: [Resident] receives a psychotropic medication for: X other with an objective of resident will receive the lowest possible dose to achieve/maintain the therapeutic benefits, maintain safety and quality of life, function and well being and will have side effects and interactions kept to a minimum ., Problem: I have Insomnia with an objective of Will have adequate sleep patterns aeb: reporting restful sleep at HS, no excessive daytime sleepiness ., Problem: [Resident] has a pacemaker/defibrillator and may be at risk for decreased cardiac output and irregular pulse; and potential for pacemaker/defibrillator malfunction, with an objective of Resident pulse will remain within baseline limits and cardiac output will remain within normal limits ., Problem: Potential for complications, s/sx related to diagnosis of hypertension. Resident receives anti hypertensive and is at risk for side effects with an objective of resident's blood pressure will remain within their normal limits ., Problem: [Resident] has episodes of edema and is at risk for fluctuating weights, injury and a decrease in adls with an objective of Resident will be able to maintain current ADLs ., Problem: Myself, or my representative, expresses a desire for long term placement at this facility Related to: Advanced Disease process/condition with an objective of I will demonstrate understanding of long term placement plans ., Problem: I HAVE THE Potential for alteration in bleeding r/t the use of anticoagulants/antiplatelets therapy for diagnosis of: AFIB with an objective of Current medical regime will be effective in management of disease process with no altered bleeding tendencies ., and Problem: Allergic rhinitis (swelling of the lining in the nose)/seasonal allergies/allergic conjunctivitis (swelling of the lining of the eyelids) with an objective of signs and symptoms of allergic rhinitis/seasonal allergies/allergic conjunctivitis will be assessed and effectively treated through medical regimen and MD orders . Review of Resident #9's electronic face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with medical diagnoses of Type 2 diabetes, difficulty walking, Pseudomonas (type pf bacteria), dementia, epilepsy (seizure disorder), heart failure, respiratory disease, weakness, arthritis, atrial fibrillation (irregular heart rate), and chronic pain. Review of Resident #9's Brief Interview of Mental Status evaluation dated 02/18/2024, revealed Resident #9 scored 15 out of 15 indicating intact cognition. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #9's Comprehensive Care Plan reviewed/revised 02/19/2024 revealed the following problem care areas with objectives that were not measurable: Problem: Enhanced Barrier Precautions due to wound care with an objective of To maintain the possible spread of infection, Problem: I sometimes make false accusations towards staff and the facility with an objective of I will have my needs met, emotionally and physically, Problem: [Resident] is non compliant with: Taking a shower X md order- O2 is ordered for 2 LLPM and he changes it himself X Other- describe- [Resident] has the potential for negative impact on health r/t failure to follow recommended treatment with an objective of resident will have knowledge of potential for harm related to refusal to follow recommended treatments/md orders and will have wishes respected ., Problem: Resident has complaints of chronic pain R/T diabetic ulcer to right foot with an objective of Resident will verbalize reduction of pain, Problem: Resident is at risk for malnutrition R/T no natural teeth or dentures (edentulous). With an objective of Weight will be maintained within acceptable parameters, Problem: I have a history of inappropriate behavior with an objective of Educate resident on appropriate behavior, Problem: Behavior problem related to other residents wandering into his room. AEB: he obsesses with residents that wanders into room with an objective of Will have behavior identified so that staff may intervene quickly with listed interventions ., Problem: I am limited in mobility/functional status and requires the use of CAM boot to my left foot with an objective of I will safely walk in room, walk in corridor, locomote on unit, locomote off unit, dress, toilet, with use of CAM boot, Problem: I am at risk for alteration in comfort and or pain with an objective of Resident will have pain/discomfort expressed at an acceptable level of pain, Problem: I desire to improve in functional abilities, I have set goals to be preforming and plans to return to previous residence with an objective of Resident will be assisted, encouraged to achieve functional goals and return to living situation of choice within their physical ability, maintaining pain at a tolerable level and with dignity intact ., and Problem: I a am a new admission with discharge potential. Stay projected to be short duration, and resident plans to D/C to home/assisted living with an objective of Will improve self-care ability to be ready for discharge to home/ assisted living . Review of Resident #19's electronic face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with medical diagnoses of high blood pressure, long term use of blood thinners, obesity, history of falls, weakness, heart failure, difficulty in walking, chronic pain, chronic blood clots, difficulty sleeping, respiratory disease, dementia, post-traumatic stress disorder, heart burn, and high cholesterol. Review of Resident #19's Brief Interview of Mental Status evaluation dated 02/18/2024, revealed Resident #19 scored 15 out of 15 indicating intact cognition. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #19's Comprehensive Care Plan reviewed/revised 02/26/2024 revealed the following problem care areas with objectives that were not measurable: Problem: [Resident] is requesting to not eat breakfast. I only wish to have beverages in the mornings with an objective of For resident to maintain adequate BMI, Problem: I have difficulty with making my bed with an objective of Assist with bed making, Problem: I am at risk of increased health issues related to labs not being able to be monitored due to my blood cannot be accessed from my veins with an objective of My health concerns can be addressed by other types of monitoring ., Problem: I may benefit from Therapy services with an objective of I will not decline or show improvement in physical abilities ., Problem: I have Dementia and an alteration in thought processes. I have poor decision-making skills with an objective of I will maintain current level of cognitive function ., Problem: I have Post trauma stress disorder, chronic with an objective of I will not exhibit signs of post-traumatic syndrome, Problem: I am at risk for alteration in comfort and or pain R/T: Dx of chronic pain with an objective of I will be able to verbalize pain and or discomfort at an acceptable level ., and Problem: I have vision impairment with an objective of I will maintain optimal quality of life within limitations. Review of Resident #26's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses of cancer, atrial fibrillation, anemia, malnutrition, pressure ulcers, Rheumatoid arthritis, dementia, constipation, and hardening of the arteries. Review of Resident #26's Brief Interview of Mental Status evaluation dated 01/31/2024, revealed Resident #26 scored 15 out of 15 indicating intact cognition. Review of Resident #26's Comprehensive Care Plan reviewed/revised 02/22/2024 revealed the following problem care areas with objectives that were not measurable: Problem Enhanced Barrier Precautions due to wound care with an objective of To prevent the spread of possible infection, Problem: Monthly weights only due to chronic pain with movement. I am bed bound, with an objective of I will have my wishes honored, Problem: I have dementia. I have impaired decision making, short and/ or long term memory loss due to Dementia with an objective of Will maintain current level of cognitive function aeb: . Problem: I am at is at risk for alteration in comfort and/or pain related to Cancer diagnosis, lack of mobility. with an objective of I will be able to verbalize pain and/or discomfort at an acceptable level ., Problem: I have a potential for complications (weakness/fatigue/weight loss/malnutrition/increased pain/ depression and ineffective coping related to diagnosis of cancer. with an objective of Current medical regimen will be effective in management of disease process with no ill effects, needs will be met. I will be kept comfortable and emotional support will be given ., and Problem: I require one to one activity due to being bedbound and I am at risk for social isolation with an objective of I will respond to bedside activities and will not have feelings of social isolation . Review of Resident #31's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses of high blood pressure, difficulty walking, hemorrhoids, chronic pain, heart attack, difficulty communicating, dementia, Type 2 diabetes, asthma, heart burn, chronic fatigue, high cholesterol, Vitamin A deficiency, low thyroid function, and major depression. Review of Resident #31's Brief Interview of Mental Status evaluation dated 02/16/2024, revealed Resident #31 scored 10 out of 15 indicating moderate impaired cognition. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #31's Comprehensive Care Plan reviewed/revised 02/19/2024 revealed the following problem care areas with objectives that were not measurable: Problem: Potential for weight fluctuations, loss and gain, related to having multiple comorbidities with an objective of Weight will either remain in a therapeutic range or reach a therapeutic range ., Problem: I have a nerve stimulator implanted in my back with an objective of I will have reduction of pain, Problem: Resident may benefit from PT/OT/ST services with an objective of Resident will not decline or show improvement in physical abilities ., Problem: Limited physical mobility related to: weakness and fatigue with an objective of Will maintain current level of mobility ., Problem: I have potential for injury related to medication allergies, resident is allergic to: with an objective of Resident will have no harm related to medication allergies ., Problem: I have episodes of anxiety and is at risk or fluctuations in moods with an objective of Resident anxiety will be maintained t level tolerable to resident and will demonstrate reduced anxiety AEB response to proper medication ., and Problem: Encourage resident to attend activities of choice ., with an objective of Resident will enjoy activities . During an interview on 04/04/2024 at 1:11 PM, LVN A stated the ADON created the care plans and the DON monitored. Changes were communicated to staff via face-to-face conversation with the DON. She stated care plans goals should be measurable. LVN A stated resident goals or objectives must be specific to the resident. She explained if the goals were not measurable, there would not be a way to determine if interventions were successful or needed to be revised. During an interview on 04/04/2024 at 1:55 PM, the DON stated the ADON created the care plans. She stated she was responsible for oversight of the care plans. During an interview on 04/04/2024 at 2:00 PM, the Regional Nurse Consultant stated ideally the MDS Coordinator should be creating the care plans with input from IDT. She stated the DON was responsible for monitoring the care plans. Stated nursing staff was educated on locating care plans during orientation but admitted few refer to the care plans regularly. The RNC acknowledged the examples of objectives from current care plans were not measurable. Examples provided were current medical regimen will be effective in management of disease process with no ill effects and maintain adequate BMI. Stated that a goal that cannot be measured also cannot give guidance on if interventions were effective or needed to be reviewed or revised. Review of the facility policy titled Comprehensive Care Plans dated September 2010 revealed the policy statement An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation section revealed 3. Each resident's comprehensive care plan is designed to: e. Reflect treatment goals, timetables and objectives in measurable outcomes

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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** 45216 Based on interview, and record review the facility failed to ensure each resident's person-centered comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 2 (Resident #9, and Resident #185) of 7 residents reviewed for care plans. -The facility failed to ensure Resident #9's care plan accurately addressed intravenous antibiotic therapy. -The facility failed to ensure Resident #185's care plan addressed an accurate smoking status. These failures could affect residents of the facility by not accurately addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings included: Review of Resident #9's electronic face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with medical diagnoses of Type 2 diabetes, difficulty walking, Pseudomonas (type pf bacteria), dementia, epilepsy (seizure disorder), heart failure, respiratory disease, weakness, arthritis, atrial fibrillation (irregular heart rate), and chronic pain. Review of Resident #9's Brief Interview of Mental Status evaluation dated 02/18/2024, revealed Resident #9 scored 15 out of 15 indicating intact cognition. Review of Resident #9's Comprehensive Care Plan reviewed/revised 02/19/2024 revealed Problem Start Date: 02/19/2024 I must have trough blood levels to be checked every 4 days while on IV [antibiotic]. Goal: Long Term Goal Target Date: 05/19/2024 Trough levels to be within normal range. Approach: Approach Start Date: 02/19/2024 Trough levels to be within normal range. Record review of Resident #9 physician's orders since admission revealed no order for intravenous antibiotic therapy. Review of Resident #185's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with medical diagnoses of Type 2 diabetes, depression, low blood potassium, low thyroid function, weakness, constipation, difficulty walking, and difficulty communicating. Review of Resident #185's Admission MDS dated [DATE] Section C Cognitive Patterns C0500 BIMS Score Summary revealed Resident #9 scored 10 out of 15 indicating moderate impaired cognition. Review of Resident #185's Smoking assessment dated [DATE] revealed a Smoking Risk Score of 2 out of 27 indicating Safe Smoker - Follow Facility Policy. Plan of Care: Indicate Plan of Care action take: Initiate Plan of Care was selected. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #185's comprehensive care plan reviewed/revised 03/26/2024 revealed her smoking status was not addressed. During an interview on 04/04/2024 at 11:11 AM, the ADON stated comprehensive care plans were done with the MDS Coordinator and should be done by 21st day after admission. She stated care plans were updated when there was a medication change, an incident such as a fall, if the resident was a smoker, and if there were any behaviors. She stated the DON reviewed the care plans and the RNC monitored the DON. The ADON stated she thought she had updated the care plans for residents who smoke. She stated smoking should be care planned. The ADON stated she did not know why Resident #185's smoking status was not care planned. She stated she was not sure how this could affect the resident except the nurses who look at care plan might not know that she smoked. During an interview on 04/04/24 at 1:11 PM, LVN A stated a possible explanation for the intravenous antibiotic on Resident #9's care plan without a physician's order or notation in the progress notes occurred due to a clerical data entry error. She stated the consequence to resident may receive medications without a physician's order and that medication could be contraindicated with other meds ordered. During an interview on 04/04/2024 at 1:15 PM, the DON stated care plans should be resident focused, applied to each resident and implemented as stated in the care plan. She stated smoking should be care planned for all smokers with safety first. She stated the facility had a list of smokers. The DON stated she was not sure why it was not care planned. The DON stated she reviewed care plans and RNC reviewed them as well. She states she was unaware of any resident that smoked had not been able to smoke regardless of the care plan. During an interview on 04/04/2024 at 2:00 PM, the Regional Nurse Consultant and DON did not have an explanation as to why Resident #9 had intravenous antibiotic therapy on his care plan without a physician's order. The Regional Nurse Consultant stated it was entered incorrectly. She stated on-going training starting with nursing leadership was planned to cover care plans. The Regional Nurse Consultant and DON stated their expectations were for care plans to be created to accurately reflect the needs of each resident. Review of the facility policy titled Comprehensive Care Plans dated September 2010 revealed the policy statement An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. The Policy Interpretation and Implementation section revealed 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on record reviews and interviews, the facility failed to complete discharge summaries that included a recapitulation of the resident's stay including, but not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results for 1 of 3 residents (Resident #16) reviewed for discharge. The facility failed to provide Resident #16 with discharge summary when discharged from facility. This failure places residents at risk for incomplete and cohesive care after discharge from the facility. Findings included: Closed record review of Resident #16's face sheet dated 04/03/2024 revealed a [AGE] year-old male that admitted into facility on 10/03/2023 and discharged on [DATE] with diagnoses that included: personal history of transient ischemic attack (mini stroke), cerebral infarction without residual deficits (stroke without deficits), hypertension (high blood pressure), and chronic obstructive pulmonary disease (chronic lung disease interfering with airflow). Closed record review of Resident #16's Admission MDS dated [DATE] revealed resident had a BIMS score of 5 meaning severe cognitive impairment. Closed record review of Resident #16's electronic MAR (medication administration record) dated for October 2023 revealed: Code Status: DNR .If resident has not had a BM in 3 days, initiate bowel protocol .O2 at 2 liters per minute to keep O2 saturations above 92% .offer snack between meals and at night .albuterol sulfate (medication to help open airways) inhaler 90 mcg/actuation 2 puffs PRN four times a day for chronic obstructive pulmonary disease .amlodipine (blood pressure medication) tablet 10mg administer 1 tablet at 9:00 a.m .aspirin tablet 325mg administer 1 chewable tablet at 9:00 a.m .atorvastatin (medication to lower cholesterol) tablet 20mg administer 1 tablet at 8:00 p.m .bisacodyl (medication for constipation) suppository 10mg administer 1 rectally PRN once a day for constipation .ipratropium-albuterol (medication to help open airways) solution for nebulization 0.5mg-3mg / 3ml administer 3ml inhalation every 4 hours PRN chronic obstructive pulmonary disease .lactulose solution (medication for constipation) 20 gram / 30 ml administer 30ml orally twice a day .morphine (pain for shortness of breath) solution 10mg / 5ml administer 5mg every 1 hour PRN chronic obstructive pulmonary disease .omeprazole (medication to help lower acid production in stomach) tablet 20mg administer 40mg orally one a day .prednisone (medication to help reduce inflammation) tablet 10mg administer 1 tablet once a day orally .senna (laxative) tablet 8.6mg administer 1 table orally once a day. Closed record review of Resident #16's file revealed no evidence that a discharge summary was completed. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/03/2024 at 2:08 p.m., the Regional Nurse Consultant stated discharge summaries should be completed and signed by resident or resident representative when a resident was discharged . She stated charge nurses or nurse managers were responsible for having discharge summaries completed. During an interview on 04/03/2024 at 2:12 p.m., the ADON stated Resident #16 was discharged on a weekend. She stated her expectation would be for the charge nurse to call her and she could perform the discharge summary and have charge nurse get the summary signed at the time of discharge. She stated she felt Resident #16's discharge summary might have been missed because he was an unplanned discharge and had unexpected issues related to the discharge . She stated she would look in medical records to see if his discharge summary was documented on a paper and was not uploaded into chart. During an interview on 04/04/2024 at 9:03 a.m., the Regional Nurse Consultant stated no discharge summary was found at that time. She stated she felt no negative effect occurred from the failure. She stated it could potentially place another resident at risk to not have information about follow up appointments and medication effecting coordination of care when discharged . Record review of facility policy titled Discharge Summary and Plan revised in September 2012 revealed: 1. When the facility anticipates a resident's discharge to a private residence, another nursing care facility, a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment. 2. The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's: Medically defined condition and prior medical history (medical history before entering the facility and current medical diagnoses, including any history of mental retardation and current mental illness); Medical status measurement (objective measurements of a resident's physical and mental abilities including, but not limited to, information on vital signs, clinical laboratory values, or diagnostic tests); Physical and mental functional status (ability to perform activities of daily living including bathing, dressing and grooming, transferring and ambulating, toilet use, eating, and using speech, language, and other communication systems. Includes determining the resident's need for staff assistance and assistive devices or equipment to maintain or improve functional abilities and the resident's ability to form relationships, make decisions including health care decisions, and participate (to the extent physically able) in the day-to-day activities of the facility); Sensory and physical impairments (neurological, or muscular deficits; for example, a decrease in vision and hearing, paralysis, and bladder incontinence); (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nutritional status and requirements (weight, height, hematological and biochemical assessment, clinical observations of nutrition, nutritional intake, resident eating habits and preferences, and dietary restrictions); Special treatments or procedures (treatments and procedures that are not part of basic services provided; for example, treatment for pressure sores, naso-gastric feedings, specialized rehabilitation services, and respiratory care); Mental and psychosocial status (the resident's ability to deal with life, interpersonal relationships and goals, make health care decisions, and indicators of resident behavior and mood); Discharge potential (the expectation of discharging the resident from the facility within the next three months); Dental condition (the condition of the teeth, gums, and other structures of the oral cavity that may affect a resident's nutritional status, communications abilities, quality of life, and the need for and use of dentures or other dental appliances); Activities potential (the resident's ability and desire to take part in activity pursuits which maintain or improve physical, mental, and psychosocial well-being. Activity pursuits refer to any activity outside of ADLs which a person pursues in order to obtain a sense of well-being. Includes activities which provide benefits in the areas of self-esteem, pleasure, comfort, health education, creativity, success, and financial or emotional independence, and the resident's normal everyday routines and lifetime preferences); Rehabilitation potential (the ability to improve independence in functional status through restorative care programs); Cognitive status (the resident's ability to problem solve, decide, remember, and be aware of and respond to safety hazards); and Drug therapy (all prescription and over-the-counter medications taken by the resident including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident). 3. The post-discharge plan will be developed by the Care Planning/Interdisciplinary Team with the assistance of the resident and his or her family and will contain, as a minimum: 1. A description of the resident's and family's preferences for care; A description of how the resident and family will access such services; A description of how the care should be coordinated if continuing treatment involves multiple caregivers; The identity of specific resident needs after discharge (i.e., personal care, sterile dressings, physical therapy, etc.); and (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A description of how the resident and family need to prepare for the discharge. 4. The resident or representative (sponsor) should provide the facility with a minimum of a seventy-two (72) hour notice of a discharge to assure that an adequate discharge plan can be developed. 5. The Social Services Department will review the plan with the resident and family twenty-four (24) hours before the discharge is to take place. 6. A copy of the post-discharge plan and summary will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 45216 Based on interview and record review, the facility failed to utilize the services of a Registered Nurse for at least 8 consecutive hours a day, seven days a week for 75 of 183 days reviewed for RN Coverage. The facility failed to provide evidence a Registered Nurse (RN) worked 8 consecutive hours a day, seven days a week for 65 days out of 92 days in Fiscal Year (FY) Quarter 1 2024 (October 1 - December 31) and 10 out of 91 days from January 1, 2024 to March 31, 2024. This failure could place residents at risk for altered physical, mental, and psychological well-being due to decisions that would have required an RN to make in the management of the residents' healthcare needs and in managing and monitoring the direct care staff. Findings included: Record review of the facility's Payroll Based Journal Staffing Data Report for Fiscal Year Quarter 4 (October 1 - December 31) revealed no RN coverage on October 1, 7, 8, 14, 15, 21, 22, 28, 29, 30, and 31, 2023, November 1, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 20, 21, 22, 23, 24, 25, 26, 27, 29 and 30, 2023, and December 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 17, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 and 31, 2023. On 04/04/2024 at 1:28 PM, documentation of RN coverage was requested from the Business Office Manager. The facility was unable to provide documentation of RN coverage on the dates listed above. Record review of RN Time Sheets for 2024 revealed no RN coverage on January 6, 7, 13, 14, 27, and 28, 2024, February 10 and 11, 2024, and March 2 and 3, 2024. During an interview on 04/04/2024 at 01:11 PM, LVN A stated an RN should be in the building at least 8 hours a day. She stated the DON would notify the staff if a scheduled RN was not going to work. LVN A stated consequences of failing to have an RN in the building for 8 hours a day, 7 days a week might be if a resident had an event that required the knowledge and skills within an RN's scope of practice, the resident might needlessly suffer. She explained if a situation occurred requiring an RN, she would call the DON to come in. During an interview on 04/04/2024 at 2:00 PM, the Regional Nurse Consultant stated the facility had difficulty attracting RN applicants due to the rural location and reluctance of RN's to work in long-term care. She stated RN staffing improved when the new DON and Administrator were hired. She stated her expectation was to have 8 hours of RN coverage daily. Leadership plays a crucial role in attracting new employees. She stated they have been persistent with recruiting. The DON stated she was responsible for ensuring the facility had RN coverage. She stated if an RN was unable to work a scheduled shift, she would cover it. The DON stated not having an RN in the building could impact resident's negatively and gave an example of a thorough RN assessment. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility policy titled Hours of Work revised December 2009 did not address an RN in the building for eight (8) consecutive hours a day, seven (7) days a week. The facility did not provide a policy specific to the RN hours requirement.

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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. 48883 Based on observations, interviews, and record reviews the facility failed to properly store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure foods were sealed and/or labeled properly in dry food storage and freezers. The facility failed to properly thaw frozen meats to prevent unsafe temperature. These failures could place residents that eat out of the kitchen at risk for food borne illnesses. Findings included: An observation of kitchen on 04/02/2024 between 8:31 a.m. and 8:48 a.m. revealed: Sink #1 Clear plastic bag of what appeared to be chicken thighs sitting in sink not surrounded by water. Tap water running over top and down the side of clear plastic bag. Freezer #1 Unsealed package of circular frozen meat patties sitting in box. Freezer #2 Unsealed package of circular frozen pastry that was not labeled or dated. Dry Storage Unsealed clear plastic bag or what appeared to be curly pasta. Unsealed bag labeled alfredo sauce mix. An observation of kitchen on 04/02/2024 between 11:40 a.m. and 12:45 p.m. revealed: Sink #1 Clear plastic bag of what appeared to be pork loin sitting in sink not surrounded by water. Tap water running over top and down the side of clear plastic bag. (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 04/02/2024 at 12:45 p.m., the DM stated she was unsure what the facility policy stated on how to defrost meat. She stated she would prefer to defrost meat in refrigerator but that it would take several days to perform. She stated she places next days meat in the refrigerator the night before then completes defrosting in the sink with water running over it. The DM stated not defrosting food properly could cause bacteria to grow and residents to become sick. The DM stated foods stored in pantry and freezer should be in a sealed container. She did not know why food was stored unsecured. She stated not sealing the container could lead to residents becoming sick. During an interview on 04/03/2024 at 11:47 a.m., the ADMN stated it was his expectation that frozen meats should be defrosted in the refrigerator if possible. He stated if meat was to be defrosted in sink, he expected it to be surrounded with cold circulating water. He felt that education was the reason meats were not defrosted to his expectations. He stated the DM was responsible for monitoring meats were defrosted appropriately and he monitored the DM. The ADMN stated incorrectly defrosting meat could cause residents to become ill from food poisoning. The ADMN stated he expected all foods to be stored in a sealed container or bags to be zip tied. He stated he felt education was the reason foods were not stored in sealed containers. He stated that both the DM and he were responsible for monitoring foods were stored correctly. He stated the effect that could have would be illness to the residents. Review of facility policy titled Food Preparation and Service revised in July of 2014 revealed: Thawing Frozen Food 1. Foods will not be thawed at room temperature. Thawing procedures include: a. Thawing in the refrigerator in a drip-proof container; b. Submerging the item in cold running water (70? or below); c. Thawing in a microwave oven and then cooking and serving immediately; or d. Thawing as part of a continuous cooking process. Review of facility policy titled Food Receiving and Storage revised on July 2014 revealed: Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date). Such foods will be rotated using a first in - first out system .The freezer must keep frozen foods frozen solid. Wrappers of frozen foods must stay intact until thawing.