STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675369	A. Building B. Wing	05/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Nursing and Rehabilitation Center	301 W Criner St Grandview, TX 76050

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 49099 Based on observation, interview, and record review, the facility failed to ensure residents were aware of where to locate the State Agency (SA) survey inspection results such as (surveys, certifications, and complaint/incident investigations) and post in a place readily accessible to residents, family members, and legal representatives of residents for 1 of 1 facility in that: 1. The facility failed to make the survey binder readily available and easily identified to all residents. 2. The facility failed to maintain the survey binder; the binder failed to include previous state visit results from 10/04/24 and recently on 02/04/25. This failure placed residents at risk of not being able to fully exercise their rights and at risk of not being aware of the facility's past deficiencies. Findings included: In an observation and interview on 04/30/25 at 09:30 AM there did not appear to be any survey results in the lobby or common area of the facility nor a sign indicating where the survey results were posted. An interview with LVN B revealed she did not know where the survey binder was located and stated she has not ever seen it. In an observation and interview on 04/30/25 at 09:32 AM with ADM, she was observed pulling a binder from behind the nurses station underneath the desk hidden from view. She stated she was not aware that the survey binder had to be in public view and accessible but said they would make it accessible if any residents had asked for it. She stated they did not have it out because they try to keep clutter off the nurse's station. Review of the binder provided by the ADM at this time revealed it did not contain the results of the previous abbreviated surveys from 10/04/24 and 02/04/25. The ADM stated she would update the binder with the missing results. During a confidential interview on 04/30/25 beginning at 10:30 AM, eight residents stated they did not know where or how to access survey results in the facility and had never learned what the results were of any SA visit. Several of them stated they would have liked access to this information. They all stated they have never seen the information out and accessible to the public. (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

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 05/02/25 at 12:37 PM with the ADM she stated the survey binder was now made accessible on a shelf near the entrance. She stated that it should be accessible to the residents and anyone else without having to ask for it . This was confirmed through surveyor observation. Review of the undated Facility Required Postings policy reflected: Policy: The facility will post required postings in an area that is accessible to all staff and residents. The facility must also post the following: a. Most Recent Survey Results of the Facility b. Other State specific postings.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172 Based on observation, interviews, and record review the facility failed to ensure the resident assessment accurately reflected the resident's status for 5 (Resident #36, #40, #42, #47, #50 and Resident #167) of 15 residents reviewed for accuracy of assessments. The facility failed to ensure Resident #36 and Resident #47's admission and comprehensive MDS assessments accurately reflected their use of dentures and having no natural teeth. The facility failed to ensure Resident #40, #42, and #50's comprehensive MDS assessments accurately reflected their use of dentures and having no natural teeth. The facility failed to accurately code a fall on the MDS Assessment completed for resident #167 on 04/19/2025. This deficient practice could have placed the resident at risk for inadequate care due to inaccurate assessments. Findings included: Record review of Resident #36's comprehensive MDS, dated [DATE], indicated Resident #36 was a [AGE] year-old male who was admitted to the facility on [DATE]. He had diagnoses of paralysis or severe weakness on one side of the body following damage to the brain, dementia, heart failure, lack of coordination, muscle weakness, anxiety (worries), bipolar disorder (extreme mood disorder), and irregular heart rhythm. His MDS reflected in Section L - Oral/Dental Status an 'x' in box 'Z. None of the above were present' when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. He had a BIMS score of 03 which indicated severe cognitive impairment. Record review of Resident #36's admission MDS dated [DATE] reflected in Section L - Oral/Dental Status an 'x' in box 'Z. None of the above were present' when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. Record review of Resident #36's progress note dated 4/25/2025 in his EHR reflected from the facility social worker that she had a meeting with the residents FM about dental services and that a dental referral was made for the resident. In an observation on 04/29/2025 of Resident #36 in his room revealed he was wearing ill-fitted upper dentures. The resident was unable to engage in meaningful conversation regarding his care with the surveyor due to his cognitive impairment. In an interview on 04/30/2025 at 2:37 PM with Resident #36's FM revealed that the resident had the dentures he was wearing for a long time (exact time unknown)., She stated he had them before he received his dementia diagnoses, which then led to weight loss. She stated that because he lost so much weight the dentures had started slipping. She stated she had a meeting with the facility on 4/25/25 to discuss getting the upper dentures better fitted through the dental services the facility used. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #40's comprehensive MDS assessment, dated 07/19/2024, indicated Resident #40 was an [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses of high blood pressure, kidney disease, viral hepatitis (inflammation of the liver caused by viral infections), arthritis, non-Alzheimer's dementia, anxiety (worriness), bipolar disorder (extreme mood disorder), depression (sadness), lack of coordination, muscle weakness, overactive bladder, and chronic pain. Her MDS reflected in Section L - Oral/Dental Status an 'x' in box 'Z. None of the above were present' when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. She had a BIMS score of 15, indicating intact cognition. Record review of Resident #40's progress note dated 4/2/2025 reflected a care plan meeting was held with Resident #40 regarding her broken bottom denture. It was noted that the team had concerns about her weight loss and refusal of meals until her denture was to be fixed . Record review of Resident #40's care plan dated last revised 04/25/2025 reflected no indication that the resident wore dentures. Record review of Resident #42's comprehensive MDS assessment, dated 01/03/2025, indicated Resident #42 was an [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses of anemia, atrial fibrillation (irregular and often rapid heartbeat), heart failure, high blood pressure, kidney disease, high cholesterol, thyroid disorder, Alzheimer's disease (memory loss, confusion, and difficulty problem-solving), stroke, anxiety (worriness), depression (sadness), and respiratory failure. Her MDS reflected in Section L - Oral/Dental Status an 'x' in box 'Z. None of the above were present' when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. She had a BIMS score of 13, indicating intact cognition. Record review of Resident #42's care plan dated last revised 04/28/2025 reflected no indication that the resident wore dentures. Record review of Resident #47's comprehensive MDS assessment, dated 02/14/2025, indicated Resident #47 was an [AGE] year-old male who was admitted to the facility on [DATE]. He had diagnoses of coronary artery disease, high blood pressure, gastroesophageal reflux disease (digestive disorder), benign prostatic hyperplasia (noncancerous enlargement of the prostate gland), kidney failure, diabetes, high cholesterol, thyroid disorder, seizure disorder, muscle weakness, lack of coordination, and fibromyalgia (widespread body pain). His MDS reflected in Section L - Oral/Dental Status an 'x' in box 'Z. None of the above were present' when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. He had a BIMS score of 15, indicating intact cognition. Record review of Resident #47's care plan dated last revised 04/08/2025 reflected no indication that the resident wore dentures. In an observation and interview on 05/01/2025 at 12:51 PM with Resident #47 he stated he did not require any assistance with his dentures, and he was able to care for them on his own. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #50's annual MDS dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included iron deficiency anemia (condition where the body does not have enough red blood cells and iron), hyperlipidemia (abnormally high levels of fats in the blood), and hypertension (high blood pressure). She had a BIMS score of 14 indicating cognition intact. Functional abilities for oral hygiene including the ability to insert and remove dentures into and from the mouth reflected setup of cleanup assistance Section L Dental reflected none of the above were present when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. Review of Resident #50's care plan last revised 03/17/25 reflected Resident #50's care plan did not identify oral care related to denture use. Record review of Resident #167's Admission Record reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnosis included: Encounter for surgical aftercare on the skin and subcutaneous tissue, contusion (injury) of the left lower leg, acute posthemorrhagic anemia (low red blood cells related to blood loss), and Atrial Fibrillation (an irregular heartbeat). Record review of Resident #167's Care Plan dated 01/29/2025 revised on 01/30/2025 reflected: Focus Resident #167 is at risk for falls related to her diagnosis of Parkinson's (a neurological disorder impairing a resident's movement). Interventions: Ensure resident has properly fitting nonskid shoes for transfers. Give verbal reminders to call for assistance with transfers. Keep area free of clutter and safety hazards. Keep call light within reach at all times. Observe for adverse reactions to medication which may make resident at risk for falls. Place items frequently used by resident within easy reach, to avoid resident reaching for items. Provide an environment with adequate lighting, free from glare. Record review of Resident 167's nurses progress notes dated 04/09/2025 reflected When going into resident's room noticed her sitting on her knees in front of her recliner. Resident stated she was sitting to close to the edge of her chair and slid down onto the floor. Residents left leg landed on the base of her bedside table. Noticed a hematoma 3 cm below left knee. Resident stated no pain at this time. Transferred resident up from the floor into her recliner x 2-person assist. with gait belt. Obtained vitals and notified doctor and family. Signed by LVN B Record review of Resident #167's PPS Scheduled Assessment for a Medicare Part A Stay MDS dated [DATE] revealed a BIMS score of 15, indicating he was cognitively intact. The MDS also reflected Resident #167 was not coded as having a fall anytime in the last month prior to admission. In an interview on 05/01/25 at 09:36 AM with the MDSC revealed she had been working for the facility for 7 years. She stated that when a resident admitted with dentures or with no natural teeth, the admission MDS assessment and all assessments afterwards should accurately reflect that. She acknowledged that Resident #36 had upper dentures and that his MDS assessments should have reflected them. She stated that an accurate assessment would help with accuracy of the care plan, in addition to the facility's funding. In an interview on 05/01/2025 at 10:20 AM with the DON she stated that her expectation is for all MDS assessments to be completed accurately due to the need for an accurate person-centered care plan as well as the facility's payor source. She stated that a negative outcome of inaccurate MDS assessments is that it would not trigger certain things on the care plan as well as accurate funding. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LVN B on 05/01/25 at 10:57 AM he stated sliding out of the chair is a fall. He stated it should have been noted on the fall assessment . He stated the potential negative outcomes for not assessing a fall appropriately could include repeated falls, death, major injury. In an additional interview with the MDSC on 05/01/25 at 11:34 AM, she stated a fall was when someone goes from an upper position down to a lower position without assistance. She stated MDS Coordinators were required to look at fall and fall documentation. She stated falls were evaluated by reviewing a risk management report. She stated sliding out of the chair is a fall that should have been coded on MDS. The MDS coordinator stated staff did review the progress notes when completing assessments and gathering pertinent information related to their assessments. Negative outcomes for not identifying a fall or fall history could have been that the fall could happen again. She stated department heads do go over falls, daily in the morning meeting and have a fall meeting weekly. In an additional interview with the DON on 05/01/25 at 12:34 PM she stated that falls were defined as a change from a higher point to a lower point. MDS coordinators were expected to code falls and MDS accurately. The MDS nurses can go to the risk management and review the falls, frequency, and dates for the look back period. She stated department heads do review falls in stand up and Medicare meetings. The DON stated staff were educated on fall prevention, interventions and fall assessments to identify risk for falls. She stated the potential negative effects for failure to correctly complete an assessment would be unidentified risk for the residents leading to falls. Record review of undated Facility policy titled Conducting an Accurate Resident Assessment: reflected: The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. Definition: Accuracy of assessment means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) (i.e. comprehensive, quarterly, significant change in status). Policy Explanation and Compliance Guidelines: 1. The Administrator will ensure that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. 2. Qualified staff who are knowledgeable about the resident will conduct an accurate assessment addressing each resident's status, needs, strengths, and areas of decline. The assessment will be documented in the medical record. 3. The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1. 19.1, dated October 2024, reflected, The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status. (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. 47926

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F 0656 Level of Harm - 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** 47172 49099 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 27 of 27 residents (Residents #6, #7, #9, #13, #19, #22, #24, #28, #31, #32, #33, #34, #36, #39, #40, #41, #42, #43, #44, #45, #47, #50, #51, #53, #55, #57, #59) who were reviewed for care plans. 1. The facility failed to develop a person- centered care plan for Resident #55's oral care needs related to denture use and interventions for oral, and nutritional maintenance despite a system generated warning on 11/15/24 for -7.5% change (comparison weight 08/09/24, 154.2 lbs, -8.0%, 12.4 lbs) and lab results on 09/05/24, 12/06/24, and 03/13/25 which reflected low albumin levels indicating low protein resulting in a 4.9 lbs (-3.62 %) loss in a month, a 12.3 lbs (-8.62 %) loss in 6 months, and 23.9 lbs (-15.49 %) loss in the last year 04/05/24 through 04/15/25 resulting in impaired nutritional status (significant weight loss) and frustration with not having her preferences and needs met. 2. The facility failed to care plan Residents' #6, #7, #9, #13, #19, #22, #24, #28, #31, #32, #33, #34, #36, #39, #40, #41, #42, #43, #44, #45, #47, #50, #51, #53, #57, #59 for their use of dentures. This failure placed residents that wear dentures at risk of impaired nutritional status (poor intake and significant weight loss) and not having their need for assistance met. Findings included: Review of Resident #6's significant change MDS assessment dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included senile degeneration of the brain, vitamin B12 deficiency anemia (low levels of healthy red blood cells or hemoglobin), dental procedure status, and hypertension (high blood pressure). She had a BIMS score of 10 indicating moderate cognitive impairment. Functional abilities for oral hygiene included the ability to insert and remove dentures into and from the mouth reflected substantial/ maximal assistance. Section L Dental reflected none of the above were present when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. Review of Resident #6's care plan last revised 04/21/25 reflected Resident #6's care plan did not identify oral care related to denture use. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Some	Record review of Resident #7's Annual MDS, dated [DATE], indicated Resident #7 was a [AGE] year-old male who was admitted to the facility on [DATE]. He had diagnoses of Heart Failure, Atrial Fibrillation (irregular heart rhythm), Cardiac Pacemaker, lack of coordination, and muscle weakness. His MDS reflected in Section L - Oral/Dental Status an 'x' in box 'Z. None of the above were present' when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. He had a BIMS score of 15 indicating cognition intact. Record review of Resident #7's care plan dated last revised 03/31/2025 revealed that his use of upper and lower dentures was not care planned. Record review of Resident #9's Annual MDS, dated [DATE], indicated Resident #9 was a [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses of Cerebral Infarction (stroke), Peripheral Vascular Disease (a lack of blood flow to the lower extremities), lack of coordination, and muscle weakness. Her MDS reflected in Section L - Oral/Dental Status an 'x' in box 'Z. None of the above were present' when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. She had a BIMS score of 12 indicating cognition intact. Record review of Resident #9's care plan dated last revised 03/28/2025 revealed that her use of upper and lower dentures was not care planned. Record review of Resident #13's Admission MDS, dated [DATE], indicated Resident #13 was a [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses of Cerebral Infarction, Peripheral Vascular Disease, lack of coordination, and muscle weakness. Her MDS reflected in Section L - Oral/Dental Status an 'X' in box 'B indicating No natural teeth or tooth fragments. She had a BIMS score of 14 indicating cognition intact. Record review of Resident #13's care plan dated last revised 04/28/2025 revealed that her use of upper and lower dentures was not care planned. Record review of Resident #19's Annual MDS, dated [DATE], indicated Resident #19 was a [AGE] year-old male who was admitted to the facility on [DATE]. He had diagnoses of Heart Failure, Atrial Fibrillation , Cardiac Pacemaker, lack of coordination, and muscle weakness. His MDS reflected in Section L - Oral/Dental Status an 'x' in box 'Z. None of the above were present' when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. He had a BIMS score of 10 indicating moderate cognitive impairment. Record review of Resident #19's care plan dated last revised 03/28/2025 revealed that his use of upper and lower dentures was not care planned. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Some	Record review of Resident #22's quarterly MDS assessment, dated 03/14/2025, indicated Resident #22 was an [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses of high blood pressure, Alzheimer's disease (memory loss, confusion, and difficulty problem-solving), anxiety (worriness), bipolar disorder (extreme mood disorder), psychotic disorder (abnormal thinking and perceptions), edema (swelling caused by trapped fluid), disease of the pancreas, neoplasm of the digestive organs, bladder, and colon (abnormal growth of tissues in these areas). Her MDS reflected in Section GG-Functional Abilities she was dependent on staff for help with oral hygiene. Her MDS reflected in Section L - Oral/Dental Status an 'X' in box 'B indicating No natural teeth or tooth fragments. She had a BIMS score of 05, indicating severe cognitive impairment. Record review of Resident #22's care plan dated last revised 03/28/2025 revealed that her use of upper and lower dentures was not care planned. Record review of Resident #24's comprehensive MDS assessment, dated 11/15/2024, indicated Resident #24 was an [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses of high blood pressure, high cholesterol, gastroesophageal reflux disease, Alzheimer's disease (memory loss, confusion, and difficulty problem-solving), anxiety, depression (extreme sadness), cataracts, and lack of coordination. Her MDS reflected in Section L - Oral/Dental Status an 'x' in box 'B. No natural teeth or tooth fragments'. She had a BIMS score of 08, indicating moderately impaired cognition. Record review of Resident #24's care plan dated last revised 04/21/2025 reflected no indication that the resident wore dentures or had no natural teeth. Review of Resident #28's quarterly MDS dated [DATE] reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included muscle weakness, vitamin D deficiency, and hypertension (high blood pressure). She had a BIMS score of 12 indicating moderate cognitive impairment. Functional abilities for oral hygiene including the ability to insert and remove dentures into and from the mouth reflected independent Section L Dental reflected was not assessed to indicate if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. Review of Resident #28's care plan last revised 06/06/24 reflected Resident #28's care plan did not identify oral care related to denture use. Record review of Resident #31's Annual MDS, dated [DATE], indicated Resident #31 was a [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses of Malignant Neoplasm of the Brain (brain cancer), Anemia (low red blood cells, Muscle Weakness, and Urinary Retention. Her MDS reflected in Section L - Oral/Dental Status an 'X' in box 'B indicating No natural teeth or tooth fragments. She had a BIMS score of 12 indicating moderate cognitive impairment. Record review of Resident #31's care plan dated last revised 04/19/2025 reflected that her use of upper and lower dentures was not care planned. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Some	Record review of Resident #32's Annual MDS, dated [DATE], indicated Resident #32 was a [AGE] year-old male who was admitted to the facility on [DATE]. He had diagnoses of Seizure Disorder, Depression, Cataracts (a cloudy opacity of the natural lens inside the eye), and Unspecified Intellectual Disabilities. His MDS reflected in Section L - Oral/Dental Status an 'x' in box 'Z. None of the above were present' when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. He had a BIMS score of 15 indicating cognition intact. Record review of Resident #32's care plan dated last revised 04/08/2025 reflected that his use of upper and lower dentures was not care planned. Record review of Resident #33's Annual MDS, dated [DATE], indicated Resident #33 was an [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses of Heart Failure, Cerebrovascular Accident (stroke), Depression, and Muscle Weakness. Her MDS reflected in Section L - Oral/Dental Status an 'X' in box 'B indicating No natural teeth or tooth fragments. She had a BIMS score of 06 indicating severe cognitive impairment. Record review of Resident #33's care plan dated last revised 03/28/2025 reflected that her use of upper and lower dentures was not care planned. Review of Resident #34's significant change MDS dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included age related cognitive decline, hypokalemia (abnormally low potassium concentration in the blood), vitamin D deficiency, and iron deficiency. She had a BIMS score of 14 indicating cognition intact. Functional abilities for oral hygiene including the ability to insert and remove dentures into and from the mouth reflected supervision or touching assistance Section L Dental reflected none of the above were present when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. Review of Resident #34's care plan last revised 04/30/25 reflected Resident #34's care plan did not identify oral care related to denture use. Record review of Resident #35's quarterly MDS dated [DATE] reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of high blood pressure, multiple sclerosis, macular degeneration, pain in right shoulder, and depression. In Section 'N' - Medications, there was not an 'x' in the box next to Antianxiety 'Is taking' or 'Indication noted'. In section 'GG-Functional Abilities he required touching assistance with oral hygiene. He had a BIMS score of 15, indicating intact cognition. Record review of Resident #35's care plan dated last revised 03/13/2025 had no indication the resident was on an antianxiety medication or had a diagnosis of anxiety or agitation. His care plan also reflected no indication that the resident wore dentures. Record review of Resident #36's comprehensive MDS assessment, dated 04/02/2025, indicated Resident #36 was a [AGE] year-old male who was admitted to the facility on [DATE]. He had diagnoses of paralysis or severe weakness on one side of the body following damage to the brain, dementia, heart failure, lack of coordination, muscle weakness, anxiety, bipolar disorder, and irregular heart rhythm. His MDS reflected in Section L - Oral/Dental Status an 'x' in box 'Z. None of the above were present' when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. He had a BIMS score of 03, indicating severe cognitive impairment. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Some	Record review of Resident #36's care plan dated last revised 03/27/2025 reflected no indication that the resident wore dentures or had no natural teeth. Record review of Resident #39's quarterly MDS assessment, dated 04/11/2025, indicated Resident #39 was an [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses of heart disease, heart failure, high blood pressure, high cholesterol, lung disease, abnormality of mobility, lack of coordination, and muscle weakness. Her MDS reflected in Section GG-Functional Abilities she required touching assistance from staff for oral hygiene. She had a BIMS score of 15 indicating intact cognition. Record review of Resident #39's care plan dated last revised 04/28/2025 reflected no indication that the resident wore dentures or partials. Record review of Resident #40's comprehensive MDS assessment, dated 07/19/2024, indicated Resident #40 was an [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses of high blood pressure, kidney disease, viral hepatitis, arthritis, non-Alzheimer's dementia, anxiety, bipolar disorder, depression (sadness), lack of coordination, muscle weakness, overactive bladder, and chronic pain. Her MDS reflected in Section L - Oral/Dental Status an 'x' in box 'Z. None of the above were present' when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. She had a BIMS score of 15, indicating intact cognition. Record review of Resident #40's progress note dated 4/2/2025 reflected a care plan meeting was held with Resident #40 regarding her broken bottom denture. It was noted that the team had concerns about her weight loss and refusal of meals until her denture was to be fixed. Record review of Resident #40's care plan dated last revised 04/25/2025 reflected no indication that the resident wore dentures. Review of Resident #41's quarterly MDS dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis that included muscle weakness, vitamin D deficiency, and hypertension (high blood pressure). Her BIMS score had not been assessed. Functional abilities for oral hygiene including the ability to insert and remove dentures into and from the mouth reflected substantial/maximal assistance Section L Dental reflected not assessed to indicate if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. Review of Resident #41's care plan last revised 04/04/25 reflected Resident #41's care plan did not identify oral care related to denture use. Record review of Resident #42's comprehensive MDS assessment, dated 01/03/2025, indicated Resident #42 was an [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses of anemia, atrial fibrillation, heart failure, high blood pressure, kidney disease, high cholesterol, thyroid disorder, Alzheimer's disease (memory loss, confusion, and difficulty problem-solving), stroke, anxiety, depression (sadness), and respiratory failure. Her MDS reflected in Section L - Oral/Dental Status an 'x' in box 'Z. None of the above were present' when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. She had a BIMS score of 13, indicating intact cognition. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Some	Record review of Resident #42's care plan dated last revised 04/28/2025 reflected no indication that the resident wore dentures. Record review of Resident #43's Annual MDS, dated [DATE], indicated Resident #43 was a [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses of Hypertension (elevated blood pressure), Gastroesophageal Reflux Disease (indigestion), Thyroid Disorder, and Muscle Weakness. Her MDS reflected in Section L - Oral/Dental Status an 'X' in box 'B indicating No natural teeth or tooth fragments. She had a BIMS score of 12 indicating moderate cognitive impairment. Record review of Resident #43's care plan dated last revised 04/25/2025 reflected no indication that the resident wore dentures. Review of Resident #44's quarterly MDS dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included hypertension (high blood pressure), vitamin D deficiency, and muscle weakness. She had a BIMS score of 15 indicating cognition intact. Functional abilities for oral hygiene including the ability to insert and remove dentures into and from the mouth reflected independent Section L Dental reflected not assessed to indicate if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. Review of Resident #44's care plan last revised 03/10/25 reflected Resident #44's care plan did not identify oral care related to denture use. Record review of Resident #45's Significant change in status MDS, dated [DATE], indicated Resident #45 was an [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses of Hypertension (elevated blood pressure), Gastroesophageal Reflux Disease (indigestion), Lack of Coordination, and Muscle Weakness. Her MDS reflected in Section L - Oral/Dental Status an 'X' in box 'B indicating No natural teeth or tooth fragments. Staff interview reflected she had short term and long-term memory problems. Record review of Resident #45's care plan dated last revised 04/11/2025 reflected no indication that the resident wore dentures. Record review of Resident #47's comprehensive MDS assessment, dated 02/14/2025, indicated Resident #47 was an [AGE] year-old male who was admitted to the facility on [DATE]. He had diagnoses of coronary artery disease, high blood pressure, gastroesophageal reflux disease (digestive disorder), benign prostatic hyperplasia (noncancerous enlargement of the prostate gland), kidney failure, diabetes, high cholesterol, thyroid disorder, seizure disorder, muscle weakness, lack of coordination, and fibromyalgia (widespread body pain). His MDS reflected in Section L - Oral/Dental Status an 'x' in box 'Z. None of the above were present' when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. He had a BIMS score of 15, indicating intact cognition. Record review of Resident #47's care plan dated last revised 04/08/2025 reflected no indication that the resident wore dentures. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #50's annual MDS dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included iron deficiency anemia (condition where the body does not have enough red blood cells and iron), hyperlipidemia (abnormally high levels of fats in the blood), and hypertension (high blood pressure). She had a BIMS score of 14 indicating cognition intact. Functional abilities for oral hygiene including the ability to insert and remove dentures into and from the mouth reflected setup of cleanup assistance Section L Dental reflected none of the above were present when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. Review of Resident #50's care plan last revised 03/17/25 reflected Resident #50's care plan did not identify oral care related to denture use. Review of Resident #51's annual MDS dated [DATE] reflected a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis that included muscle weakness, secondary hypertension (high blood pressure), and vitamin B12 deficiency. She had a BIMS score of 09 indicating moderate cognitive impairment. Functional abilities for oral hygiene including the ability to insert and remove dentures into and from the mouth reflected substantial/maximal assistance Section L Dental reflected none of the above were present when indicating if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. Review of Resident #51's care plan last revised 06/28/24 reflected Resident #51's care plan did not identify oral care related to denture use. Review of Resident #53's quarterly MDS dated 04.04/25 reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included iron deficiency anemia (condition where the body does not have enough red blood cells and iron), vitamin D deficiency, and iron deficiency. She had a BIMS score of 13 indicating cognition intact. Functional abilities for oral hygiene including the ability to insert and remove dentures into and from the mouth reflected partial/moderate assistance Section L Dental reflected was not assessed to indicate if the resident had natural teeth, dentures, oral abnormalities, pain, or inability to examine oral cavity. Review of Resident #53's care plan last revised 01/02/25 reflected Resident #53's care plan did not identify oral care related to denture use. Review of Resident #55's face sheet dated 04/30/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis that included cerebral aneurysm (bulge or ballooning in a blood vessel in the brain), vitamin D deficiency, depression (mental health condition causing persistent feeling of sadness and loss of interest and can interfere with daily life), hyperlipidemia (excess lipids or fats in the blood), anemia (not having enough red blood cells or when your red blood cells to not function properly), and essential (primary) hypertension (high blood pressure). Review of Resident #55's annual MDS assessment dated [DATE] reflected a BIMS score of 15 indicating cognition intact. Section GG for functional abilities reflected oral hygiene; the ability to use suitable items to clean teeth. Dentures (if applicable); the ability to insert and remove dentures into and from the mouth and manage denture soaking and rinsing with the use of equipment indicated supervision or touching assistance. Eating reflected setup or cleanup assistance. MDS assessment indicated Resident #55 was currently on a mechanically altered diet. Section L dental indicated no natural teeth or tooth fragments. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Some	Review of Resident 55's care plan last revised 03/17/25 reflected, Resident #55 is at risk for weight loss related to CVA. She is on a mechanical soft diet per her request due to her having no teeth. She had a vitamin D deficiency. Interventions included, administer vitamins as ordered by physician, allow ample time to ingest meal, health shakes three times daily (initiated 06/20/23), monitor labs, monitor monthly weights, RD/dietary to assess dietary needs, and take in consideration residents likes and dislikes. The care plan did not indicate Resident #55's use of dentures. Review of Resident #55's physician orders reflected an order with a start date of 06/16/23 for health shakes three times a day between meals. Review of Resident #55's labs dated 09/06/24 reflected a low albumin level that was flagged at 3.2 mg/dL indicating low protein. Review of Resident #55's labs dated 12/06/24 reflected a low albumin level that was flagged at 3.3 mg/dL indicating low protein. Review of Resident #55's labs dated 03/13/25 reflected a low albumin level that was flagged at 3.2 mg/dL indicating low protein. Review of Resident #55's weights reflected: 04/05/24 154.3 LBS 05/10/24 150.0 LBS 06/07/24 151.0 LBS 07/05/24 151.5 LBS 08/09/24 154.2 LBS 09/06/24 146.5 LBS 09/20/24 146.9 LBS 10/04/24 142.7 LBS 11/15/24 141.8 LBS System warning reflected, -7.5% change [Comparison Weight 08/09/24, 154.2 lbs., - 8. 0%, -12.4 lbs.] 12/06/24 140.1 LBS 12/16/24 140.1 LBS 01/10/25 139.3 LBS 02/06/25 139.8 LBS (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Some	03/06/25 135.3 LBS 04/04/25 130.4 LBS 04/15/25 130.4 LBS On 03/06/25, Resident #55 weighed 135.3 lbs. On 04/04/25, the resident weighed 130.4 pounds which was a -3.62 % Loss in the last month. On 10/04/24, Resident #55 weighed 142.7 lbs. On 04/04/25, the resident weighed 130.4 pounds which was a -8.62 % Loss in the last 6 months. Review of Resident #55's progress notes reflected there were no notes indicating the system generated warning for 11/15/24 was addressed related to significant weight loss. Review of the facility's weights and dietary consultants binder reflected consultant dietician reports for 11/12/24 and 11/19/24, and weight meetings dated 11/07/24, 11/15/24, 11/22/24 which did not reflect that Resident #55's weight loss or system generated alert 11/15/24 for weight loss was addressed. Review of Resident #55's progress notes revealed the most recent quarterly nutritional review note dated 03/11/25 by RDN identified the weight trended down in the quarter and stated, 12/19 diet upgraded to mech soft with thin liquids, health shakes three times a day between meals; snacks as needed and at bedtime. Intake range 50-100. No new nutrition related labs available. Continue with current plan of care. DM will honor food preferences. Goals: abnormal lab correction, weight to stabilize, maintain skin integrity, tolerance of diet. Review of Resident #55's laminated reusable daily meal ticket provided by DM I reflected: - Mechanical soft diet - Breakfast: scrambled eggs, gravy, chocolate shake, coke - Lunch: Chicken noodle soup, tea, coke - Dinner: chicken noodle soup, tea, coke Meal ticket did not identify likes/dislikes, allergies, portion sizes, or any other additional information. Review of Resident #55's Dental notes reflected delivery of the dentures occurred on 07/30/24 after adjustments, with a follow up 11/05/24 for evaluation of mouth for lesions, red spots, and sensitive area. Adjustments made. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Some	In an interview and observation on 04/29/25 at 12:00 PM with Resident #55, while eating her lunch in the dining room which was observed to consist of chicken noodle soup, Resident #55 was observed pulling some of the noodles out of her mouth. She stated the food was good but that it was all she could eat because she didn't have any teeth. An observation of Resident #55's mouth revealed no teeth and no dentures in place. Resident #55 stated she had dentures, but that the staff did not assist with putting them on. She stated she would like to be able to eat a variety of food and expressed frustration, but stated she cannot because she doesn't have teeth. In an interview and observation on 04/29/25 at 03:07 PM with Resident #55 in her room, she was observed pointing to her dentures in a case located on a shelf near her nightstand. She once again stated she did not wear them because staff have not assisted her to use them. She again expressed frustration and stated she would like to try other food items but can't with no teeth. She stated she believed she needed to put glue on them to make them stick but simply did not know how to put them on. She stated she asked staff for assistance when she first got them, but after not getting any help she simply stopped asking. She stated if she was still hungry after her soup, she would return to her room to eat her snacks which was either chocolate or cookie cakes from a specific brand that are soft and manageable for her to break down with her gums. In an interview and observation on 04/30/25 at 05:10 PM with Resident #55 in the dining room for dinner, she was observed eating chicken noodle soup. She stated she was not wearing her dentures because nobody assisted her with them and she did not wear them for lunch that day either. She stated she was eating chicken soup once again which was not so difficult to eat. But she stated she wanted more of a variety. In an interview on 04/30/25 at 05:14 PM with CNA E working on Resident #55's hall. She stated she frequently worked with Resident #55, and that to her knowledge, she was not aware of the resident having dentures. CNA E stated she believed that Resident #55 had her own teeth. She stated that CNAs do assist the residents if they have dentures and that they are responsible for assisting the residents to put them on, take them off, brush them and add the cleaning tablets. She stated a negative outcome of a resident not getting assistance with dentures would be the resident would not be able to eat their food which could lead to weight loss. When asked how she would identify if a resident wore dentures, CNA E stated she would just ask. CNA E stated she did not look at the charts or anywhere else to identify if a resident required help with dentures. In an interview on 04/30/25 at 05:30 PM with LVN B, she stated she was the nurse for Resident #55's hall and had worked with her frequently. She stated she was aware that Resident #55 had dentures, but she has never seen the resident wear them and just assumed she did not like wearing them. She stated staff would assist residents, that have dentures, to put them on and take them off. She stated that Resident #55 required supervision and touch assistance with oral care which means she would have needed assistance with her dentures. She stated the CNA's have the primary responsibility to be the ones to assist the residents who wear dentures. She stated if a resident uses dentures, that should also be in the care plan with is updated by the MDS Coordinator. She stated a potential negative outcome of not assisting a resident with dentures would be significant weight loss. LVN B stated CNAs will get a sheet at the beginning of their shift that would tell them what the resident requires assistance with. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Some	In an interview on 05/01/25 at 09:36 AM with the MDSC revealed she had been working for the facility for 7 years. She stated that she was responsible for creating and updating most items on the care plans and that in the past they had not put dentures on the care plan, and she was not sure why they did not include them. She stated that if a resident admits with their natural teeth, then gets dentures later the social worker would be responsible for updating the care plan. She stated that it was important to include on the care plan because the CNAs are the ones who help residents take care of the dentures and insert and remove the dentures. She stated that a negative outcome of denture not being care planned is that a residents' nutrition could be hindered if the resident ha issues with their denture, as well as their self-worth. In an interview on 05/01/25 at 09:56 PM with DM I, she stated Resident #55 eats the same thing every day, she stated for breakfast she will have scrambled eggs and a shake and will have chicken noodle soup for both lunch and dinner. She stated it was her responsibility to update food preferences but had not because she believed Resident #55 enjoyed the chicken noodle soup and her family would even bring it to her. DM I stated she was not aware of Resident #55 having dentures or needing them. She stated using the dentures would allow her to have more of a variety of food options. She stated they have tried pureed meals with Resident #55, but she did not like them and is currently on a grounded-up texture. In an interview and observation on 05/01/25 at 10:11 AM with CNA F, she stated it was the responsibility of the CNAs to assist residents with their dentures which included putting them on, taking them off, and helping to clean them. CNA F stated she was not sure if dentures were listed anywhere on a resident's record, but if they were verbal, she would ask if they wore dentures. She stated that at the beginning of their shift, CNAs were given a sheet which tells them a resident's transfer requirements (x1 staff or x 2 staff assist etc.) She stated prior to today, it did not include dentures or assistive devices listed. In an observation of the sheet CNA F was provided a

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49099 Based on interviews and record review, the facility failed to maintain acceptable parameters of nutritional status in such as usual body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicate otherwise for 1 of 4 (Resident #55) residents reviewed for weight loss. 1. The facility failed to recognize, evaluate, and address the nutritional needs of Resident #55 despite a system generated warning on 11/15/24 for -7.5% change (comparison weight 08/09/24, 154.2 lbs, -8.0%, 12. 4 lbs) and lab results on 09/05/24, 12/06/24, and 03/13/25 which reflected low albumin levels indicating low protein resulting in a 4.9 lbs (-3.62 %) loss in a month, a 12.3 lbs (-8.62 %) loss in 6 months, and 23.9 lbs (-15.49 %) loss in the last year 04/05/24 through 04/15/25. 2. The facility failed to provide assistance to Resident #55 in the use of her dentures and consider her food preferences resulting in the continuation of impaired nutritional status. This failure places residents at risk for impaired nutritional status, not having their needs or preferences considered, and decreased quality of life. Finding included: Review of Resident #55's face sheet dated 04/30/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis that included cerebral aneurysm (bulge or ballooning in a blood vessel in the brain), vitamin D deficiency, depression (mental health condition causing persistent feeling of sadness and loss of interest and can interfere with daily life), hyperlipidemia (excess lipids or fats in the blood), anemia (when you do not have enough red blood cells or when your red blood cells to not function properly), and essential (primary) hypertension (high blood pressure). Review of Resident #55's annual MDS assessment dated [DATE] reflected a BIMS score of 15 indicating cognition intact. Section GG for functional abilities reflected oral hygiene; the ability to use suitable items to clean teeth. Dentures (if applicable); the ability to insert and remove dentures into and from the mouth and manage denture soaking and rinsing with the use of equipment indicated supervision or touching assistance. Eating reflected setup or cleanup assistance. MDS assessment indicated Resident #55 was currently on a mechanically altered diet. Section L dental indicated no natural teeth or tooth fragments. Review of Resident 55's care plan last revised 03/17/25 reflected, Resident #55 is at risk for weight loss related to CVA. She is on a mechanical soft diet per her request due to her having no teeth. She has a vitamin D deficiency. Interventions included, administer vitamins as ordered by physician, allow ample time to ingest meal, health shakes three times daily (initiated 06/20/23), monitor labs, monitor monthly weights, RD/dietary to assess dietary needs, and take in consideration residents likes and dislikes. The care plan did not indicate Resident #55's use of dentures. Review of Resident #55's physician orders reflected an order with a start date of 06/16/23 for health shakes three times a day between meals. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #55's labs dated 09/06/24 reflected a low albumin level that was flagged at 3.2 mg/dL indicating low protein. Review of Resident #55's labs dated 12/06/24 reflected a low albumin level that was flagged at 3.3 mg/dL indicating low protein. Review of Resident #55's labs dated 03/13/25 reflected a low albumin level that was flagged at 3.2 mg/dL indicating low protein. Review of Resident #55's weights reflected: 04/05/24 154.3 LBS 05/10/24 150.0 LBS 06/07/24 151.0 LBS 07/05/24 151.5 LBS 08/09/24 154.2 LBS 09/06/24 146.5 LBS 09/20/24 146.9 LBS 10/04/24 142.7 LBS 11/15/24 141.8 LBS System warning reflected, -7.5% change [Comparison Weight 08/09/24, 154.2 lbs., - 8. 0%, -12.4 lbs.] 12/06/24 140.1 LBS 12/16/24 140.1 LBS 01/10/25 139.3 LBS 02/06/25 139.8 LBS 03/06/25 135.3 LBS 04/04/25 130.4 LBS 04/15/25 130.4 LBS On 03/06/25, Resident #55 weighed 135.3 lbs. On 04/04/25, the resident weighed 130.4 pounds which was a -3.62 % Loss in the last month. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	On 10/04/24, Resident #55 weighed 142.7 lbs. On 04/04/25, the resident weighed 130.4 pounds which was a -8.62 % Loss in the last 6 months. Review of Resident #55's progress notes reflected there were no notes indicating the system generated warning for 11/15/24 was addressed related to significant weight loss. Review of the facility weights and dietary consultants binder reflected consultant dietician reports for 11/12/24 and 11/19/24 and weight meetings dated 11/07/24, 11/15/24, 11/22/24 which did not reflect that Resident #55's weight loss or system generated alert 11/15/24 for weight loss was addressed. Review of Resident #55's progress notes revealed the most recent quarterly nutritional review note dated 03/11/25 by RDN identified the weight trend down in the quarter and stated, 12/19 diet upgraded to mech soft with thin liquids, health shakes three times a day between meals; snacks as needed and at bedtime. Intake range 50-100. No new nutrition related labs available. Continue with current plan of care. DM will honor food preferences. Goals: abnormal lab correction, weight to stabilize, maintain skin integrity, tolerance of diet. Review of Resident #55's laminated reusable daily meal ticket provided by DM I reflected: 3. Mechanical soft diet 4. Breakfast: scrambled eggs, gravy, chocolate shake, coke 5. Lunch: Chicken noodle soup, tea, coke 6. Dinner: chicken noodle soup, tea, coke Meal ticket did not identify likes/dislikes, allergies, portion sizes, or any other additional information. Review of Resident #55's Dental notes reflected delivery of the dentures occurred on 07/30/24 after adjustments, with a follow up 11/05/24 for evaluation of mouth for lesions, red spots, and sensitive area. Adjustments made. In an interview and observation on 04/29/25 at 12:00 PM with Resident #55, revealed while eating her lunch in the dining room which was observed to consist of chicken noodle soup, Resident #55 was observed pulling some of the noodles out of her mouth. She stated the food was good but that it was all she could eat because she didn't have any teeth. An observation of Resident #55's mouth revealed no teeth and no dentures in place. Resident #55 stated she does have dentures but that she staff did not assist with putting them on. She stated she would like to be able to eat a variety of food and expressed frustration but stated she cannot because she doesn't have teeth. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	In an interview and observation on 04/29/25 at 03:07 PM with Resident #55 in her room, she was observed pointing to her dentures in a case located on a shelf near her nightstand. She once again stated she did not wear them because staff have not assisted her to use them. She expressed once again frustration and stated she would like to try other food items but can't with no teeth. She stated she believed she needed to put glue on them to make them stick but simply did not know how to put them on. She stated she asked staff for assistance when she first got them, but after not getting any help, she simply stopped asking. She stated if she was still hungry after her soup, she would return to her room to eat her snacks which was either chocolate or cookie cakes from a specific brand that are soft and manageable for her to break down with her gums. In an interview and observation on 04/30/25 at 05:10 PM with Resident #55 in the dining room for dinner, she was observed eating chicken noodle soup. She stated she was not wearing her dentures because nobody assisted her with them and stated she did not wear them for lunch that day either. She stated she was eating chicken soup once again which was not so difficult to eat. But she did say she wanted more of a variety. In an interview on 04/30/25 at 05:14 PM with CNA E working on Resident #55's hall. She stated she frequently worked with Resident #55 and that to her knowledge she was not aware of the resident having dentures. CNA E stated she believed that Resident #55 had her own teeth. She stated that CNA's do assist the residents if they have dentures and that they are responsible for assisting the residents to put them on, take them off, brush them and add the cleaning tablets. She stated a negative outcome of a resident not getting assistance with dentures would be the resident would not be able to eat their food which could lead to weight loss. When asked how she would identify if a resident wore dentures, CNA E stated she would just ask. CNA E stated she did not look at the charts or anywhere else to identify if a resident required help with dentures. In an interview on 04/30/25 at 05:30 PM with LVN B, she stated she was the nurse for Resident #55's hall and has worked with her frequently. She stated she was aware that Resident #55 had dentures, but she has never seen the resident wear them and just assumed she did not like wearing them. She stated that staff would assist residents that have dentures to put them on and take them off. She stated that Resident #55 required supervision and touch assistance with oral care which means she would have needed assistance with her dentures. She stated the CNA's have the primary responsibility to be the ones to assist the residents who wear dentures. She stated if a resident uses dentures, that should also be located in the care plan with is updated by the MDS Coordinator. She stated a potential negative outcome of not assisting a resident with dentures would be significant weight loss. LVN B stated CNAs will get a sheet at the beginning of their shift that would tell them what the resident requires assistance with. In an interview on 05/01/25 at 09:56 PM with DM I, she stated Resident #55 eats the same thing every day, she stated for breakfast she will have scrambled eggs and a shake and will have chicken noodle soup for both lunch and dinner. She stated it was her responsibility to update food preferences but has not because she believed Resident #55 enjoyed the chicken noodle soup and her family would even bring it to her. DM I stated she was not aware of Resident #55 having dentures or needing them. She stated using the dentures would allow her to have more of a variety of food options. She stated they have tried pureed meals with Resident #55 but she did not like them and is currently on a grounded up texture. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	In an interview and observation on 05/01/25 at 10:11 AM with CNA F she stated it was the responsibility of the CNA's to assist residents with their dentures which included putting them on, taking them off and helping to clean them. CNA F stated she was not sure if dentures were listed anywhere on a resident's record, but if they were verbal, she would ask if they wore dentures. She stated that at the beginning of their shift, CNA's are given a sheet which tells them a residents transfer requirements (x1 or x 2 assist etc.) she stated prior to today it did not include dentures or assistive devices listed. In an observation of the sheet CNA F was provided at the beginning of her shift for the day, it reflected the residents' names, their transfer requirements, and a section for dentures that was highlighted. CNA F stated she was not aware that Resident #55 had dentures and assumed she did not have them because she never saw them. CNA F stated a negative outcome of not assisting a resident with dentures would be the resident would not be able to chew their food which could lead to weight loss. In an interview on 05/01/25 at 10:23 AM with RDN she stated Resident #55's weight has had a downward trend but stated she did not have any notes or could say what she attributed the weight loss to. She stated after reviewing the residents' chart she saw that Resident #55's fluid intake was good, she was not on hospice, and not on Lasix, but did not see any notes related to her weight loss. RDN stated she believed Resident #55 weight loss may have been a matter of her being more active. RDN stated it was the responsibility of the DM to update any food preferences for resident meals. RDN stated she was not aware of Resident #55 wearing dentures and after reviewing her chart she could not find information on Resident #55 having dentures. She stated that if a resident had dentures and did not get assistance wearing them that it could contribute to weight loss. RDN stated she would need to in-service staff at the facility to ensure that care staff are taking care of residents who need assistance with dentures, updating food preferences, and monitoring for changes. She stated sometimes residents will say they are ok but really have concerns that need to be addressed. RDN stated she did not participate in weight meetings but does her own monitoring of weights and will also get notification from the facility of they have concerns. In an interview on 05/01/25 at 10:35 AM with Resident #55's family, she stated Resident #55 has not had teeth since her admission into the facility. She stated the reason she wanted dentures was to be able to eat a variety of food which is what initially prompted the dental consult in 2024 to get them. Resident #55's family stated that they have tried to put the resident on a puree diet to give her more of a variety but that the resident did not like that. She stated Resident #55 has told her she wants her dentures to fit so she can eat different foods. In an interview on 05/01/25 at 10:44 AM with the DON, she stated it was the responsibility of the CNAs to assist residents with their dentures to put them on and take them off or clean them, but that nurses could also assist. She stated she believed that dentures were marked on the sheets CNAs get to assist them with care but was not aware it did not indicate denture use prior to today. She stated, a lot of the residents and staff have been here so long they usually know who has them and will just ask any of the new residents if they have dentures. DON stated a negative outcome of not getting assistance with dentures would be the inability to chew food which could result in weight loss. She also stated if the resident didn't wear their dentures for an extended period of time it would result in them no longer fitting. The DON stated she has never seen Resident #55 with dentures and was not aware she had any. She stated it was the responsibility of the MDS coordinator to update the care plans with dentures and her expectation that they are accurate and that residents get the help with dentures if they need it. She stated a negative outcome of dentures not being in the care plan staff would not have the accurate information to care for the resident. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	c. the relationship between current medical condition or clinical situation and recent fluctuations in weight; and d. whether and to what extent weight stabilization or improvement can be anticipated. Care Planning 1. Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident's legal surrogate. 2. Individualized care plans shall address, to the extent possible: a. the identified causes of weight loss; b. goals and benchmarks for improvement; and c. time frames and parameters for monitoring and reassessment. Interventions 1. Interventions for undesirable weight loss are based on careful consideration of the following: a. Resident choice and preferences; b. Nutrition and hydration needs of the resident; c. Functional factors that may inhibit independent eating; d. Environmental factors that may inhibit appetite or desire to participate in meals; e. Chewing and swallowing abnormalities and the need for diet modifications; f. Medications that may interfere with appetite, chewing, swallowing, or digestion; g. The use of supplementation and/or feeding tubes; and h. End of life decisions and advance directives. 2. Interventions for undesired weight gain consider resident preferences and rights. A weight loss regimen will not be initiated for a cognitively capable resident without his/her approval and involvement. 3. If a resident declines to participate in a weight loss goal, the dietitian will document the resident's wishes, and those wishes will be respected. Review of the undated facility Provision of Quality Care policy reflected: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Policy: Based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the residents' choices. 5. Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. 6. A comprehensive care plan will be developed for each resident in accordance with procedures for development of the care plan. 7. Responsibility for interventions on the care plan will be clearly identified. 8. Qualified persons will provide the care and treatment in accordance with professional standards of practice, the resident's care plan, and the resident's choices. Review of the undated Care of Dentures facility policy reflected: Policy: It is the practice of this facility to provide denture care to residents in order to avoid gingival infection and irritation as per current standards of practice. 5. Determine which nursing staff member will provide denture care. It is usually the nurse aide assigned to the resident. 6. Ask the resident if they have a preference for denture care and products used. If resident is unable to care for their own dentures, dentures will be cleaned for them during routine oral care. 7. Ask the resident if the dentures feel as though they fit, and if there is any tenderness of the gums or mouth. 8. If resident is unable to remove dentures independently, perform hand hygiene and apply gloves. To remove upper denture, grasp at the front with thumb and index finger and pull downward. To remove lower denture, gently lift it from the jaw, and rotate one side downward. Place dentures in emesis basin or sink. Review of the undated Comprehensive Care Plan facility policy reflected: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. 7. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	b. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment. 8. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172 Based on observation, interview and record review, the facility failed to ensure residents' drug regimen was adequately monitored and free from unnecessary drugs for 4 (Resident's #35, #61, #63, and #167) of 12 residents reviewed for pharmacy services. The facility failed to provide a diagnosis for the use of an antianxiety medication-Lorazepam (a prescription drug used for the management of anxiety orders) for Resident #35. The facility failed to provide a diagnosis for Resident #61's order for Doxycycline (an antibiotic used to treat types of infections). The facility failed to monitor Residents' #61, #63, and #167 for side effects of anticoagulant (blood thinner) medications. These failures could place residents at risk of ineffective interventions/treatments related to infections, risk of unobserved side effects of blood thinning medications such as bruising, bleeding, dark tarry stools resulting in hospitalization s. Findings included: Record review of Resident #35's quarterly MDS dated [DATE] reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of high blood pressure, multiple sclerosis (chronic autoimmune disease that affects the central nervous system, leading to neurological issues), macular degeneration (age-related eye condition that affects central vision and can lead to significant vision loss), pain in right shoulder, and depression. In Section 'N' - Medications, there was not an 'x' in the box next to Antianxiety 'Is taking' or 'Indication noted'. He had a BIMS score of 15, indicating intact cognition. Record review of Resident #35's care plan dated last revised 03/13/2025 had no indication the resident was on an antianxiety medication or had a diagnosis of anxiety or agitation. Record review of Resident #35's order summary reflected a start date of 03/05/2025 for antianxiety monitoring, and a start date of 04/18/2025 for: Lorazepam Oral Concentrate 2 MG/ML give .25 ml as needed every 4 hours for anxiety/agitation for 90 days. Lorazepam Oral Concentrate 2 MG/ML give .5 ml as needed every 4 hours for anxiety/agitation for 90 days. Lorazepam Oral Concentrate 2 MG/ML give .75 ml as needed every 4 hours for anxiety/agitation for 90 days. Lorazepam Oral Concentrate 2 MG/ML give 1 ml as needed every 4 hours for anxiety/agitation for 90 days. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #61's Admission Record reflected he was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnosis included: Non-ST Elevation Myocardial Infarction (a heart attack), Heart Failure, Chronic Obstructive Pulmonary Disease (a group of diseases affecting the ability to breath), and non-pressure chronic ulcer of the back. Record review of Resident #61's Physicians Progress Notes dated 12/14/2024 reflected He has a chronic wound in back from multiple surgeries and the drainage was cultured for MRSA (Methicillin -resistant Staphylococcus aureus a type of staph bacteria that's resistant to many antibiotics), caution with drainage, recent MRSA bacteria wound. Record review of Resident #61's Care Plan dated 12/20/2024 revised on 10/06/2025 reflected: Focus Resident #61 is on antibiotics related to an infection in the wound on his back. Interventions/task: Administer antibiotic as per orders, administer treatment to wound as ordered by physician. Maintain contact isolation precautions when providing resident care. Monitor wound for increased redness, swelling or drainage and notify physician of any abnormal findings. The care plan also reflected Focus Resident #61 is on anticoagulant therapy related to his diagnosis heart attack. Interventions/task: Administer anticoagulant medication as ordered by physician. Monitor for blood in urine or stool and report to physician. Observe for any abnormal bleeding not resolved with pressure. Also observe for any abnormal bruising. Order blood work/lab per physician orders and report results to physician. Record review of Resident #61's quarterly MDS dated [DATE] revealed a BIMS score of 00, indicating he was cognitively impaired. The MDS also reflected Resident #61 had a surgical wound and was taking an antibiotic and anticoagulant daily. Record review of Resident #61's Physicians Order Summary dated April 2025 reflected he had an order for Contact Isolation for MRSA in wound on back dated 12/20/24. Resident #61 had an order Doxycycline Oral Tablet 100 MG, give 1 tablet by mouth one time a day for Infection dated 01/23/2025. The order did not have a related diagnosis in place of MRSA for the use of Doxycycline. The Physicians Order Summary also reflected Resident #61 had an order for Xarelto Oral Tablet 2.5 MG (an anticoagulant/blood thinner) 1 tablet by mouth two times a day related to NON-ST ELEVATION. Record review of Resident #61's April 2025 Medication Administration Record reflected Resident #61 was administered Doxycycline Oral Tablet 100 MG, 1 tablet by mouth one time a day for Infection. The MAR reflected there was no diagnosis of MRSA attached to the order. The April medication administration record also reflected Resident #61 was administered Xarelto Oral Tablet 2.5 MG 1 tablet by mouth two times a day related to NON-ST ELEVATION. Record review of Resident #61's April 2025 Treatment Administration Record reflected there was no monitoring for side effects related to anticoagulation medication. In an observation and interview with Resident #61 on 04/29/25 at 10:20 AM there was a sign reflecting he was on contact precautions on the front of his room door. Resident #61 stated he had a current infection. He stated he was not sure what type of infection he had but it was in his back. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #63's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of deep vein thrombosis (blood clot develops in veins deep in the body), high blood pressure, diabetes, thyroid disorder, respiratory failure, sepsis (when the body's immune system has a dangerous reaction to an infection), muscle weakness, encephalopathy (any disease or disorder that affects the brain's function), and acute respiratory failure with hypoxia (insufficient oxygen in the blood) . She had a BIMS score of 15 , indicating intact cognition. In Section 'N' - Medications, there was an 'x' in the boxes next to Anticoagulant for 'Is taking' and 'Indication noted'. Record review of Resident #63's order summary reflected there was no order to monitor for abnormal bleeding due to anticoagulant use. Record review of Resident #63's April 2025 Treatment Administration Record reflected there was no monitoring for side effects related to anticoagulant medication. Record review of Resident #167's Admission Record reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnosis included: Encounter for surgical aftercare on the skin and subcutaneous tissue, contusion (injury) of the left lower leg, acute posthemorrhagic anemia (low red blood cells related to blood loss), and Atrial Fibrillation (an irregular heartbeat). Record review of Resident #167's Care Plan dated 01/29/2025 revised on 01/30/2025 reflected: Focus Resident #167 is on anticoagulant therapy related to her diagnosis of Atrial Fibrillation. Interventions/task: Administer anticoagulant medication as ordered by physician. Monitor for blood in urine or stool and report to physician. Observe for any abnormal bleeding not resolved with pressure. Also observe for any abnormal bruising. Order blood work/lab per physician orders and report results to physician. Record review of Resident #167's admission MDS dated [DATE] revealed a BIMS score of 15, indicating he was cognitively intact. The MDS also reflected Resident #167 was taking an anticoagulant medication. Record review of Resident #167's Physicians Order Summary dated April 2025 reflected she had an order for Apixaban (a blood thinner) Oral Tablet 5 MG Give 1 tablet by mouth two times a day related to Atrial Fibrillation. Record review of Resident #167's April 2025 Medication Administration Record reflected Resident #61 was administered Apixaban (a blood thinner) Oral Tablet 5 MG Give 1 tablet by mouth two times a day related to Atrial Fibrillation. Record review of Resident #167's April 2025 Treatment Administration Record reflected there was no monitoring for side effects related to anticoagulation medication. (continued on next page)

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	675369	A. Building B. Wing	05/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Nursing and Rehabilitation Center	301 W Criner St Grandview, TX 76050

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LVN B on 05/01/25 at 10:57 AM he stated when the nurses receive an order from the physician, it is placed into the electronic medical records. He stated the nurses ensure the order reflects the right medication, right time, right dosage, and any special requirements for example blood pressure parameters. He stated there should be a specific diagnosis on the orders for antibiotics to know what is being treated. He stated anticoagulants do require monitoring, but there is no order that states the nurses are to monitor. He stated some side effects of anticoagulant could be bruising and bleeding. He stated there was no specific place for anticoagulant side effect monitoring documentation, but if the nurses were to see any bleeding or bruising, they would notify the doctor. He stated potential negative outcomes from not assessing side effects of anticoagulant medications could include low hemoglobin, or anemia. In an interview with the DON on 05/01/25 at 12:34 PM she stated a diagnosis should be on the order for all medications. If the nurse was unsure of the diagnosis they should ask and clarify it with the physician or refer to the medical chart. She stated the DON, ADON and another RN that works once weekly review all the orders for clarification. She stated the nurses have a book where verbal orders are written down and then the order is transcribed in the electronic medical records. She stated nurses were educated upon hire on how to place orders in the computer and as needed. She stated potential negative effects for not adding a diagnosis to the medication order were that staff or others may be unaware of the needs for the medication. She stated that facility staff do monitor for bleeding, bruising, and blood in urine for resident receiving anticoagulant medications. She stated if staff were to suspect some type of adverse effects from the anticoagulant such as bruising or bleeding. then they would notify the doctor. She stated there was no specific process for monitoring for anticoagulant side effects. She stated staff just observe residents visually. She stated potential negative side effects for not monitoring side effects of anticoagulant medications include bleeding, low blood count. Record review of undated Facility policy titled Unnecessary Drugs reflected: It is the facility's policy that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being free from unnecessary drugs. 1. The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents and/or representatives, other professionals, and the interdisciplinary team. Each resident's drug regimen will be reviewed on an ongoing basis, taking into consideration the following elements: a. Dose (including duplicate therapy). b. Duration of use. c. Indications and clinical need for medication. d. Adequate monitoring for efficacy and adverse consequences. 47926

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49099 Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure stored foods in 2 of 2 reach in refrigerators and 1 of 1 walk in freezer were properly labeled and dated with a use by date. 2. The facility failed to ensure food in 1 of 1 walk-in freezer was properly sealed from air-borne contamination. 3. The facility failed to ensure DC K sanitized the blender in between usage during pureed meal preparation and practiced hand hygiene during handling of pureed and regular texture foods to prevent cross contamination. These failures could place residents who received prepared meals from the kitchen at risk for food borne illness and cross-contamination. The findings included: During an initial tour on [DATE] beginning at 09:14 AM of the one and only kitchen revealed: - 2 of 2 three compartment refrigerators observed contained 3 bowls of potato salad, a bowl of pea salad, 6 prepared bowls of oatmeal, 6 pureed egg and 6 pureed sausage bowls with a prepared date of [DATE]; none of the items were labeled to identify the item and did not contain the use-by date. Items were identified by DC K. - 1 of 1 walk in freezer contained a medium size vacuum sealed ground beef package with no use by date labeled, no printed manufacturer expiration date, and not in its original manufacturer packaging to identify its use by date. It also contained a medium clear zip seal bag of beef and bean burritos that was observed not properly sealed from air-borne contamination and with no use by date. In a follow up observation on [DATE] at 10:46 AM of the one and only kitchen revealed: DC K was observed preparing a pureed meal of chopped BBQ with bread. After removing the pureed mixture from the blender, DC K was observed setting the blender and its blade separately at the bottom of the soiled 1 compartment sink next to the food preparation area that contained other used dishes. DC K was then observed only rinsing the blender and the blade with water in the 1 compartment sink before proceeding to the second pureed item of the pureed beans which she gathered from the steamtable with the other regular textured food items. No soap or sanitizer was used on the blender. DC K was observed wearing 1 set of gloves from start to finish without changing them or washing her hands and touching the sink to rinse off equipment and participating in food preparation at the blender and the steamtable. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on [DATE] at 11:39 AM with DC K, she stated that use by dates have not been used because staff were just trained to throw out items after 3 days. She stated it was also the procedure to wash the blender with soap and water in between pureed items. She also stated she was supposed to change her gloves and wash her hands after touching the sink before returning to food preparation due to contamination. She stated a negative outcome of not sanitizing the blender or hand hygiene with hand washing and glove use would be it could get the residents sick or spread germs. In an interview on [DATE] at 01:14 PM with DM I she stated use by dates have not been used for a while. She stated they were used in the past and stopped because staff were just trained to throw out items by the 3rd day after they are prepared. She stated it was her expectation that if items were removed from the manufacturers packaging, they contained the use by date from the manufacturer so staff knew when it expires by. She said all items should be sealed to prevent contamination. DM I stated it was her expectation that the blender was sanitized in between usages via the dishwasher or there could be cross contamination of the items used. She stated it was also her expectation that staff washed their hands after touching anything that contaminates them and changing their gloves as well if they switch from one task to another and the gloves touch something that could contaminate them. She stated she monitored for compliance daily. In an interview on [DATE] at 12:37 PM with the ADM she stated food items delivered should be labeled with a received date, a date the item was opened, and an expiration date. She said items prepared in house should be labeled with a date it was made and a use by date of 3 days from the date prepared. She said it was her expectation that all food items stored in the freezer and refrigerator were properly sealed with a tight-fitting lid or in a zip seal bag. She stated a negative outcome of not being properly sealed would be the potential for bacteria, and not having a use by date could result in expired food making it to the residents which has the potential to make them sick. She stated it was her expectation that dietary staff are washing their hands before food preparation and changing their gloves as needed to prevent cross contamination. The ADM stated the blender should be cleaned and sanitized using the dishwasher as to also prevent cross contamination and illness. Review of the undated Handwashing Guidelines for Dietary Employees policy reflected: Policy: Handwashing is necessary to prevent the spread of bacteria that may cause foodborne illnesses. Dietary employees shall clean their hands in a handwashing sink or approved automatic handwashing facility and may not clean hands in a sink used for food preparation, dishwashing, or in a service sink used for the disposal of mop water or similar waste. 1. Dietary employees shall keep their hands and exposed portions of their arms clean. 2. Frequency of Handwashing: Dietary employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single service and single use articles and also in the following situations: a. Every time an employee enters the kitchen; at the beginning of the shift; after returning from break; after using the toilet. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. After hands have touched anything unsanitary i.e., garbage, soiled utensils/equipment, dirty dishes, etc. c. After hands have touched bare human body parts other than clean hands (such as face, nose, hair etc.). d. After coughing, sneezing, or blowing your nose, using tobacco products, eating, or drinking. e. After handling chemicals and before beginning to work with food. f. While preparing food, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. g. When switching between working with raw food and working with ready to eat food. h. Before donning gloves for working with food. i. After caring for or handling service animals or aquatic animals. j. After engaging in any activity that may contaminate the hands. Review of the undated Kitchen Sanitation and Cleaning policy reflected: Policy Statement: The food service area is maintained in a clean and sanitary manner. 1. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. 2. Manual washing and sanitating is a three-step process for washing, rinsing, and sanitizing: a. Scrape food particles and wash using hot water and detergent. b. Rinse with hot water to remove soap and residue; and c. Sanitize with hot water (at least 171 F for 30 seconds) or chemical sanitizing solution. Chemical sanitizing solutions (e.g. chlorine, iodine, quaternary ammonium compound) are used according to manufacturer's instructions. 3. Food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical. Drying food preparation equipment and utensils with at towel or cloth may increase risks for cross contamination. Review of the undated Date Marking for Food Safety policy reflected: Policy: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 2. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. 3. The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded. 4. The Dietary Manager, or designee, shall spot check refrigerators weekly for compliance, and document accordingly. Corrective action shall be taken as needed. Review of the 2022 U.S. Food and Drug Administration Food Code revealed: ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S ,d+[DATE].12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: P if (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; Of and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. ,d+[DATE].18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in ,d+[DATE].17(A) or (B) shall be discarded if it: (2) Is in a container or PACKAGE that does not bear a date or day; or ,d+[DATE].11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. FOOD shall be protected from cross contamination by: (4) Except as specified under Subparagraph ,d+[DATE].15(B)(2) and in (B) of this section, storing the food in packages, covered containers, or wrappings.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 47172 Based on interview and record review, the facility failed to implement the facility's Quality Assessment and Performance Improvement (QAPI) plan and program, in which data was to be gathered and analyzed, and plans of action were to be developed, implemented, and evaluated to address adverse events related to potential deficient practice for 1 of 1 QAPI programs reviewed. The facility failed to conduct at least one performance improvement project (PIP) annually that focused on high risk or problem prone areas identified by the facility, through data collection and analysis. This failure could place residents of the facility at risk of the facility not developing, monitoring and implementing corrective actions for identified areas of improvement. Findings include: In an interview on 05/01/2025 at 1:30 PM with the ADM and the DON regarding the facility's QAPI/QAA program, it was revealed that the facility did not conduct at least one PIP annually. The DON stated that they identify issues in their morning meetings and that issues are addressed as they come, so when an issue arises, she will conduct an in-service or CNA check-off with the staff. The ADM stated that she is responsible for the QAPI program and knows what a PIP is, but when she began with the facility, she saw how well the system [facility] was doing and did not want to change anything. Review of the facility's undated 2025- Quality Assurance & Performance Improvement (QAPI) Plan indicated, PIP and PIP Team Members The facility conducts PIPs to examine and improve care and/or services in specifically identified areas. PIPs are chosen based upon their importance and meaningfulness, in relation to the scope of services provided by the facility. The focus is on preventing problems and improving current systems and services. The facility seeks to prioritize projects in high risk, high frequency and/or problem prone areas that impact quality of care and quality of life for our residents and conducts one improvement project annually based on these areas.