STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview Nursing & Rehabilitation	1102 River Rd Boerne, TX 78006

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41937 Based on interviews and record reviews the facility failed to ensure allegations neglect were reported immediately, but not later than 24 hours if the events that caused the allegation do not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures, for 1 of 1 facility's reviewed for reporting allegations of abuse, neglect, exploitation. On 1/21/2025 the facility's exhaust fan, located in the women's memory care unit's pantry closet, began to produce large amounts of smoke, which caused staff to engage the fire alarm system, alerted the fire department, and staff used a fire extinguisher to extinguish the smoke from the exhaust fan. This failure could place residents at risk for not reporting allegations of ANE. The findings included: A record review of the Texas Unified Licensure Information Portal accessed 3/5/2025 revealed no report and or investigation for the 1/21/2025 incident. A record review of the facility's Facility Assessment for (the facility) dated 1/14/2025 revealed, Information About Our Physical Resources . fire alarm and sprinkler system: one system, fully functional, including fire extinguishers. During an interview on 3/06/25 at 6:44 AM CNA A stated she has worked at the facility for the past 6 months during the 6 AM to 6 PM shift in the Memory Care Unit (MCU). CNA A stated one day in January 2025, a fan caught fire in a closet in the women's MCU. CNA A stated she immediately alerted staff to include the ADON of the fire. CNA A stated she organized the 14 residents from the MCU to the MCU secured courtyard and took a census count to ensure all residents were evacuated. CNA A stated the MCU became filled with smoke, the fire alarm was sounding, and the fire department arrived and assisted staff to relocate residents back indoors to the safe lobby due to the cold winter weather. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/06/25 at 9:55 AM CNA B stated she had worked in the facility for the past 6 months in the men's MCU and recalled an evacuation event for the women's MCU due to a fire in the women's MCU in January 2025. CNA B advised surveyor to speak with CNA A due to her direct witness of the fire. During an interview on 3/06/25 at 10:04 AM CNA C stated she worked the women's MCU for the past 2 years and she was not on duty the day of the fire but did learn the women's MCU had a ceiling exhaust fan which caught fire and the fire department was dispatched. CNA C stated the fan was replaced and the closet repainted. During an observation on 3/6/2025 at 10:05 AM revealed the pantry closet in the women's MCU to have an exhaust fan. The fan appeared new and was running. During an interview on 3/06/25 at 10:32 AM LVN D, stated he was on duty from 6:00 AM to 6:00 PM the day the fire was in the women's MCU unit. LVN D stated he understood the ADON used the fire extinguisher on the exhaust fan and the residents were evacuated to the facility's lobby. LVN D stated the fire alarm sounded and the fire department arrived. LVN D stated the staff received an in-service for fire prevention and control and all women's MCU residents were assessed for safety. During a joint interview on 3/06/25 at 10:33 AM with the Administrator and the DON, the administrator stated he was on vacation the week when the fan smoked. The Administrator stated the Regional Director of Operations and the DON were on duty in the facility while he was away. The Administrator stated he learned the smoke incident was 1/21/2025 in the women's MCU. The Administrator stated the fire department was dispatched and used fans to evacuate the facility of smoke and checked the exhaust fan for a fire. The administrator stated the fire department cleared the building for safety and left. The administrator stated the DON and the RDO decided the incident was not eligible for a report to the state agency due the lack of any flames. The DON stated the incident was 1/21/2025, during the day. The DON stated she heard CNA A alert for a fire in the women's MCU and the ADON ran and used the fire extinguisher in the women's MCU's pantry. The DON stated she reviewed and ensured the 14 residents of the MCU were assessed for safety and reviewed and ensured 46 of the 46 staff received in-services, which included, the fire dept responded to the fire alarm, During an interview on 3/06/25 at 10:46 AM the RDO stated he had reviewed the smoke incident with his leadership and the decision was made the incident was not eligible to be reported to the state agency due to the lack of any flames. The RDO stated all the exhaust fans were inspected by the maintenance director, the local physical maintenance contractor, and the fire department. The RDO stated the fire suppression contractor inspected the fire suppression and alarm system, and the maintenance director replaced the exhaust fan. A record review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated September 2022, revealed, Policy Statement: All reports of Resident abuse (including injuries of unknown origin), neglect, exploitation, or theft / misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations arc documented and reported. Policy Interpretation and Implementation: (continued on next page)

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Riverview Nursing & Rehabilitation	1102 River Rd Boerne, TX 78006

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reporting Allegations to the Administrator and Authorities: l. If resident abuse, neglect. exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law and HHSC reporting guidelines. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; . 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury: or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on interviews and record reviews the facility failed to report the results of all investigations in response to allegations of abuse, neglect, exploitation (ANE), or mistreatment to the State Survey Agency, within 5 working days of the incident, for 1 of 1 facility's reviewed for investigating an alleged fire. On 1/21/2025 the facility investigated an alleged fire in the facility without a report to the state agency, when an exhaust fan in the women's Memory Care unit (MCU) produced a large amount of smoke, causing the fire alarm to activate and the local fire department response. This failure could place residents at risk for ANE. The findings included. A record review of the Texas Unified Licensure Information Portal accessed 3/5/2025 revealed no report and or investigation for the 1/21/2025 incident. A record review of the facility's Facility Assessment for (the facility) dated 1/14/2025 revealed, Information About Our Physical Resources . fire alarm and sprinkler system: one system, fully functional, including fire extinguishers. A record review of the facility's Quality Assessment and Performance Improvement Plan dated 1/21/2025 revealed the facility held an ad hoc Quality Assurance Improvement Plan (QAPI) meeting which included attendees: the Administrator, the Medical Director, the Director of nursing (DON), the Assistant Director of Nursing (ADON), the Minimum Data Set nurse (MDS) the Business Office Manager (BOM), the Human Resources Manager (HRM), the Director of Rehab (DOR), and the Activities Director (AD). Further review revealed, facility review; one to one in service with maintenance director on cleaning and checking exhaust fans, maintenance checklist daily. Inservice staff on fire safety and storage of items on top of fridge. Code drill followed. Residents on B hall were assessed for any respiratory issues 1/21/2025. (name of contractor) Fire inspection on 1/21/2025. (name of contractor for equipment) inspection on 1/21/2025. Ad hoc with the medical director. A record review of the facility's Training In-Service Form dated 1/21/2025 revealed 45 of 45 employees received the in-service training Fire Safety and Prevention which included, Policy Statement; All personnel must learn methods of fire prevention and must report condition(s) that could result in a potential fire hazard. Policy Interpretation and Implementation 1. Fire prevention is the responsibility of all personnel, residents, visitors, and the general public. 2. Whoever identifies a fire hazard, or other conditions that could develop into a fire hazard, must report the situation to the department director or maintenance director as soon as practical. 3. The following fire safety precautions must be followed in the facility at all times: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electrical Precautions: . 1. h. Do not use defective equipment. Overheating: . b. Keep filters on heating systems, dryers, etc., free of lint. All personnel must report observations of: . a. unusual odors or conditions; . b. malfunctioning equipment and supplies; c. any unusual incidents; d. sounding of false alarms A record review of the facility's Training In-Service Form dated 1/21/2025 revealed the ADON provided training for the Maintenance Director for Cleaning / Checking Exhaust Fans; Maintenance Checklist which included a form worksheet for monthly checking exhaust fans in the facility, A record review of the women's MCU census for 1/21/2025 revealed 14 residents, Further review revealed all 14 residents were assessed for respiratory distress which included Shortness of Breath (SOB). A record review of Resident #3s post incident safety assessment dated [DATE] revealed, 1/21/2025 5:25 PM, assessment performed resident with no SOB, cough or change from baseline. T 97.8, P 60, R 18, 106 / 67, 98% oxygen on room air. Resident denies pain or discomfort. Monitoring for safety. MD / RP aware. During an interview on 3/06/25 at 6:44 AM CNA A stated she has worked at the facility for the past 6 months during the 6 AM to 6 PM shift in the Memory Care Unit (MCU). CNA A stated one day in January 2025, a fan caught fire in a closet in the women's MCU. CNA A stated she immediately alerted staff to include the ADON of the fire. CNA A stated she organized the 14 residents from the MCU to the MCU secured courtyard and took a census count to ensure all residents were evacuated. CNA A stated the MCU became filled with smoke, the fire alarm was sounding, and the fire department arrived and assisted staff to relocate residents back indoors to the safe lobby due to the cold winter weather. During an interview on 3/06/25 at 10:32 AM LVN D, stated he was on duty from 6:00 AM to 6:00 PM the day the fire was in the women's MCU unit. LVN D stated he understood the ADON used the fire extinguisher on the exhaust fan and the residents were evacuated to the facility's lobby. LVN D stated the fire alarm sounded and the fire department arrived. LVN D stated the staff received an in-service for fire prevention and control and all women's MCU residents were assessed for safety. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview on 3/06/25 at 10:33 AM with the Administrator and the DON, the Administrator stated he was on vacation the week when the fan smoked. The Administrator stated the Regional Director of Operations and the DON were on duty in the facility while he was away. The Administrator stated he learned the smoke incident was 1/21/2025 in the women's MCU. The Administrator stated the fire department was dispatched and used fans to evacuate the facility of smoke and checked the exhaust fan for a fire. The administrator stated the fire department cleared the building for safety and left. The administrator stated the DON and the RDO decided the incident was not eligible for a report to the state agency due the lack of any flames. The DON stated the incident was 1/21/2025, during the day. The DON stated she heard CNA A alert for a fire in the women's MCU and the ADON ran and used the fire extinguisher in the women's MCU's pantry. The DON stated she reviewed and ensured the 14 residents of the MCU were assessed for safety and reviewed and ensured 46 of the 46 staff received in-services, which included, the fire dept responded to the fire alarm, During an interview on 3/06/25 at 10:46 AM the RDO stated he had reviewed the smoke incident with his leadership and the decision was made the incident was not eligible to be reported to the state agency due to the lack of any flames. The RDO stated all the exhaust fans were inspected by the maintenance director, the local physical maintenance contractor, and the fire department. The RDO stated the fire suppression contractor inspected the fire suppression and alarm system, and the maintenance director replaced the exhaust fan. A record review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated September 2022, revealed, Policy Statement: All reports of Resident abuse (including injuries of unknown origin), neglect, exploitation, or theft / misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations arc documented and reported. Policy Interpretation and Implementation: Reporting Allegations to the Administrator and Authorities: l. If resident abuse, neglect. exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law and HHSC reporting guidelines. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; . 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury: or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on interviews and record reviews the facility failed to ensure a comprehensive care plan was developed within 7 days after completion of the comprehensive assessment and reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 4 of 9 (#20, #28, #33, #35) residents reviewed for IDT meetings/ care plans in that: 1. The facility failed to review and revise Resident #28's care plan after the MDS assessment on 2/17/25. 2. The facility failed to review and revise Resident #35's care plan after the MDS assessment on 2/25/25 3.The facility failed to review and revise Resident #33's care plan after each assessment in 2023. 4. The facility failed to review and revise Resident #20 care plan after the MDS assessment on 3/3/24, 6/1/24, 9/1/24, 10/9/24 and 1/9/25. This could result in residents not receiving necessary care. The Finding were: Record review of the list of Residents that still required a care plan conference with the end date of 3/6/2025 reflected 22 residents, and included Residents #20, #28, #33, #35. 1. Record review of Resident #28's Admission Record dated 3/6/2025 reflected he was admitted on [DATE] and readmitted on [DATE] with diagnoses of Human immune deficiency virus, respiratory disease, herpes viral infection, muscle wasting, bipolar disorder, dementia, cognitive communication deficit , diabetes II, altered mental status, and acquired absence of right and left leg below the knee. Record review of Resident #28's Quarterly MDS assessment dated on 2/17/25 reflected his BIMS score was 10/15 (moderately cognitively impaired), he had no impairment to upper extremity, had impairment to both sides of lower extremity, and he used a wheelchair for mobility. Record review of Resident #28's care plan dated 10/15/2024 and there was no care plan conference after the MDS assessment on 2/17/25. Record review of Resident #28's assessments revealed two care plan conferences were held dated 8/20/2024 and 10/15/2024. There is no no evidence the IDT met to review/revise the care plan after the MDS assessment on 2/17/25. In an interview on 3/05/2025 at 11:41 AM, Resident # 28 stated he had not been invited to a care plan conference in a while. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #35's Admission Record dated 3/6/2025 reflected she was admitted on [DATE] and readmitted on [DATE] with diagnoses of cerebral infarction (stroke), hemiplegia and hemiparesis (paralysis or weakness), diabetes II (a chronic disease that affects how the body uses glucose (sugar) for energy), psychotic disorder with delusions. and chronic pain. Record review of Resident #35's significant change MDS assessment dated on 2/25/2025 reflected her BIMS score was 13/15 (cognitively intact), she had impairment on upper and lower extremity, and she used a wheelchair for mobility. Record review of Resident #35's care plan dated 2/22/2025 . Record review of Resident #35's three care plan conference were dated 11/16/2022, 8/14/2024 and 11/15/2024. No other evidence of care plan conferences / IDT met after these dates for Resident #35. In an interview on 3/05/2025 at 12:04 PM, Resident #35 stated she had not had a care plan conference every 3 months and does not remember when she had the meeting. 3. Record review of Resident #33's Admission Record dated 3/7/2025, reflected he was admitted on [DATE], and readmitted on [DATE] with diagnoses of Parkinson's disease (a progressive neurodegenerative disorder that affects movement, balance, and coordination) schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder), anxiety, and delusional disorders. Record review of Resident #33's Quarterly MDS assessment dated [DATE] reflected his BIMs score was 14/15 (cognitively intact), he had 2 impairments to lower extremity and used a wheelchair/walker for mobility. Record review of Resident #33's care plan was dated 2/7/2025. Record review of the MDS Assessments for 2023 the care plan should have been reviewed/revised by IDT/care plan conference. Record review of Resident #33 had three care plan conferences dated 12/20/2022, 4/12/2024 and 2/7/2025. No IDT/care plan conferences for year 2023. 4. Record review of Resident #20's Admission Record dated 3/7/25 revealed Resident #20 admitted to the facility on [DATE] and readmitted [DATE]. Diagnoses listing revealed diagnosis of encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition), schizoaffective disorder bipolar type (a mental health condition that combines symptoms of schizophrenia (a chronic mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interacitons) and bipolar disorder (a mental condition characterized by extreme mood swings, including perioeds of intense hights and lows)), Major depression disorder, hypotension (low blood pressure), EPS (a group of movement disorders caused by certain medications), Vit. D deficiency, anxiety, age related nuclear cataracts, orthostatic hypotension (a condition in which blood pressure drops significantly when a person stands up from a sitting or lying position), hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #20's Quarterly MDS assessment dated [DATE] revealed she has a BIMs score of 6/15 indicating severe cognitive impairment and she required set up assistance with self-feeding, upper body dressing, supervision with toilet hygiene, lower body dressing and moderate assistance in bathing, personal hygiene. Record review of Resident #20's MDS schedule revealed Annual MDS dated [DATE], Quarterly MDS completed 6/1/24, Quarterly MDS dated [DATE], Significant change in status MDS dated [DATE], and Quarterly MDS dated [DATE]. Based on completed Conference Reports, facility failed to review and revise care plan after a comprehensive and quarterly review assessments completed 3/3/24, 6/1/24, 9/1/24, 10/9/24 and 1/9/25. Record review revealed a Care Conferences were completed 7/24/24 and 10/25/24. No evidence of care plan conferences and care plan revision for 2023. No evidence of care plan revision completed within 21 days of MDS assessments. Care plan revision date 1/23/25. In an interview on 3/07/2025 4:07 PM the SW stated she had just started working and was catching up on resident care plan conferences. The SW stated she had a plan to finish the care plan conference and be up to date on 3/28/2025. In an interview on 3/07/2025 at 10:12 AM, the MDS Nurse stated they missed the care plan conferences, but they do have a plan and know they are late on care plan conferences. The MDS Nurse stated they will include care plan conferences as part of their routine audits and a complete audit will be done by 3/28/2025 for all residents. In an interview on 3/07/2025 at 11:30 AM, the ADM stated he was not aware the resident care plan conferences were not being done as scheduled. The ADM stated the resident care plan conferences would need to be done timely, and devise a plan and start over with a new rotation. Review of facility policy named Care Plans, Comprehensive Person-Centered, Comprehensive Assessments and comprehensive Care Plans, revised March 2022 reflected 12. The interdisciplinary team reviews and updates the care plan: d. where there has been a significant changein the resident's condition, a. when the resident has been readmitted to the facility from a hospital stay; and b. at least quarterly.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50531 Based on observation, record review and interview, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for 1 of 8 residents (Resident 35) reviewed for nursing services. The facility failed to follow physicians' orders to monitor for edema (swelling caused by fluid building up in body tissue) for Resident #5 as ordered on 4/30/24. This failure could place residents at risk for not receiving appropriate care and treatment and/or a decline in their health. Findings included: Record review of Resident #5's Admission Record dated 3/7/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted [DATE]. Diagnoses listing revealed DMII (Diabetes Type 2, a chornic metabolic disorder characterized by high blood sugar levels due to insulin resistance and/or deficiency), COPD (a group of lung diseases that cause ongoing breathing problems), MDD (Major Depressive Disorder), Anxiety, Hyperlipidemia (elevated lipid levels in the blood which can increase the risk of heart disease), Heart Disease, Dysphagia (difficulty swallowing), Seizures, (temporary disruptions in brain electrical activity), Bilateral age-related cataracts, Myopia (nearsightedness), Dementia (a decline in mental ability severe enough to interfere with daily life) , Alzheimer's Disease (progressive, neurodegenerative disorder tha primarily affects memory, leading to a decline in cognitive function and eventually impacting daily activities). Record review of Resident #5's current Quarterly MDS dated [DATE] revealed a BIMS Score of 4 indicating severe cognitive impairment. Resident #5 required set up assistance in self-feeding, supervision with upper and lower body dressing, moderate assistance in bathing, personal hygiene, and maximum assistance in toilet hygiene. Record review of Resident #5's care plan last reviewed/revised 2/19/25 revealed problem identification of potential for complications, s/sx related to diagnosis of COPD. Approaches included administer medications as ordered and monitor for side effects, administer oxygen as ordered, assess/record/report to MD prn: anxiety, restlessness, SOB, wheezing, dyspnea (difficulty breathing), respiration rapid or shallow, cough cyanosis (coughing resulting in a bluish discoloration of the skin around lips and fingertips indicating there is not enough oxygen in the blood to support the body's tissues), confusion, altered mental status, fatigue, headache, encourage adequate fluid intake, provide extra fluid on meals trays, encourage physical mobility, exercise as tolerated, monitor V/S as ordered, nebulizer treatments and/or inhalers as ordered, obtain and monitor lab / diagnostic work as ordered. Record review of Resident #5's physicians order dated 4/30/24 revealed order for edema checks: Check extremities Q shift and report to MD any abnormalities. Observation of Resident #5 on 3/5/25 at 10:00 AM, 3/5/25 at 3:35 PM and 3/6/25 at 10:45 AM revealed no noted edema. Resident #5 is alert, pleasantly confused and a poor historian. Unable to conduct interview regarding edema. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's March 2025 MAR revealed resident was not being monitored for edema. During an interview on 3/6/25 at 1:30 PM, LVN D stated that he used to monitor edema on the MAR for this resident but has not done it in a long time. LVN D stated he checks for edema but does not document it on a MAR or in progress notes. LVN D stated, sudden increase in edema could cause problems. During an interview on 3/6/25 at 2:00 PM, the ADON revealed order was put in the EMR system inaccurately and should have been linked to the HCTZ order. ADON stated order has been corrected and is now on the nurse's MAR to monitor. During an interview on 3/6/25 at 2:15 PM, the DON stated failure to monitor edema could result in exacerbation of disease process with shortness of breath, elevated heart rate or possibly death if left unmonitored. The DON said the expectation of nursing staff is to monitor this resident for edema and follow physicians orders. Requested Policy &Procedures for following physicians orders on 3/7/25 at 10:45 a.m., did not receive.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 26869 Based on observations, interviews, and record review the facility failed to provide food that was palatable, and at a safe and appetizing temprature for 1 of 1 test tray. 1. Test tray was not hot and lukewarm. 2. No food temperatures were logged for lunch. These failures could affect all residents who ate their meals prepared by the facility kitchen by placing them at risk of weight loss, altered nutritional status, and diminished quality of life. The findings were: 1. In an observation on 3/06/2025 at 1:17 PM of a lunch test tray, revealed the chicken patty melt was not hot, but lukewarm. 2.In an interview on 3/06/2025 at 1:33 PM, DM U stated the test tray was taken from staff and went directly to the conference room, near the kitchen. DM U said to write down the food temperature on the food temperature log for lunch to Dietary Aide L. In an interview on 3/6/2025 at 1:35 PM, Dietary aide L stated he did take the food temperatures for lunch and wrote them on a piece of paper. Dietary aide L stated he was washing dishes and the piece of paper got wet and he misplaced it. Dietary aide L stated were at a good temperature and he did not document on the food temperature log. In an interview on 03/06/2025 at 1:42 PM, the Dietician consultant stated she would educate staff on keep food temperatures in a food log for every meal, in the kitchen. In an interview on 3/06/2025 at 1:16 PM, Resident #28 stated his food was not hot, but he just ate because he was hungry. In an interview on 3/06/2025 at 2:43 PM, Resident #44 stated his food was not hot. Record review of the Food temperature log was blank for lunch meal dated 3/6/2204. Record review of Policy dated November 2002, Food Preparation and Service, Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices. General Guidelines 3. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Food Distribution and Services 2. The temperature for foods held in steam tables are monitored throughout the meal service by food and nutrition services staff.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 26869 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 for 1 of 1 kitchen in that: 1. Food containers in the storage room, rice container lid was open and had a smaller container. The flour container lid was not tightly closed. The flour container was on a shelf, underneath the shelf of the flour container was on had a rat trap box. 2. DM Q was not wearing a hairnet while in the kitchen. 3. Dietary aide L was not wearing gloves while placing chicken patties in the deep fryer oil. These failures could place residents at risk for food borne illness. The Findings were: 1. Observation on 3/05/2025 at 9:25AM in the kitchen revealed in the storage room, a rice container on a shelf. The lid was open and there was a smaller container in the rice container. The lid of the flour container on the shelf was not tightly closed. Under the shelf was a rat trap box. Interview on 3/05/2025 at 9:25AM with DM R confirmed the rice container was open with a smaller container in it. , The flour container lid was not tight, and the rat trap at the bottom of shelf above the flour container . DM R stated the containers need to be closed to keep pests away and containers cannot be in the food buckets due to contamination. DM R stated he was not sure why the rat trap box was under the food storage containers, after observation. 2. Observation on 3/5/2025 at 4:30 PM revealed DM Q was in the kitchen about to take food temperatures. DM Q was not wearing a hairnet in the kitchen. Interview on 3/5/2025 at 4:32 PM with DM Q confirmed she was not wearing a hairnet in the kitchen; she had just come in from outside . 3. Observation on 3/5/2025 at 11 AM revealed Dietary aide L was not wearing gloves while putting chicken patties in the deep fryer. Interview on 3/5/2025 at 10:59 AM with Dietary L had no response to not wearing gloves while handling food in the kitchen. In an interview on 03/06/2025 at 1:42 PM, the Dietician consultant stated she would educate staff on wearing gloves while handling food, wearing hairnets, keeping containers closed, and that no containers should have containers in them. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Policy dated November 2022, Food Receiving and Storage, Foods shall be received and stored in a manner that complies with safe food handling practices. Dry Food Storage 1. Non-refrigerated foods, .are stored in a designated dry storage unit which is temperature and humidity controlled, free of insects and rodents and kept clean. 5. Other opened containers are dated and sealed or covered during storage. Record review of Policy dated November 2002, Food Preparation and Service, Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices. General Guidelines 3. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Food Distribution and Services 7. Bare hand with food is prohibited. gloves are worn when handling food directly and changed between task. 8. Food and nutrition service staff wear hair restraints, so that hair does not contact food.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observation, interview and record review the facility failed to ensure storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption 1 of 1 (#35) residents' personal refrigerator in that: Resident #35's personal refrigerator had 3-4 Styrofoam empty cups with mold in them. This failure could affect residents by placing them at risk for food borne illness. Findings included: Observation on 3/04/2025 at 10:36 AM in Resident #35, revealed her personal refrigerator had 3-4 Styrofoam empty cups with mold in them. Resident #35 was asleep at the time and had just came back from the hospital. Interview on 3/4/2025 at 10:37 AM with the DON stated Resident #35's personal refrigerator had 3-4 Styrofoam empty cups with mold in them. The DON stated the resident personal refrigerators were cleaned periodically by staff. asked for policy. Interview on 3/06/2025 at 12:01 PM with ADM stated he was aware of Residents #25's personal refrigerate had empty cups with mold in them. The ADM stated the cups were thrown away. Record review of policy, Foods brought by Family/Visitors, dated March 2022 was documented Food [NAME] to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. 6. The nursing staff will discard perishable foods on or before the use by date. 7. Potentially hazardous foods that are left out for resident without a source of refrigeration longer than 2 hours are discarded.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. 26869 Based on observations, interviews and record review the facility failed to ensure the Dispose of garbage and refuse properly for 1 of 1 facility in that: The dumpster door on the left side was open. This deficient practice could place residents at risk for exposure to germs and diseases carried by vermin and rodents. The findings were: Observation on 3/6/2025 at 10:50 AM revealed the door on the left side, was open on the dumpster. Interview on 3/6/2025 at 10:54 AM Maintenance Director stated the the dumpster outside side, door was open. The Maintenance Director stated he told staff all the time to make sure the dumpster doors were closed, and stated he posted the staff need to close the doors to dumpster. The Maintenance Director stated if the door to dumpster were left open and can create more pest coming around. Interview on 3/06/25 at 12:11 PM ADM stated he was not aware the dumpster door was left opened. The ADM stated this could lead to lead to pest/rodents. Record review of policy dated November 2022 Sanitization, . 14. Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpster with lids. 15. Areas used for garbage disposal are free from odors and waste fats, and maintained to prevent pest. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 5-501.113 Covering Receptacles. Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered: (B) With tight-fitting lids or doors if kept outside the food establishment. 5-501.114 Using Drain Plugs. Drains in receptacles and waste handling units for refuse, recyclables, and returnables shall have drain plugs in place.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews the facility failed to ensure the establishment and maintenance of an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections to include standard and transmission-based precautions to be followed to prevent spread of infections, for 2 of 8 residents (Residents #16 and #162) reviewed for Enhanced Barrier Precautions (EBP). 1. On 3/6/2025 CNA I provided catheter care to Resident #16 while not donning Personal Protection Equipment (PPE). 2. On 3/5/2025 CNA J provided incontinent care for Resident #162 while not donning PPE. These failures could place residents at risk for cross contamination and spread of communicable diseases. The findings included: 1. A record review of Resident #16's Face Sheet record dated 3/6/2025 revealed an admitted [DATE] with diagnoses which included obstructive uropathy (a blockage that prevents urine from flowing naturally through the urinary system). A record review of Resident #16's quarterly MDS assessment dated [DATE] revealed Resident #16 was a [AGE] year-old male admitted for long term care and was assessed with a BIMS score of 11 out of a possible 15 which indicated mild cognitive impairment. further review revealed Resident #16 could make himself understood and could understand others, had adequate vision to see large print and had adequate hearing. Further review revealed Resident #16 needed assistance with his urinary catheter (an indwelling tube into the bladder through the urethra), Toileting hygiene: the ability to maintain perineal hygiene, adjust close before and after using the toilet, commode, bedpan, or urinal. substantial maximal assistance - helper does more than half the effort. does the resident use a wheelchair . yes . bladder and bowel indwelling catheter, yes . urinary continence - resident had a catheter A record review of Resident #16's physicians' orders dated 3/6/2025 revealed the physician ordered for Resident #16 to receive EBP care. A record review of Resident #16's care plan dated 3/7/2025 revealed, Resident has a DX of Urinary Tract Infection & is at risk for complications. Perform catheter care as indicated. (See Indwelling Urinary Catheter Care Plan) . Report signs of UTI (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain, difficulty urinating, low back/flank pain, malaise, nausea/vomiting, chills, fever, foul odor, concentrated urine, blood in urine). Infection - There is risk for developing and/or spreading infection related to: Indwelling Urinary Catheter . Enhanced Barrier Precautions will reduce risk of the spread of organisms . Utilize enhanced barrier precautions as ordered Every Shift; Created: 08/01/2024 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 03/06/25 05:50 AM CNA I assisted Resident #16 seated in his wheelchair into the shower room, where CNA I performed hand hygiene and donned gloves. CNA I handled Resident #16's urine collection bag and drained the bag of urine. CNA I measured 1300ml of urine. CNA stated Resident #16 had an indwelling urinary catheter and Resident #16 needed assistance to drain the urine. CNA I stated he was not aware of Resident #16's EBP and believed the use of gloves was sufficient for infection control. 2. A record review of Resident #162's face sheet dated 3/6/2025 revealed an admitted [DATE] with diagnoses which included malignant neoplasm of sigmoid colon (colon cancer, and colostomy status (a surgical opening on the belly, needed because a problem is causing the colon to not work properly, or a disease is affecting a part of the colon and it needs to be removed. The end of the colon (large intestine) is brought through this opening in the skin to form an opening.) further review revealed Resident #162 was a [AGE] year-old female. A record review of Resident #162's physicians' orders dated 3/6/2025 revealed the physician ordered for Resident #162 to receive EBP care. A record review of Resident #162's care plan dated 3/6/2025 revealed, Infection - There is risk for developing and/or spreading infection related to: Colostomy Status - Created: 03/03/2025 . Enhanced Barrier Precautions will reduce risk of the spread of organisms . Utilize enhanced barrier precautions as ordered During an observation and interview on 3/06/25 at 2:10 PM revealed Resident #162's door to her room presented without signage to indicate any EBP precautions. Observation in the room revealed CNA J with Resident #162, Resident #162 laid in bed while CNA J wore gloves and assisted with Resident #162's incontinent care. CNA J had not donned a gown for PPE. CNA J stated resident #162 had a colonoscopy. CNA J stated she was confused on resident #162's status because she had not seen any EBP signage on the door. CNA J stated she had been trained to wear EBP PPE to include the use of gloves and a gown during check and change for a resident with EBP precautions. CNA J stated the risk for residents was cross-contamination of infectious diseases. During an interview on 3/06/25 at 1:10 PM the DON stated the expectation was for residents with colostomy bags and or indwelling urinary catheters to be cared for under EBPs, specifically, at a minimum, for staff to DON PPE to include a gown and gloves. A record review of the United States of America's Centers for Disease Prevention and Control's website titled Enhanced Barrier Precautions in Skilled Nursing Facilities https://www.cdc. gov/infection-control/media/pdfs/Webinar-EBPinNH-Nov2022-Slides-508.pdf accessed 3/6/2025, revealed, What are Enhanced Barrier Precautions (EBP)? A risk-based approach to PPE use designed to reduce the spread of multidrug-resistant organisms (MDROs). The use of a gown and gloves during high-contact Resident care activities for residents at high risk of colonization* with an MDRO to disrupt spread. Expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated. Used in coordination with good infection prevention and control measures. What are High-Contact Resident Care Activities? . Changing Briefs or Assisting with Toileting . When Should I Use Enhanced Barrier Precautions? . Residents with any of the following: . Indwelling medical devices (e.g., ., urinary catheter, .)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 26869 41937 Based on observations and interviews the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition, for 1 of 1 facility's reviewed for maintenance and operation of essential equipment. 1. Laundry facility essential equipment was not operational. a. 2 of the 3 commercial clothing dryers were not operational. b. 1 of the 2 commercial clothing washers was not operational. c. 1 of the 1 Heating, ventilation, and air-conditioning (HVAC) system for the laundry facility was not operational. 2. The stove and deep fryer were not restrained. Deep fryer back right-side leg was propped up by wood. These failures could place residents at risk for neglect and not having their needs met. The findings included. During an observation 3/06/25 at 1:20 PM of the facility's laundry department revealed the departments HVAC system not operational, 2 of the 3 dryers were not operational, and 1 of the 2 washers was not operational. During an interview 3/06/25 at 1:24 PM with LA K stated she had been an employed as the laundry aide for the last year. LA K stated the laundry department has installed 3 commercial dryers, 2 commercial washers and 1 HVAC system. LA K stated the HVAC system was inoperative for the winter and has malfunctioned again after a recent repair. LA K stated of the 3 dryers only 1 was operational and of the 2 washers only worked. LA K stated her ability to produce clean clothes was challenging with only 1 dryer and washer. LA K stated the Maintenance Director was aware of the equipment failure and had provided a small window air-conditioner for the dryer room but not the washer room. LA K stated the dryers and washer were broken for longer than 4-5 months. During an observation and interview on 3/06/25 at 1:55 PM the Maintenance Director toured the Laundry Department and stated the dryers were not operational and recently the 1 dryer was repaired and now functions. The maintenance director stated the HVAC system could not be maintained due to excessive coolant gas leaks. The Maintenance Director stated only 1 of the 2 commercial washers was operational. During an interview on 3/07/25 at 11:43 AM the Administrator stated he was aware of the malfunctioning laundry equipment and has not been able to replace the equipment. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on 3/5/2025 at 4:35 PM in the kitchen, revealed the deep fryer next to the stove was missing a leg on the far-right side. The Deep fryer far right-side leg had a piece of wood under it. Observation of the stove and deep fryer were not restrained. Interview and Observation on 3/5/2025 at 11 AM with dietary aide L was at the deep fryer cooking chicken Pattie, he said the piece of wood was under the deep fryer to keep it balanced. Interview on 3/06/2025 at 11:23 AM with kitchen vendor M stated the piece of wood under the deep fryer, between the stove, should not be there. The vendor stated the piece of wood was not a good conductor and could cause fire if grease spilled on the piece of wood. Interview and Observation on 3/6/2025 at 10:54 AM with Maintenance Director stated he stated he placed the piece of wood under one of the legs of the deep fryer to keep it balanced and he knows he should have used a brick, instead of wood. The Maintenance Director stated the piece of wood placed under leg of deep fryer could cause a fire. The Maintenance Director stated the stove and deep fryer were not restrained and should have been. This could cause the stove and deep fryer to move forward causing an accident with kitchen staff. Interview on 3/06/25 at 12:11 PM with ADM stated he was not aware of the piece of wood under the deep fryer leg and could cause fire. Record review of Sanitation policy dated November 2022 documented 2. All .equipment are maintained in good repair. A policy for maintenance and operation of essential equipment was requested on 3/6/2025 and was not provided.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 26869 50531 Based on observations and interviews, the facility failed to provide a safe, functioning, and comfortable environment for residents, staff and public for A wind and B wing in that: 1. The window blinds in three windows in the A Wing common room were broken. 2. The B wing shower tile on ground had mold and the shower curtain had mold spots. This failure could affect residents by placing them at risk for diminished quality of life due to the lack of a well-kept environment. Findings included: 1. Observation Rounds on 3/4/25 at 9:35 AM of A Wing common area revealed three windows with missing, broken, or bent window blind slats. During an interview on 3/5/25 at 10:30 AM, LVN B stated he would put the concern in the maintenance logbook. During an interview on 3/6/25 at 1:40 PM, Administrator stated, we routinely purchase window blinds due to the male unit frequently breaking blinds and replace them at each occurrence. 2. Observation on 3/04/25 at 10:24 AM in the secure B wing revealed the tile floor had mold and the shower curtain had spots of mold. Interview on 3/4/2025 at 10:25 AM in the B wing shower room, with CMA/CNA N stated black substance along the tile floor and black spots on the curtain in multiple areas. Interview on03/04/2025 at 10:32 AM with Housekeeper O stated the B wing shower was cleaned yesterday. The Housekeeper O stated he was not aware of mold on the tile floor and on the shower curtain. Housekeeper stated he cleaned mold with bleach, HSK O stated the black substance on tile and shower was mold. HSK O stated mold can cause illness to residents. Record review of policy, Cleaning and Disinfecting of Environmental Surfaces, dated August 2019 was documented Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA bloodborne pathogens standards. C non-critical items are those that come in contact with the intact of skin but not mucous membranes. 1, Non environmental surface include furniture and floors. 1, most non c-critical items cand be decontaminated where they are used. 11. Walls, blinds and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled. Facility maintenance policy was not provided at time of exit.