STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675379	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havencare Nursing and Rehabilitation Center LLC	111 Ruthlynn Dr Longview, TX 75601

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 ased on interview and record review the facility failed to provide respect, dignity, and care in a manner and in an environment that promoted maintenance or enhancement of quality of life for 1 of 18 residents reviewed for resident rights. (Resident #178) The facility failed to treat Resident #178 with respect and dignity when staff told her to urinate in her brief. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth. Findings included: Record review of the face sheet dated 07/17/24 revealed Resident #178 was [AGE] years old female and admitted on [DATE] with diagnoses including Unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), insomnia (persistent problems falling and staying asleep) and Parkinsonism (brain conditions that cause slowed movements, rigidity (stiffness) and tremors). Record review of the MDS dated [DATE] revealed Resident #178 BIMS was not performed and required maximal assistance for toilet use and moderate assistance for transfers, dressing, personal hygiene, and bathing. Record review of the care plan dated 04/04/24 revealed Resident #178 was at risk for skin breakdown/pressure injury related to decreased mobility and incontinence. Interventions included: Complete Braden assessment for early identification of risk factors and interventions. Nursing assistants to examine resident's skin daily for signs of redness or discoloration especially areas prone to breakdown such as boney prominences. Provide peri-care after each incontinent episode. Monitor labs per physician orders. (Especially albumin and pre-albumin) (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide nutritional assessment per RD and administer vitamins/supplements/medications as ordered by MD. Licensed Nurse to complete skin checks weekly. During an interview on 07/15/24 at 6:48 PM, Family Member #1 of Resident #178 said she was on the phone with Resident #178 when she heard a staff member told her to urinate on herself. Family Member #1 said she called the nursing station to get Resident #178 assistance to the bathroom when staff would not answer Resident #178's call light. Family Member #1 said Resident #178's roommate heard the staff tell her to urinate in her brief. Family Member #1 said she took Resident #178 home that night from the facility. During an interview on 07/16/24 1:45 PM, Resident #13 said she remembered Resident #178. Resident #13 said staff always tried to help her, but she refused their help. It depends on which time of day it waws with the accuracy of how long it would take for someone to come help her. Resident #13 said when Resident #178 told staff she had to use the bathroom, the staff would take her and she would not be able to urinate for about 30-45 minutes with staff waiting, so staff told her to go in her brief and they would change her. Resident #13 said one night Resident #178 called Family Member #1 and she came to get her, then took her home. Resident #13 said she thought the facility took care of Resident #178 while she was in the facility, but she was very difficult to take care of. During an interview on 07/16/24 at 1:59 PM, Family member #2 said Resident #178 called Family Member #1, because she had called for staff to assist her to the bathroom, but no one came. Family Member #2 said Family Member #1 told her that a staff member told Resident #178 to urinate in her brief. Family Member #2 stated she assisted Family Member #1 with transferring Resident #178 to the car, to go home. Family member #2 said Resident #178 cried when she got in the car, because she said the staff member told her to urinate in her brief. During an interview on 7/17/24 at 9:06 AM, RN L said he remembered Resident #178 leaving the facility. RN L said there was nothing the staff or the facility could do was satisfactory to the resident or the family. RN L said at night Resident #178 was on the call light nonstop, calling for items she could do on her own, like turn the light on and turn the light off. RN L said Family Member #1 told him she was taking Resident #178 home, because we could not provide adequate care for her at the facility. RN L said he remembered if she needed to go to the restroom the staff would take her. RN L said he does not recall telling Resident #178 to urinate in her brief. RN L said he did remember telling Resident #178 if she did wet her brief, he would change her brief. RN L said he remembered a couple times taking Resident #178 to the bathroom and she was very weak, so changing her brief was probably a safety precaution. During an interview on 7/17/24 at 2:57 PM, the DON said a staff member should never encourage a resident to urinate in their brief if they were aware of when they need to go to the bathroom. The DON said if a staff member told a resident to urinate on themselves, that was a dignity issue and potential for skin breakdown. During an interview on 7/17/24 at 3:15 PM, ADM said it is not ok for a staff member to tell a resident to urinate in their brief. We want the residents to stay independent as long as possible. If it were me, I would feel like they would not want to help me. I feel I am an adult, and it is a huge blow to your dignity, and it would make me feel like staff did not have time for me. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility resident admission agreement dated 12/1/23 revealed . the facility shall offer personal care . the facility will also offer nursing care, activities, restorative and rehabilitative services and psychosocial care as identified by the Resident's Plan of Care established by the Facility Standards and in accordance with the policies of the facility.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35295 Based on interviews and record review the facility failed to ensure residents have the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives and to choose the option he or she prefers for 5 of 21 residents reviewed for the right to be informed. (Resident's #21, #31, #33, #35, and #69) 1. The facility failed to ensure Resident #21 had a signed psychotropic consent form for Duloxetine (antidepressant medication) or Haloperidol (antipsychotic medication). 2. The facility failed to ensure Resident #31's psychoactive (substances that, when taken in or administered into one's system, affect mental processes) medication therapy consent was completed for Depakote (is used to treat seizure disorders, certain psychiatric conditions (manic phase of bipolar disorder), and to prevent migraine headaches). 3. The facility failed to ensure Resident #33's psychoactive medication therapy consent was completed for Seroquel (is an antipsychotic medication that treats several kinds of mental health conditions including schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs)). 4. The facility failed to ensure Resident #35's psychoactive medication therapy consent was completed for Paroxetine (is used treat depression (is a mood disorder that causes a persistent feeling of sadness and loss of interest), obsessive-compulsive disorder (is a long-lasting disorder in which a person experiences uncontrollable and recurring thoughts (obsessions), engages in repetitive behaviors (compulsions), or both) and anxiety disorders (persistent and excessive worry that interferes with daily activities)). 5. The facility failed to ensure Resident #69's psychoactive medication therapy consent was completed for Hydroxyzine (is used to treat anxiety disorders and allergic conditions, especially those that involve the skin) and Mirtazapine (is an atypical antidepressant (are prescription medicines to treat depression) and is used primarily for the treatment of a major depressive disorder (is a mood disorder that interferes with daily life)). These failures could place residents at risk for treatment or services provided without their informed consent. Findings included: 1 .Record review of the undated face sheet revealed Resident #21 originally admitted [DATE] and readmitted [DATE]. She was an [AGE] year-old female. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the quarterly MDS dated [DATE] revealed Resident #21 understood others and was understood by others. She had a BIMS of 14 indicating her cognition was intact. The MDS revealed she had disorganized thinking that fluctuated in severity. She had a diagnosis of Schizophrenia. The MDS indicated she was taking an antipsychotic and antidepressant. Record review of the care plan dated 1/30/24 indicated Resident #21 had a potential for complications related to antipsychotic medication with a goal of stabilizing major psychiatric diagnosis, minimize agitated behaviors, and would not have side effects. Resident #21 had an alteration in thought process, memory impairment and confusion related to dementia .with paranoia/delusions (frequently speaks of her husband as having an affair, will say it is staff members at times,) history of behaviors, verbal and physical aggression, anger and wandering. She had a potential for psychotic behavior with a diagnosis of psychosis related to Schizophrenia. Record review of the physician's orders dated 7/17/24 revealed Resident #21 had diagnoses that included: dementia with behavioral disturbance (loss of cognitive functioning, including restlessness and accusatory behaviors), Parkinsonism (brain conditions that cause slowed movements, rigidity and tremors), and schizoaffective disorder (hearing voices, unusual beliefs, depression or mania). Further review of the orders included the following medications: *7/8/24 Duloxetine HCL Oral Capsule Delayed Release, give 1 capsule by mouth two times a day related to unspecified dementia, moderate, with other behavioral disturbance. *7/8/24 Haloperidol oral tablet 0.5 mg by mouth at bedtime related to unspecified dementia, moderate, with other behavioral disturbance. Give with 1 mg tablet for a total of 1.5 mg. *7/8/24 Haloperidol oral tablet 1 mg by mouth at bedtime related to unspecified dementia, moderate, with other behavioral disturbance. Give with 0.5 mg tablet for a total of 1.5 mg. During an interview on 07/17/24 at 2:26 PM, the DOO said they could not find the consents for Resident #21's Duloxetine or her Haloperidol. He said there was a problem with consents, and they were currently doing an audit. 44933 2. Record review of Resident #31's face sheet dated 07/16/24, indicated Resident #31 was an [AGE] year-old female admitted on [DATE] with diagnoses including pseudobulbar affect (is a condition that's characterized by episodes of sudden uncontrollable and inappropriate laughing or crying), depression, anxiety disorder, and mood affective disorder (is a mental health condition that primarily affects your emotional state). The face sheet indicated Resident #31 family members were her responsible party. Record review of Resident #31's quarterly MDS assessment dated [DATE], indicated Resident #31 was sometimes understood and sometimes had the ability to understand others. Resident #31 was unable to complete the BIMS assessment. Resident #31 had short-and-long term memory recall problem and moderately impaired cognitive skills for daily decision making. Resident #31 was prescribed an antianxiety during the last 7 days of the assessment period. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #31's care plan dated 12/28/23, edited on 06/19/24, indicated Resident #31 had potential for drug related complication related to anxiolytic /sedative medications. Intervention included monitor side effects. Record Review of Resident #31's order summary report dated 07/16/24 indicated Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 mg, give 1 capsule by mouth two times a day for anxiety/agitation. Start date 07/05/24. Record review of Resident #31 MAR dated 07/01/24-07/31/24 indicated Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 mg, give 1 capsule by mouth two times a day for anxiety/agitation. Order date 07/05/24. On 07/17/24 at 12:57 p.m., requested Resident #31's Depakote consent from ADM and Regional DOO by email. Resident #31's consent was not received prior or after exit. 3. Record review of Resident #33's face sheet dated 07/16/24, indicated Resident #33 was a [AGE] year-old female admitted on [DATE] with diagnoses including depression, dementia (is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and bipolar disorder. Resident #33's face sheet indicated a family member was her responsible party. Record review of Resident #33's quarterly MDS assessment dated [DATE], indicate Resident #33 was usually understood and sometimes had the ability to understand others. Resident #33's BIMS score was 09 which indicated moderately impaired cognition. Resident #33's MDS indicated she had been prescribed an antipsychotic, antianxiety, and antidepression during the last 7 days of the assessment period. Record review of Resident #33's care plan dated 12/01/23, edited on 06/04/24 indicated Resident #33 had potential for drug related complication related to psychotropic drug use related to medical diagnoses of depression, bipolar, and insomnia. Resident #33 received antianxiety medication, antidepressant medication, and antipsychotic medication. Intervention included obtain consent for psychotropic drug use. Record review of Resident #33's order summary dated 07/17/24, indicated the following medications : *Seroquel Oral Tablet 25 mg, give 1 tablet by mouth one a day related to bipolar disorder. Start date 05/14/24. *Seroquel Oral Tablet 50 mg, give 1 tablet by mouth at bedtime related to depression. Start date 05/14/24. Record review of Resident #33's MAR dated 07/01/24-07/31/24 indicated: *Seroquel Oral Tablet 25 mg, give 1 tablet by mouth one a day related to bipolar disorder. Order date 05/14/24. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Seroquel Oral Tablet 50 mg, give 1 tablet by mouth at bedtime related to depression. Order date 05/14/24. On 07/17/24 at 8:34 a.m., requested Resident #33's Seroquel consent from ADM and Regional DOO by email. Resident #33's consent was not received prior or after exit. 4. Record review of Resident #35's face sheet fated 07/16/24, indicated Resident #35 was a [AGE] year-old female admitted on [DATE] and 04/17/24 with diagnoses including anxiety disorder and dementia. The face sheet indicated Resident #35 family member were her responsible party. Record review of Resident #35's significant change in status MDS assessment dated [DATE], indicated resident #35 usually understood and sometimes had the ability to understand others. Resident #35 was unable to complete the BIMS assessment. Resident #35 had short-and-long term memory recall problem and moderately impaired cognitive skills for daily decision making. The MDS indicated Resident #35 received an antianxiety and antidepressant during the last 7 days of the assessment period. Record review of Resident #35's care plan dated 04/16/24 indicated Resident #35 had potential for drug related complications related to antidepressant medications. Intervention included monitor side effects. Record review of Resident #35's order summary dated 07/16/24, indicated Paroxetine Oral Tablet 20 mg, give 1 tablet by mouth at bedtime for mood. Start date 07/02/24. Record review of Resident #35's MAR dated 07/01/24-07/31/24 indicated Paroxetine Oral Tablet 20 mg, give 1 tablet by mouth at bedtime for mood. Order date 07/02/24. On 07/17/24 at 10:16 a.m., requested Resident #35's Paroxetine consent from ADM and Regional DOO by email. Resident #35's consent was not received prior or after exit. 5. Record review of Resident #69's face sheet dated 07/16/24, indicated Resident #69 was an [AGE] year-old female admitted on [DATE] with diagnosis including dementia with other behavioral disturbance. The face sheet indicated Resident #69 family member was her responsible party. Record review of Resident #69's admission MDS assessment dated [DATE] indicated Resident #69 was usually understood and usually understood others. Resident #69's BIMS score was 08 which indicated moderately impaired cognition. The MDS indicated Resident #69 received an antianxiety and antipsychotic during the last 7 days of the assessment period. Record review of Resident #69's care plan dated 07/03/24, indicated Resident #69 had potential for drug related complication related to anxiolytic /sedative medications. Intervention included monitor side effects. Record review of Resident #69's order summary dated 07/17/24 indicated the following medications: *Hydroxyzine Oral Tablet 25 mg, give 1 tablet orally every 8 hours as needed for anxiety. Start date 06/22/24. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Mitrazapine Oral Tablet 7.5 mg, give 1 tablet by mouth at bedtime for appetite stimulation. Start dated 07/15/24. Record review of Resident #69's MAR dated 07/01/24-07/31/24 indicated: *Hydroxyzine Oral Tablet 25 mg, give 1 tablet orally every 8 hours as needed for anxiety. Order date 06/22/24. *Mitrazapine Oral Tablet 7.5 mg, give 1 tablet by mouth at bedtime for appetite stimulation. Order dated 07/15/24. On 07/16/24 at 2:07 p.m., called Resident #69's RP to discuss psychotropic consents. Resident #69's RP did not answer, and voicemail left with call back number. Call back was not received prior or after exit. On 07/17/24 at 10:16 a.m., requested Resident #69's Hydroxyzine and Mitrazapine consent from ADM and Regional DOO by email. Resident #69's consent was not received prior or after exit. During an interview on 07/17/24 at 4:10 p.m., LPN M said the nurses were responsible for obtaining consent for psychotropic medications. She said consent should be obtained before the medication was given. She said the power of attorney or resident should give consent for the psychotropic medication, verbally or in person. She said it was important to get consent for psychotropic medications to make sure the resident was not allergic to the medication and able to take the medication. She said if consent was not given, the resident or power of attorney may not be aware of the risk and benefits of the medication. During an interview on 07/17/24 at 5:07 p.m., the DON said the nurses were responsible for obtaining consent for psychotropic medications. She said consent should be obtained from the RP. She said consent should be done on admission and when the medication was ordered. She said the ADON was responsible for ensuring the nurses obtaining consent for psychotropic medications. She said she did not know the ADON's process in monitoring psychotropic consents being obtained by the nurses. She said it was important to obtain consent, so the facility was not medicating a resident without consent. She said it was important to obtain consent, so the RP and resident knew the risk and benefits and to decide if they want to take it. She said she did not know why Residents #21, #31, #33, #35, and #69 did not have consent for their psychotropic medications. She said the ADON was at home with a family situation. During an interview on 07/17/24 at 6:00 p.m., the ADM said the admitting nurse should get the psychotropic consents signed by the RP or resident on admission. She said verbal consent could be obtained and signed eventually when the family visited. She consents should be obtained prior to the medication being administered. She said getting consent was important so the RP and resident could make an informed decision and be clear on what the medication was treating. She said the DON should be monitoring resident's psychotropic consents. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility's Psychotherapeutic Drug Management policy revised 10/24/22, indicated . attending medical practitioner responsibility .the psychotherapeutic medication order will include the following information .informed consent from resident and/or surrogate decision maker for each drug and for each increase in dosage .nursing responsibilities .the licensed nurse will not administer the psychotherapeutic medication until an informed consent form has been obtained and documented by the attending physician from the resident and/or surrogate decision maker, unless it is an emergency situation .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interviews and record review, the facility failed to ensure residents had the right to a clean, comfortable, and homelike environment, which included but not limited to receiving treatment and supports for daily living safety, for 1 of 5 residents (Resident #31) reviewed for a homelike environment. The facility failed to ensure Resident #31's wheelchair was clean. This failure could place residents at risk for diminished quality of life due to the lack of a well-kept environment. Findings included: Record review of Resident #31's face sheet dated 07/16/24, indicated Resident #31 was an [AGE] year-old female admitted on [DATE] with diagnoses including Alzheimer's disease (is a progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment), muscle weakness, and abnormalities of gait and mobility. Record review of Resident #31's quarterly MDS assessment dated [DATE], indicated Resident #31 was sometimes understood and sometimes had the ability to understand others. Resident #31 was unable to complete the BIMS assessment. Resident #31 had short-and-long term memory recall problem and moderately impaired cognitive skills for daily decision making. Resident #31 used a wheelchair as a mobility device. Resident #31 required supervision for oral hygiene, maximal assistance for personal hygiene and putting on/taking off footwear, and dependence for toileting hygiene and dressing. Record review of Resident #31's care plan dated 12/28/23, edited on 06/19/24, indicated: *Resident #31 had ADL functional status/rehabilitation potential and self-care deficit with oral care, dressing, eating, bathing, grooming, and resistive to ADL assistance at times. Intervention included able to feed self after tray set-up. *Resident #31 had falls and was high risk related to cognitive deficits with poor safety awareness. Intervention included lock all moveable equipment before transferring residents. During an observation on 07/15/24 at 11:30 a.m., Resident #31 was a dining room table in her wheelchair. Resident #31 made constant noise, humming, or counting out load. Resident #31 was un-interviewable. Resident #31's wheelchair wheels had moderate amount of dried substance splattered throughout both wheels. Resident #31's wheelchair had a moderate amount of hair tangled where the wheels and the frame connected. During an observation on 07/16/24 at 9:00 a.m., Resident #31 was self-propelling herself aimlessly up and down the secured unit hallway. Resident #31's wheelchair wheels had moderate amount of dried substance splattered throughout both wheels. Resident #31's wheelchair had a moderate amount of hair tangled where the wheels and the frame connected. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 07/17/24 at 3:48 p.m., CNA J said Resident #31 used her wheelchair to get around. She said maintenance was responsible for the upkeep of resident's wheelchairs. She said the CNAs were responsible for wiping down the wheelchairs. CNA J entered Resident #31's room and inspected her wheelchair. She said the wheelchair was dirty, but the CNAs normally cleaned the seat area not the wheels. She said maintenance would be able to take the wheels off and clean them better than the CNAs. She said residents should not have dirty wheelchair because of infection control. She said the dried food could attract pest and the dementia residents could eat the food particle from the wheelchair not knowing it was dirty. CNA J said she would take the wheelchair out of Resident #31's room so maintenance could look at it. CNA J left the secured unit to locate the maintenance supervisor. During an interview and observation on 07/17/24 at 4:07 p.m., the maintenance supervisor arrived on the secured unit and inspected Resident #31's wheelchair. He said Resident #31's wheelchair needed cleaning. He said the CNAs and maintenance was responsible for cleaning resident's wheelchairs. He said residents should not have dirty wheelchairs because of infection control. During an interview on 07/17/24 at 4:10 p.m., LPN M said the night shift CNAs were probably responsible for cleaning the resident's wheelchairs. She said that would be the best time since the residents would be asleep. She said but anyone who noticed a dirty wheelchair should clean it. She said a dirty wheelchair was unsanitary and staff who put the resident it the wheelchairs should be inspecting them for cleanliness all the time. During an interview on 07/17/24 at 5:07 p.m., the DON said anyone could clean resident's wheelchairs. She said maintenance was responsible for the upkeep of resident's wheelchairs, but staff had to inform him of the issue. She said it was an infection control issue if a resident was using a dirty wheelchair. During an interview on 07/17/24 at 6:00 p.m., the ADM said CNAs were responsible for cleaning resident's wheelchairs. She said it was important for residents to not have dirty wheelchairs because of esthetic and infection control. She said ultimately it was maintenance responsibility to maintain resident's wheelchairs. Record review of a facility's Cleaning and Disinfection of Environmental Surfaces and Equipment policy revised 06/2020 indicated .to ensure that the cleaning and disinfection of environmental surfaces is in accordance with Centers for Disease Control and Prevention (CDC) and Occupational Safety and Health Administration (OSHA) guidelines .non-critical items are those that come in contact with intact skin but not mucous membrane .most non-critical items can be decontaminated where they are used .

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 44933 Based on interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, for 4 of 6 staff (CNA F, CNA H, CNA G, the DOR) reviewed for abuse policy. 1. The facility failed to ensure CNA F, CNA G, and DOR had criminal history background checks in their personnel file. 2. The facility failed to ensure CNA H had EMR in the personnel file. These failures could place residents at risk for unsafe environment and abuse. Findings included: Record review of a facility's Abuse Prevention and Prohibition Program policy revised 10/24/22, indicated .to ensure the facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse .the administrator is responsible for coordinating and implementing the facility's abuse prevention policies, procedures, training programs, and systems .screening .the facility does not knowingly employee anyone who has disciplinary action .a finding entered into the state nurse aide registry related to abuse .reporting/response .the facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown origin .immediately, but no later than 2 hours after forming suspicion . 1. Record review of the Personnel File Review completed on 07/16/24, indicated CNA F, CNA G, and DOR did not have a criminal history on file. The personnel file review indicated CNA H did not have a EMR report on file. The personnel file review indicated the DOH (date of hire) for CNA F was 04/27/2010, CNA G 08/06/2013, DOR 11/02/2020, and CNA H 01/22/2002. During an interview on 07/17/24 at 4:59 p.m., the HR Payroll said she had been at the facility for 4 months. She said she was responsible for background checks and running EMR reports. She said the previous HR Payroll did not tell her how often she was supposed to do background checks and EMR reports. She said with the new company, which took over at the beginning of the month (July 2024), their policy was to do it on hire and yearly. She said if the background checks or EMR report were not done, resident were at risk for abuse and facility hiring sex offenders. During an interview on 07/17/24 at 5:07 p.m., the DON said HR was responsible for running background checks and EMR on employees. She said not doing background checks and EMR reports risked the facility employing someone with a criminal history or misconduct on their license. During an interview on 07/17/24 at 6:00 p.m., the ADM said HR was responsible for performing background checks and EMR reports upon hire and annual. She said HR was responsible for the information being on the employee's file. She said when background checks and EMR reports were not done it risked sex offender being employed and employing someone with a conviction on the barred from hiring list. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's 2024 Employee Handbook dated 11/2020 indicated .criminal and other background checks .at the company, we pride ourselves on providing the highest level of quality care .one of the best ways to give our residents/patients and their families peace of mind that we have a safe and secure environment is to ensure we hire and maintain a workforce of high integrity .we therefore conduct reference checks, criminal background checks, and other background checks on hire and as required or appropriate at other times, to the extent permitted by law .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, including injuries of unknown source were reported immediately, but not later than 24 hours if the events that caused the allegation did 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 and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 18 residents (Resident #35) reviewed for abuse and neglect. The facility failed to report Resident #35's injury of unknown origin to her face, within 24 hours to the state agency. This failure could place residents at risk for continued abuse and neglect due to inappropriate interventions and failure to report the allegations of abuse timely. Findings included: Record review of a facility's Abuse Prevention and Prohibition Program policy revised 10/24/22, indicated .to ensure the facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse .the administrator is responsible for coordinating and implementing the facility's abuse prevention policies, procedures, training programs, and systems .reporting/response .the facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown origin .immediately, but no later than 2 hours after forming suspicion. Record review of Resident #35's face sheet fated 07/16/24, indicated Resident #35 was a [AGE] year-old female admitted on [DATE] and 04/17/24 with diagnoses including anxiety disorder and dementia. Record review of Resident #35's significant change in status MDS assessment dated [DATE], indicated resident #35 usually understood and sometimes had the ability to understand others. Resident #35 was unable to complete the BIMS assessment. Resident #35 had short-and-long term memory recall problem and moderately impaired cognitive skills for daily decision making. Resident #35 had other behavioral symptoms not directed toward others and daily behavior of rejection of care. The MDS indicated her current behavior status have worsen compared to prior assessment. Resident #35 required moderate assistance for toileting and personal hygiene, dressing, putting on/taking off footwear and dependent for shower/bathe self. Record review of Resident #35's care plan dated 04/16/24, indicated Resident #35 had an alteration in thought process related to dementia with memory deficits, impaired decision making, confusion/disorientation, making self-understood: impaired, and understanding others: impaired. Intervention included always approach in a calm nurturing manner. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #35's care plan dated 05/02/24, indicated Resident #35 had a risk for bruises/discoloration related to fragile skin, restless movements, repeated falls, aspirin use. Intervention included monitor arms and legs during transfer and ADL care. Record review of Resident #35's weekly skin check dated 07/01/24 indicated no skin impairments found. Record review of Resident #35's accident/incident report dated 07/01/24, indicated .Resident #35 .resident's room .incident time: 6:30 p.m.reported by: family member (present in room) .reported to: LVN N .family member in room alerted nurse small bruise noted to Resident's [#35] right jaw .dime size bruise black/blue in color .no indication of pain .no pain voiced .level of consciousness: alert and oriented x1 .injury: bruise . Record review of Resident #35's accident/incident final disposition report completed by LVN N on 07/01/24, indicated .Resident #35 .date of incident: 07/01/24 .type: bruise/right jaw .outcome of interview with staff: spoke with all nurses, cnas, and hospice staff regarding bruise, upon interviewing it was discovered that resident sleeps with bed controller close to face and occasionally wakes up with remote under head/face also sleeps with a baby doll in bed that stays by her face/head and has hard hands and feet .state cause: unknown .did occurrence require notification of state agency .no .was equipment involved .unknown .LVN N . DON .ADM . Record review of Resident #35's hospice coordination notes report dated 07/02/24 indicated .call center-general .time of call:0756 .caller: ADON .the HHA gave the patient a bath last evening and the facility staff noted a bruise to the patient's jawline shortly after .the caller reports that because it is a suspicious bruise, they are conducting an investigation .they would like to know if the patient had been combative or if this bruise was noticed by the HHA during the shower .the patient has a history of being combative during care . During an interview on 07/17/24 at 3:29 p.m., the ADM said she was the abuse coordinator. She said Resident #35 had a history of sleeping with a baby doll and the bed controller remote. She said Resident #35 could not tell how she got the bruise to her jaw. She said after her, ADON, and DON talked about the incident, they did not think it was an injury of unknown origin due to history of sleeping with a baby doll and remote near her face. She said she did not know Resident #35 had a history of being resistive to cares and agitation. She said injury of unknown origin was supposed to be reported to HHSC. She said she was responsible for investigating and reporting. She said when injury of unknown origin was not reported the resident could get injured. She said it was important to report because better safe than sorry. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/17/24 at 5:07 p.m., the DON said Resident #35's family member was visiting on 07/01/24 and noticed the bruise on her jawline. She said Resident #35's bruise was dime sized. She said nurses reported they sometimes find Resident #35 laying on her remote and she slept with a baby doll too. She said we attributed the bruise to her bed remote or baby doll. She said Resident #35 was confused and could be confused about what staff are doing to her. She said after the incident, staff were supposed to ensure Resident #35 was not laying on the remote or baby doll. She said HHA R bathed Resident #35 the morning of or within a 24-hour period of when the bruise being found. She said she did not think it was an injury of unknown origin. She said Resident #35 could not say what happened. She said the ADM was the abuse coordinator. She said the ADM was responsible for investigating and reporting to HHSC within 2 hours for allegation of abuse. She said not reporting to HHSC placed resident at risk for harm if abuse or neglect was suspected. She said the facility had implemented a new abuse policy on July 1st, 2024.

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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** 44933 Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident's status for 3 of 10 resident reviewed for assessments. (Resident #31, Resident #33, and Resident #54) The facility failed to ensure Resident #31's diagnoses of anxiety (persistent and excessive worry that interferes with daily activities) and depression (is a mood disorder that causes a persistent feeling of sadness and loss of interest) was coded on her MDS. The facility failed to ensure Resident #33's diagnoses of bipolar (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and depression was coded on her MDS. The facility failed to ensure Resident #54's diagnosis depression was coded on her MDS. These failures could place residents at risk of not having individual needs met. Findings included: 1. Record review of Resident #31's face sheet dated 07/16/24, indicated Resident #31 was an [AGE] year-old female admitted on [DATE] with diagnoses including depression and anxiety disorder. Record review of Resident #31's quarterly MDS assessment dated [DATE], indicated Resident #31 was sometimes understood and sometimes had the ability to understand others. Resident #31 was unable to complete the BIMS assessment. Resident #31 had short-and-long term memory recall problem and moderately impaired cognitive skills for daily decision making. Resident #31 was prescribed an antianxiety during the last 7 days of the assessment period. The MDS did not indicate Resident #31 had diagnoses including anxiety and depression. Record review of Resident #31's care plan dated 12/28/23, edited on 06/19/24, indicated Resident #31 had potential for drug related complication related to anxiolytic /sedative medications. Intervention included monitor side effects. 2. Record review of Resident #33's face sheet dated 07/16/24, indicated Resident #33 was a [AGE] year-old female admitted on [DATE] with diagnoses including depression and bipolar disorder. Record review of Resident #33's quarterly MDS assessment dated [DATE], indicate Resident #33 was usually understood and sometimes had the ability to understand others. Resident #33's BIMS score was 09 which indicated moderately impaired cognition. Resident #33's MDS indicated she had been prescribed an antipsychotic, antianxiety, and antidepression during the last 7 days of the assessment period. The MDS did not indicate Resident #33 had diagnoses including bipolar and depression. (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 #33's care plan dated 12/01/23, edited on 06/04/24 indicated Resident #33 had potential for drug related complication related to psychotropic drug use related to medical diagnoses of depression, bipolar, and insomnia. Resident #31 received antianxiety medication, antidepressant medication, and antipsychotic medication. Intervention included obtain consent for psychotropic drug use. 3. Record review of Resident #54's face sheet dated 07/15/24 indicated Resident #54 was a [AGE] year-old, female admitted on [DATE] with a diagnosis of depression . Record review of Resident #54's quarterly MDS assessment dated [DATE], indicated Resident #54 was usually understood and sometimes understood others. Resident #54 had a BIMS of 00 which indicated severe cognitive impairment. The MDS indicated Resident #54 had received an antianxiety and antidepressant during the last 7 days of the assessment period. The MDS did not indicate Resident #54 had diagnosis including depression. Record review of Resident #54's care plan dated 03/14/24, edited on 06/07/24, indicated Resident #54 had depression as evidence by diagnosis/history of depression and mood disorder, and wandering. Intervention included administer anti-depressant medication as ordered by MD. During an interview on 07/17/24 at 3:10 p.m., the MDS coordinator said she was responsible for resident's MDSs. She said medical records put diagnoses in the electronic computer system. She said active resident's diagnoses were obtained from physician notes and the diagnoses list. She said some of the resident's diagnoses may not be added because another staff member in training completed their MDS. She said RUGS, during their yearly review, recommended MDSs have active diagnoses only which are obtained from the most recent physician's progress notes. She said the other staff member in training probably followed those recommendations when she completed Residents #31, #33, and #54's MDS. She said she did not check over every MDS the staff member in training completed independently to make sure they were correct. She said all of Resident #31, #33, and #54's mental health diagnoses should be coded on their MDSs. She said she did check the progress notes for active diagnoses but if the resident was on a medication to treat a diagnosis not listed, she coded it on the MDS anyway. She said it was important for MDSs to be accurate so it could be reflected on the resident's care plan. During an interview on 07/17/24 at 5:07 p.m., the DON said the MDS coordinator was responsible for coding resident diagnoses. She said resident's psychiatric diagnoses should be coded on their MDSs. She resident's MDS should reflect the condition of the resident. She said the new company's regional MDS coordinator was the one who provided oversight and monitored the MDS coordinator. She said inaccurate MDSs affected the resident's plan of care and the facility's billing. During an interview on 07/17/24 at 6:00 p.m., the ADM said the RN who reviewed the MDS before submission was responsible for the MDS accuracy. She said she expected resident's mental illnesses to be coded on their MDS. She said MDSs should be accurate because it ensured care of the resident and proper medication and treatment. She said the RN coordinator or MDS coordinator should monitor the submitted MDSs for accuracy. Requested an accuracy of assessment policy from the ADM. Record review of a facility's Documentation-Nursing policy revised 06/2020, indicated .minimum data set (MDS) completion per CMS and Medicare guidelines .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure the baseline care plan that included the instructions for resident care needed to provide effective and person-centered care was completed and provided to the resident and/or their representative for 1 of 6 residents reviewed for new admissions. (Resident #69) The facility failed to complete a baseline care plan for Resident #69 within 48 hours of admission. The facility failed to provide Resident #69's RP, a copy of the summary of the baseline care plan. These failures could place residents at risk of not receiving care and services to meet their needs. Findings included: Record review of Resident #69's face sheet dated 07/16/24, indicated Resident #69 was an [AGE] year-old female admitted on [DATE] with diagnosis including dementia with other behavioral disturbance. The face sheet indicated Resident #69 family member were her responsible party. Record review of Resident #69's admission MDS assessment dated [DATE] indicated Resident #69 was usually understood and usually understood others. Resident #69's BIMS score was 08 which indicated moderately impaired cognition. Resident #69 required supervision for eating, maximal assistance for oral hygiene, shower/bathe self, dressing and personal hygiene and dependent for toileting hygiene. During an interview on 07/15/24 at 4:53 p.m., the responsible party for Resident #69 said Resident #69 was admitted to the facility for rehabilitation. She said she had not been involved in a care plan meeting to develop a baseline care plan and had not received a copy of a baseline care plan. She said she visited a lot and spoke to the rehab department about her family member's progress. She said a baseline care plan would have been nice to have. During an interview on 07/16/24 at 3:15 p.m., the MDS coordinator said she was not responsible for baseline care plans. She said the DON was responsible for initiating baseline care plan. She said that was the way with the old company but did not know how the new company was going to do it. During an interview on 07/16/24 at 3:20 p.m., the DON said she did not know she was responsible for initiating baseline care plans. She said she thought the MDS coordinator was responsible for baseline care plans. Requested copy of Resident #69's baseline care plan from the DON. Resident #69's baseline care plan was not received prior or after exit. During an interview on 07/17/24 at 3:10 p.m., the MDS Coordinator said before the current DON started in April (2024), the DON or a RN initiated the baseline care plans. She said after the DON or RN initiated the baseline care. The nurses completed it within 48 hours of admission. She said she was not responsible for the baseline care plans. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/17/24 at 4:10 p.m., LPN M said she had not done a lot of admission at the facility. She said she assumed the admission nurse started the baseline care plan. She said she assumed the ADON or DON ensured it was completed within 24-48 hours of admission. She said the care plan helped you know how to take care of the resident. During an interview on 07/17/24 at 5:07 p.m., the DON said the LVN on admission was responsible for resident's baseline care plans. She said baseline care plan needed to be completed within 24 hours of admission. She said the ADON or DON should ensure resident's baseline care plan were completed within 24 hours of admission. She said new admission were talked about in morning meeting and that where we should be making sure baseline care plans were completed. She said if baseline care plan were not done, it did not alert staff what patient care should be provided. She said without a baseline care plan, a standard of care was not established, and the facility would not know of the resident was progressing or if something needed to be changed. During an interview on 07/17/24 at 6:00 p.m., the ADM said the admitting nurse started the baseline care plan and the DON finished it within 48 hours of admission. She said all facility departments had input on the baseline care plan. She said the DON was responsible for ensuring the baseline care plan were completed timely. She said if baseline care were not done, staff may not know how to properly care for the resident. Record review of a facility's Care Planning policy revised 10/24/22, indicated .the Facility's Interdisciplinary Team (IDT) will develop a Baseline and/or Comprehensive Care Plan for each resident in accordance with OBRA and MDS guidelines .the care plan serves as a course of action where the resident, resident's attending physician, and IDT work to help the resident move towards resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs .a licensed nurse will initiate the Care Plan, and will be finalized in accordance with OBRA/MDS guidelines .the Facility will develop a person-centered Baseline Care Plan for each resident within 48 hours of admission .once the baseline Care Plan is completed, the Facility must provide the resident and/or resident's representative with a written summary of the Baseline Care Plan .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on observation, interview, and record review the facility failed to develop, and implement a comprehensive care plan to meet the medical, nursing, mental and psychosocial needs for 2 of 18 residents (Resident #17 and Resident #68) reviewed for care plans. 1. The facility failed to implement a comprehensive person-centered care plan for Resident #17's positioning rail. 2. The facility failed to ensure Resident #68 was care planned as smoker. 3. The facility failed to perform quarterly smoking assessments for Resident #68. 4. The facility failed to perform Resident #68's quarterly elopement risk assessments. These failures could place residents in the facility at an increased risk of a decline in physical or functional well-being, of not receiving necessary care or services, and having personalized plans developed to address their needs. Findings included: 1. Record review of Resident #17's face sheet dated 7/17/24 revealed he was [AGE] years old and admitted to the facility on [DATE]. Resident #17 had diagnoses of a cerebral infarction (stroke-occurs when there is a lack of oxygen to the brain and brain cells die), hemiplegia and hemiparesis of left side (muscle weakness or partial paralysis (not able to move) on one side of the body that affects arms, legs, and/or facial muscles) following a brain bleed, and weakness. Record review of Resident #17's annual MDS assessment dated [DATE] revealed he was understood and understood others. Resident #17 had a BIMS of 14, which indicated he was cognitively intact. The MDS indicated Resident #17 required total to maximum assistance for most ADLs. The MDS did not indicate the use of bed rail. Record review of Resident #17's undated Physician Orders revealed there were no orders for his positioning rail on his bed. Record review of Resident #17's undated care plan revealed he had a history of cerebral infarction and was at risk of complications r/t left sided hemiplegia with goals to maintain or improve current levels of ADLs and not have another cerebral infarction over the next 90 days. He had pain with interventions to assist with turning and repositioning to find a comfortable position. He had a history of falls. The care plan did not address Resident #17's use of a bed rail for positioning. Record review of Resident #17's therapy screening dated 7/15/24 revealed he was screened for the use of assist bar and was appropriate for assist bar to left side to facilitate mobility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 7/15/24 at 10:39 AM, Resident #17 said things were going pretty good. Resident #17 said he had a positioning bed rail on his left side of his bed, but he also needed one on his right side to assist with turning and it would make him feel safer when being turned to the right side during his incontinent care. Resident #17 had a positioning bed rail on his left side of the bed. During an interview on 7/17/24 at 1:45 PM, Resident #17 said he wanted a positioning bed rail on his right side to help with turning himself. Resident #17 said he was not able to use his left arm or leg. Resident #17 said he received his current bed three or four weeks ago and it came with the one positioning bed rail on his left side. Resident #17 said the bed he had prior to his current one had positioning bed rails on both sides. During an interview on 7/17/24 at 1:30 PM, CNA D said she had worked at the facility for five years and usually worked on the day shift. CNA D said she thought Resident #17 had his positioning bed rails since he had been in his room for some time. During an interview on 7/17/24 at 1:54 PM, the Regional Director of Therapy said she had screened Resident #17 on 7/15/24 because they were a new company for the facility as of 7/1/24 and their policy was to screen everyone and look at everyone to see if they were appropriate to use positioning rails, wheelchairs, etc. She said they had already scheduled to come to the facility that week to screen all the residents. She said she did not know what the previous company's policy was, but they required residents to be screened for positioning bed rails and to be care planned, and to have an order. During an interview on 7/17/24 at 1:57 PM, the Director of Therapy said previously, if nursing felt like a resident needed positioning bed rails, nursing would tell the Maintenance Supervisor and he would install the positioning bed rails on the bed. She said if therapy felt a resident needed the positioning bed rails, therapy would tell the nursing staff and the nursing staff would tell the Maintenance Supervision and he would put them on. She said therapy did not do screenings or evaluate residents for the use of positioning bed rails. During an interview on 7/17/24 at 2:05 PM, LVN B said she had worked at the facility for fourteen years. LVN B said if a resident needed positioning bed rails, they just called the Maintenance Supervisor, and he would put the positioning bed rails. LVN B said therapy would also tell them if a resident needed positioning bed rails and then nursing would notify the Maintenance Supervisor and he would install them. LVN B said they did not put orders in for the positioning bars with the previous company or do consents. LVN B said she did not know what the new company would require. LVN B said the MDS coordinator was responsible for doing any care plans and/or changes in the morning meetings. LVN B said the care plan was to go over expectations for staff to take care of the resident related to all aspects of life. LVN B said positioning bed rails should be care planned to monitor the resident for safety of the bars to help the resident turn and not get tangled up in them or anything that would negatively affect the resident. LVN B said she did not know how long Resident #17 had been using the positioning bed rail, but it had been over a year. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/17/24 at 2:15 PM, the MDS coordinator said she had worked at the facility for [AGE] years. She said she was responsible for the admission, quarterly, annual, and significant change MDSs and implementing/updating the care plans with each MDS schedule. She said she reviewed everything during the MDS assessment and updated the care plan as indicated and if she was asked to update a care plan she would, but she was not responsible for the acute care plan changes/updating. She said she believed nursing was responsible for the acute care plan changes/updates. She said she would update the care plan to include positioning bed rails and interventions for assessments and monitoring, if she knew a resident had the positioning bed rails. She said she would have to see documentation, such as an order, nurse's note, or have someone tell her if a resident had positioning bed rails to know to update the care plan. She said she did not know Resident #17 had positioning bed rails. She said the purpose of the care plan was so residents received the care needed and it was a guide to staff of what care the resident needed. She said the resident should be assessed to ensure they know how to use the positioning bed rails and were using them appropriately. She said the negative affect to the resident of not having something care planned would depend on what was not care planned. During an interview on 7/17/24 02:27 PM, LVN C said the MDS Coordinator, and the RNs were responsible for updating the care plans. LVN C said as an LVN, she was not allowed to do care plans. LVN C said she could update orders. LVN C said an order was needed for a resident to have positioning bed rails. LVN C said if a resident needed positioning bed rails, she would let therapy know and then tell the Maintenance Supervisor to install them. LVN C said positioning bed rails should be included on the care plan. LVN C said the purpose of the care plan was to guide the resident's care and if something was not care planned, then the resident may not receive the care they needed. During an interview on 7/17/24 at 3:44 PM, the DON said therapy should evaluate the resident to see if they could use positioning bed rails correctly and the Maintenance Supervisor installed the positioning bed rails on the resident beds. The DON said the positioning bed rails should be on the care plan to include assessments and monitoring for safety. The DON said the nurses initiated the base line care plan and the MDS Coordinator was responsible for the comprehensive care plan and for revising the care plans. The DON said the nurses and/or herself were responsible for revising the acute care plans with changes. The DON said the LVNs, and RNs could update/revise the care plans, but mainly the nurse managers did it. The DON said the positioning bed rails should have an order, consents signed, and be care planned, per their new company's policy, but she said she did not know what the old company required. The DON said once they get completely switched over to the new software system, when the nurses did their assessments, the system would automatically update the care plans. The DON said the purpose of the care plan was so everyone to be updated and everyone to be on the same page in what care the resident needed or required. The DON said if the positioning bed rails were not care planned, the rails could serve as a restraint, or the resident could injure themselves if not being assessed for safety and appropriate use. During an interview on 7/17/24 at 4:01 PM the ADM said the MDS nurse was responsible for the development and revising of the care plans. The ADM said the admitting nurse initiated the baseline care plans and the DON reviewed and signed off on it. The ADM said the DON also signed off on the comprehensive care plan when it was completed. The ADM said the care plan was the recipe to care for each resident and should be very specific to that resident on how to care for them and it was the prescription for the resident's care. The ADM said she would expect the positioning bed rails to be care planned with interventions to ensure the residents safety. The ADM said if not care planned the resident may not receive the care they needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #68's face sheet dated 07/16/24, indicated Resident #68 was an [AGE] year-old, female admitted on [DATE] with diagnoses including dementia (is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), nicotine dependence, and tremors. Record review of Resident #68's admission MDS assessment dated [DATE], indicated Resident #68 was usually understood and usually understood others. Resident #68's BIMS score was 15 which indicated intact cognition. The MDS indicated Resident #68 did not wander or reject care. The MDS indicated Resident #68 was a current tobacco user. Record review of Resident #68's quarterly MDS assessment dated [DATE], indicated Resident #68 was understood and understood others. Resident #68's BIMS score was 14 which indicated intact cognition. The MDS indicated Resident #68 did not wander but rejected care. Record review of Resident #68's care plan dated 11/08/23, edited 04/29/24 indicated Resident #68 was at risk for elopement due to cognitive deficits, history of wandering behavior, and history of exit seeking. Resident #68 resided in secured unit of facility. Intervention included reassess secured unit placement quarterly and as needed with significant change. Resident #68's care plan did not indicate she was a smoker and to complete quarterly smoking assessments. Record review of Resident #68's elopement risk dated: *01/22/24 *07/16/24 Resident #68 did not have quarterly elopement assessment performed. Record review of Resident #68's smoking safety risk assessment dated [DATE], indicated Resident #68 used cigarettes and was a modified independent smoker. Resident #68 did not have quarterly smoking assessment. Record review of a Smokers list provided by the ADM on 07/15/24, indicated Resident #68 was a smoker on the secured unit. During an observation on 07/16/24 at 8:41 p.m., Resident #68 headed outside with a staff member to smoke. During an interview on 07/17/24 at 3:10 p.m., the MDS coordinator said she did resident's care plans. She said the resident's MDS coded for smoking should prompt staff to develop a smoking care plan. She said Resident #68 having a smoking care plan was important to know what care or supervision she required. She said without a smoking care plan, Resident #68 could not get the supervision she needed, and injury could happen. She said she did not know why Resident #68 did not have a smoking care plan. She said the ADON completed smoking assessments. She said nurses completed elopement risk assessments. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/17/24 at 4:10 p.m., LPN M said Resident #68 should have smoking on her care plan. She said the care plan let staff know about smoke breaks and what accommodations was needed. She said the care plan helped you know how to care for the resident. She said if the wrong accommodations were given to Resident #68 during smoking, injury could happen or if not taken when scheduled, Resident #68 could become combative. She said smoking and elopement risk assessments should be completed on schedule. She said the assessment were completed quarterly by the DON. During an interview on 07/17/24 at 5:07 p.m., the DON said nurses completed the smoking and elopement risk assessments. She said but anyone could complete the assessments if needed. She said elopement risk assessment should be completed quarterly and smoking assessments should be done on admission and quarterly. She said the ADON should be monitoring the completion of smoking and elopement risk assessments. She said the chart system also triggered when the resident's assessments are due. She said Resident #68's care plan should have smoking as a care area. She said the MDS coordinator or nurses were responsible for care planning smoking on resident's care plans. She said when smoking was not care planned, residents could be injured because they could be not safe smoking. She said when elopement risk assessments were not done, it placed resident at risk for elopement and being inappropriate placed on the secure unit. During an interview on 07/17/24 at 6:00 p.m., the ADM said each disciplinary made sure resident's intervention addressed the care area. She said the DON was responsible for reviewing the comprehensive care plan to ensure all care areas were addressed. She said smoking should be care planned for a resident who smoked. She said the MDS coordinator was responsible for care plan with the old company. She said smoking needed to be on the resident's care plan to know how to care and special needs of the resident. She said nurses were responsible for elopement risk assessments and safe smoking assessments. She said assessments were done on admission, quarterly, and as needed. She said when elopement risk assessment was not performed, staff could not be in tuned with residents attempts to elope. She said staff members could not pay close attention to the resident and the resident could elope. She said if smoking assessments were not done, then may not know if a resident is a safe smoker. She said staff may not know how to safely smoke the resident and injury can happen. She said the DON and MDS coordinator should ensure care plan are comprehensive. Record review of the facility's policy titled Care Planning dated revised October 24, 2022, revealed . the purpose of care planning was . to ensure that a comprehensive person-centered care plan was developed for each resident based on their individual assessed needs . the care plan serves as a course of action where the resident (resident's family and/or guardian or other legally authorized representative), resident's attending physician, and interdisciplinary team work to help the resident move toward resident specific goals that address the resident's medical, nursing, mental and psychosocial needs . a licensed nurse would initiate the care plan, and the plan would be finalized in accordance with . guidelines and updated as indicated for change in condition, onset of new problems, resolution of current problems, and as deemed appropriate by clinical assessment and judgement on an as needed bases . each resident's comprehensive care plan would describe the following . services that were 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Bed Rails dated revised 06/2020, revealed . the purpose was to determine the appropriateness of bed rail use for individual residents . decisions to use or to discontinue the use of a bed rail would be made in the context of an individualized resident assessment using an Interdisciplinary Team and would take into account the resident's medical needs, comfort, and freedom of movement . the resident's plan of care would be updated to reflect the use of bed rails . the plan of care should also include documentation of the type of specific direct monitoring and supervision provided during the use of the bed rails and the identification of how needs would be met during the use of bed rails (such as repositioning, hydration, etc.) . Record review of a facility's Smoking by Residents policy revised 06/2020, indicated .to respect resident choice to smoke and to maintain a safe healthy environment for both smokers and non-smokers .residents who want to smoke will be assessed for their ability to smoke safely prior to being allowed to smoke in these areas .a licensed nurse will complete a Safe Smoking Assessment for residents who wish to smoke .all smokers shall be assessed related to smoking safety at the time of admission and then at least quarterly as outlined by OBRA assessment timeframe .the IDT shall create a Smoking Care Plan for the resident . Record review of a facility's Secure Care Neighborhood policy revised 08/2020, indicated .the secure care neighborhood may be used to keep residents who are a high risk for elopement safe from exiting the facility . the resident should have an Elopement Risk Assessment completed with a physician order completed . 44933

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on interview and record review, the facility failed to ensure that a resident received appropriate treatment and services to prevent urinary tract infections (UTI) for 1 of 3 residents who were reviewed for quality of care. (Resident #279) 1. The facility failed to ensure Resident #279 had orders for the size and amount of fluid in the bulb of her indwelling urinary catheter (tube inserted into the bladder to drain urine). 2. The facility failed to ensure Resident# 279 had orders catheter care with an indwelling urinary catheter. The failures could place residents at risk for indwelling urinary catheter pain, urinary tract infections, and not receiving needed care. Findings included: 1. Record review of Resident #279's face sheet dated 7/17/24 indicated Resident #279 was a [AGE] year old female and admitted to the facility initially on 7/13/24 with diagnosis chronic kidney disease stage 3 unspecified (when the kidneys have mild to moderate damage and less able to filter waste and fluid out of your blood). Record review of Resident #279's quarterly MDS assessment dated [DATE] indicated Resident #279 was usually understood and understood others. The MDS indicated Resident #279 had no BIMs conducted. Resident #279 was maximal assistance on staff for toileting hygiene. The MDS indicated Resident #279 had an indwelling catheter (urinary catheter) and was always incontinent of bowel. Record review of Resident #279's baseline care plan dated 7/13/2024 indicated she was cognitively intact. She was always incontinent to urine. She had a wound to sacral area. She was on enhanced barrier precautions with interventions of gloves and gown should be donned (put on) if any of the following activities occurred: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bathing, or other high contact activity. Record review of Resident #279's Order Summary Report dated 7/16/24 revealed there was no order noted related to Resident #279's urinary Foley catheter size, amount of fluid in the bulb and no catheter care. During an interview on 7/17/24 at 9:30 AM the DON stated Resident #279's urinary catheter size, bulb and catheter care orders were not in the resident's chart, but she had updated the resident's chart and put the orders in after made aware by surveyor. During an interview on 7/17/2024 at 10:15 AM the Director of Operations voiced Resident #279's foley catheter orders were not in the system, but after notified by surveyor orders had been added to system. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/17/24 at 2:12 PM, revealed LVN C said the nurses had the residents' orders on the paper MAR and in electronic record. She said the orders should show the catheter size, how much fluid should be in the bulb and catheter care each shift or as needed. She said she could not find Resident #279's catheter orders on the medication administration report. During an interview on 7/17/24 at 2:37 PM, LVN P said normally the residents came to the facility with a catheter order on admission and the nurses should know to performed standard care with the catheter. She said if she could not find the resident's catheter orders she would call the physician to get orders. She said not performing catheter care could cause the resident discomfort or pain, it could have an effect on their vital signs and cause sepsis. During an interview on 7/17/24 at 2:57 PM, the DON said the foley catheter orders should be put in the system on resident's admission. She said the orders for an indwelling catheter should include a secured to leg device, check urine in bag and ensure proper placement. She said the order should had the size of the catheter, the amount of fluid in the bulb and when to change the catheter. The DON said the foley catheter on admission order was probably missed due to the facility changed to a new charting system and their nurse has not been trained on the system yet. The DON said the negative effects of catheter orders not available for nurses could cause urinary tract infections and sepsis for residents with catheters. She said if the catheter orders were not on the medication administration report it was not monitored. She said if a nurse could not find the catheter orders they should ask her or a co-worker with point click care knowledge or notify the physician that foley catheter orders were needed for a resident. During an interview on 7/17/24 at 3:15 PM, the ADM said there should be an order for an indwelling catheter. The ADM said when applying a catheter, the nurse should be following the physicians' orders. The ADM said the nurse should always make sure they have a supporting diagnosis for a catheter, if not call the physician get an order or to discontinue the order for the foley catheter. The nurse should follow their facility policy in taking care of a catheter. Our nursing staff had not been taught how to add orders to this new point click care system. We are in orientation on how to use this system. If Resident #279 had a catheter her orders should have been put in the system. The ADM said if a foley catheter was not cleaned properly, that could lead to urinary tract infection or sepsis. Review of a Catheter- Care of, Urinary Policy dated revised 6/2022 revealed .the purpose of this procedure is to prevent urinary catheter-associated urinary tract infections while ensuring that residents are not given indwelling catheters unless medically necessary. Documentation of catheter care will be maintained in the resident's medical record. Review of Physician Orders Policy dated revised 6/2020 revealed .This will ensure that all physician orders are complete and accurate. The Medical Records Department will verify that physician orders are complete, accurate and clarified as necessary. Orders will include a description complete enough to ensure clarity of the physician's plan of care. Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order. Medication/treatment orders will be transcribed onto the appropriate resident administration record. Documentation pertaining to physician orders will be maintained in the resident's medical record. Current month's administration records will be maintained in the MAR/TAR.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 1 of 3 residents reviewed for respiratory care. (Resident #35) The facility failed to ensure Resident #35's nasal cannula (is a medical device to provide supplemental oxygen therapy to people who have lower oxygen levels) was stored in a bag when not in use. The facility failed to ensure Resident #35's nebulizer mask (provide vaporized medicine into the airway) was stored in a bag after use. These failures could place residents at risk of respiratory infections. 1. Record review of Resident #35's face sheet fated 07/16/24, indicated Resident #35 was a [AGE] year-old female admitted on [DATE] and 04/17/24 with diagnoses including chronic obstructive pulmonary disease (is a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and acute and chronic respiratory failure with hypercapnia (is a condition in which your lungs have a hard time loading your blood with oxygen or removing carbon dioxide). Record review of Resident #35's significant change in status MDS assessment dated [DATE], indicated resident #35 usually understood and sometimes had the ability to understand others. Resident #35 was unable to complete the BIMS assessment. Resident #35 had short-and-long term memory recall problem and moderately impaired cognitive skills for daily decision making. The MDS indicated Resident #35 had oxygen therapy while a resident and within the last 14 days. Record review of Resident #35's care plan dated 04/19/24, edited 05/19/24, indicated Resident #35 had oxygen use related to COPD, respiratory failure, and need for Bi PAP as ordered. Intervention included change oxygen tubing every week and as needed. Record review of Resident #35's order summary dated 07/16/24 indicated: *Ipratropium-Albuterol Inhalation Solution 0.5-2.5 mg/3 ml, 1 vial inhale orally three times a day related to chronic obstructive pulmonary disease. *Oxygen at 3 liters per minute per nasal cannula continuously, every shift. Started date 04/26/24. During an observation on 07/15/24 at 11:00 a.m., Resident #35's nasal cannula was wrapped and laying on top of the oxygen concentrator, not stored in a bag, in her room. On Resident #35's nightstand was a nebulizer mask not stored in a bag. During an observation on 07/15/24 at 1:00 p.m., Resident #35's nasal cannula was wrapped and laying on top of the oxygen concentrator, not stored in a bag, in her room. On Resident #35's nightstand was a nebulizer mask not stored in a bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/17/24 at 4:10 p.m., LPN M said Resident #35's nasal cannula and nebulizer mask should be stored in a bag when not in use. She said the staff member who removed the nasal cannula or nebulizer from Resident #35, was responsible for storing it correctly. She said the nasal cannula and nebulizer mask should be stored in a bag because it is sanitary. She said if the equipment was not stored correctly the resident could get sick because mold and bacteria grow in the cannulas and masks. During an interview on 07/17/24 at 5:07 p.m., the DON said the CNAs and LVNs were responsible for storing resident's nasal cannula and nebulizer mask when not in use. She said the nasal cannula and nebulizer mask should be stored in a clear bag when not in use. She said the nurse should ensure resident's respiratory equipment was stored in a bag. She said it was important to store the equipment correctly for infection control. She said the equipment could get contaminated from what it touched. She said the resident could get a respiratory infection. Record review of a facility's Cleaning and Disinfection of Environmental Surfaces and Equipment policy revised on 06/2020, indicated .semi-critical .items consist of items that come in contact with mucous membranes or non-intact skin (e.g., respiratory therapy equipment) .such devices are to be free from microorganisms .

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 44933 ased on interview and record review the facility failed to complete a performance review of each Certified Nurse Assistant (CNA) at least once every 12 months, for 5 of 5 (CNA J, CNA F, CNA H, CNA K, and CNA G) reviewed for annual competency evaluations. The facility failed to complete annual CNA competency evaluations for CNA J, CNA F, CNA H, CNA K and CNA G based on the personnel file review results. This failure could affect residents and place them at risk of not receiving consistent, appropriate interventions necessary to meet the residents' needs. Findings included: Record review of the Personnel File Review completed on 07/16/24, indicated CNA J, CNA F, CNA H, CNA K, and CNA G did not have a competency evaluation on file. The Personnel File Review indicated CNA J's date of hire was 03/07/17, CNA F 04/27/10, CNA H 01/22/02, CNA K 06/17/02, and CNA G 08/06/13. During an interview on 07/17/24 at 5:07 p.m., the DON said the staffing coordinator was responsible for the CNA trainings and competency evaluations. She said CNAs evaluation were supposed to be done annually. She said when trainings and evaluations were not done, CNAs were working but not trained correctly. She said this risked the residents not getting the care they needed, and it being done incorrectly. During an interview on 07/17/24 at 6:00 p.m., the ADM said if CNAs were not trained properly or evaluated, CNAs may not be aware of changes, informed of new processes, and new information the facility wanted them to know. She said staff would be working with a lack of knowledge which placed residents at risk. A policy regarding staff development and training was requested at this time. On 07/18/24 at 4:29 p.m., the ADM sent an email stating the facility did not have a policy for staff development and training. The employee handbook was requested at this time. Record review of the facility's 2024 Employee Handbook dated 11/2020, indicated .the purpose of a performance review is to evaluate your past performance and to guide you to maintain and/or improve your future job performance .generally, your job performance may be reviewed 90 days after hire, transfer or promotion, and annually thereafter .all performance reviews become part of your personnel file .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interviews and record review, the facility failed to ensure each residents' drug regimen was free from unnecessary psychotropic drugs (without adequate behavior monitoring) for 4 (Resident # 33, Resident #35, Resident #54, Resident #69) of 5 residents whose medications were reviewed in that: 1. The facility failed to ensure Resident #33 had side effect monitoring (are defined as unintended responses to approved pharmaceuticals (is any kind of drug used for medicinal purposes) given in appropriate dosages) for her prescribed Seroquel ((is an antipsychotic medication that treats several kinds of mental health conditions including schizophrenia (is a serious mental illness that affects how a person thinks, feels, and behaves) and bipolar disorder (is a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration)), Buspirone (antianxiety; is used to treat anxiety disorders or in the short-term treatment of symptoms of anxiety, and Venlafaxine (antidepressant; is used to treat depression) and Remeron ((is an atypical antidepressant (are prescription medicines to treat depression)) for July 2024. 2. The facility failed to ensure Resident #35 had behavior monitoring (monitor activities and mood) for her prescribed Paroxetine ((antidepressant; is used treat depression (is a mood disorder that causes a persistent feeling of sadness and loss of interest)) and Lorazepam (antianxiety; is used to treat anxiety) for July 2024. 3. The facility failed to ensure Resident #35 had side effect monitoring for her prescribed antidepressant and antianxiety for July 2024. 4. The facility failed to ensure Resident #54 had side effect monitoring for her prescribed Depakote (anticonvulsant; is used to treat seizure disorders, certain psychiatric conditions (manic phase of bipolar disorder), and to prevent migraine headaches) used to treat a mood disorder for July 2024. 5. The facility failed to ensure Resident #69 had an appropriate diagnosis for her prescribed Seroquel and Hydroxyzine (Antihistamines (medicines often used to relieve symptoms of allergies,), Miscellaneous anxiolytics (are medications that can treat anxiety and related conditions), sedatives, and hypnotics (used to reduce tension and anxiety and induce calm (sedative effect) or to induce sleep (hypnotic effect)); is used to treat anxiety disorders and allergic conditions, especially those that involve the skin). 6. The facility failed to ensure Resident #69 had behavior monitoring for her prescribed Seroquel and Hydroxyzine for July 2024. 7. The facility failed to ensure Resident #69 had side effect monitoring for her prescribed Seroquel and Mirtazapine (Remeron) for July 2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	These failures could place residents at risk of not receiving the intended therapeutic benefits of their psychotropic medications. Findings included: 1. Record review of Resident #33's face sheet dated 07/16/24, indicated Resident #33 was a [AGE] year-old female admitted on [DATE] with diagnoses including depression, dementia (is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and bipolar disorder. Record review of Resident #33's quarterly MDS assessment dated [DATE], indicate Resident #33 was usually understood and sometimes had the ability to understand others. Resident #33's BIMS score was 09 which indicated moderately impaired cognition. Resident #33's MDS indicated she had been prescribed an antipsychotic, antianxiety, and antidepression during the last 7 days of the assessment period. Record review of Resident #33's care plan dated 12/01/23, edited on 06/04/24 indicated Resident #33 had potential for drug related complication related to psychotropic drug use related to medical diagnoses of depression, bipolar, and insomnia. Resident #31 received antianxiety medication, antidepressant medication, and antipsychotic medication. Intervention included obtain consent for psychotropic drug use. Record review of Resident #33's order summary dated 07/17/24, indicated: *Buspirone tablet 5 mg, give 1 tablet by mouth two times a day related to depression. Started date 11/20/23. *Venlafaxine Oral Tablet 37.5 mg, give 1 tablet by mouth one time a day related to depression. Started date 11/20/23. *Remeron Oral Tablet 15 mg (Mirtazapine), give 1 tablet by mouth at bedtime related to depression. Started date 05/15/24. *Seroquel Oral Tablet 25 mg, give 1 tablet by mouth one a day related to bipolar disorder. Started date 05/14/24. *Seroquel Oral Tablet 50 mg, give 1 tablet by mouth at bedtime related to depression. Started date 05/14/24. Further review revealed there was no order for side effect monitoring noted for AP, AA, and AD. Record review of Resident #33's MAR dated 07/01/24-07/31/24 indicated there was no documentation of behavior or side effect monitoring noted for AP, AA, and AD. On 07/17/24 at 2:37 p.m., requested behavior and side effect monitoring for July 2024 from the ADM and Regional DOO by email. Only received behavior monitoring flowsheet for AP, AA, and AD for Resident #33. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #54's care plan dated 03/14/24, edited on 06/07/24, indicated Resident #54 had depression as evidence by diagnosis/history of depression and mood disorder, and wandering. Intervention included administer anti-depressant medication as ordered by MD. Record review of Resident #54's order summary dated 07/17/24, indicated: *Depakote Extended-Release Oral Tablet 24-hour 250 mg, give 1 tablet by mouth one time a day for mood disorder. Started date 02/26/24. *Depakote Delayed Release Oral 500 mg, give 1 tablet by mouth at bedtime for mood disorder. Started date 03/02/24. Further review revealed there was no order for side effect monitoring noted for an AC. Record review of Resident #54's MAR dated 07/01/24-07/31/24, indicated there was no documentation of behavior or side effect monitoring noted for AC: On 07/17/24 at 2:37 p.m., requested behavior and side effect monitoring for July 2024 from the ADM and Regional DOO by email. Received side effect and behavior monitoring for AD and AA for Resident #54. 4. Record review of Resident #69's face sheet dated 07/16/24, indicated Resident #69 was an [AGE] year-old female admitted on [DATE] with diagnosis including dementia with other behavioral disturbance. No diagnosis of anxiety noted. No appropriate diagnosis for AP noted. Record review of Resident #69's admission MDS assessment dated [DATE] indicated Resident #69 was usually understood and usually understood others. Resident #69's BIMS score was 08 which indicated moderately impaired cognition. The MDS indicated Resident #69 received an antianxiety and antipsychotic during the last 7 days of the assessment period. Record review of Resident #69's care plan dated 07/03/24, indicated: *Resident #69 had potential for drug related complication related to anxiolytic /sedative medications. Intervention included monitor side effects. *Resident #69 had potential drug related complication to antipsychotic medication. Intervention included monitor for side effects of antipsychotic medication every shift. Record review of Resident #69's order summary dated 07/17/24 indicated: *Seroquel Oral Tablet 25 mg, give 1 tablet by mouth at bedtime for antipsychotic. Started date 06/22/24. *Hydroxyzine Oral Tablet 25 mg, give 1 tablet orally every 8 hours as needed for anxiety. Start date 06/22/24. *Mitrazapine Oral Tablet 7.5 mg, give 1 tablet by mouth at bedtime for appetite stimulation. Start dated 07/15/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review revealed there was no order for behavior and side effect monitoring for AP ,hypnotic , and AD noted. Record review of Resident #69's MAR dated 07/01/24-07/31/24 indicated there was no documentation of behavior or side effect monitoring noted for AP, hypnotic, and AD. On 07/17/24 at 2:37 p.m., requested behavior and side effect monitoring for July 2024 from the ADM and Regional DOO by email. Received side effect monitoring for hypnotic only for Resident #69. During an interview on 07/17/24 at 3:10 p.m., the MDS coordinator said medical records put diagnoses in the electronic computer system. She said active resident's diagnoses were obtained from physician notes and the diagnoses list. During an interview on 07/17/24 at 4:10 p.m., LPN M said behavior and side effect monitoring was done every shift by the nurse. She said when the psychotropic medication was ordered, the nurse should also add behavior and side effect monitoring that correlated with the medication. She said it was important to assess behaviors and potential side effects to understand why the medication was prescribed and treating and to know if the medication was helping with the resident's behaviors. She said if the side effect were not being monitored, side effect to the medication could be missed. She said the orders for behavior and side effect monitoring noted behaviors and side effects to look for, which helped staff know what side effects and behaviors to look for. She said she did not know who was responsible for resident's having appropriate diagnoses for antipsychotic medications. During an interview on 07/17/24 at 5:07 p.m., the DON said the nurse on admission and/or the nurse who took the psychotropic medication order was responsible for ordering behavior and side effect monitoring for each type of medication ordered. She said the ADON and DON should be ensuring psychotropic medication had side effect and behavior monitoring. She said the ADON reviewed new medication orders and should at that time ensure monitoring was ordered. She said behavioral monitor let you know if the medication was effective treating the diagnosis or behavior. She said the behavior monitoring could also show if the medication was too effective. She said if monitoring was not done, staff did not know if the medication was helping or not and if the resident was experiencing adverse side effects. She said the MDS coordinator and nurses were responsible in ensuring residents had an appropriate diagnosis for medications. She said antipsychotic on Resident #69's order as being the diagnosis, was not an appropriate diagnosis for Seroquel use. She said the facility should have contacted Resident #69's previous admitting facility to get appropriate diagnosis for Seroquel and Lorazepam or contact the transferring hospital. She said the facility could have also contacted her physician about her diagnoses. She said appropriate diagnoses for psychotropic medications were important to make sure residents were not being treated with the wrong medication, helped prevent oversedation, and helped them not receive a medication not needed. She said the ADON reviewed admission orders and should be noticing inappropriate diagnoses for medication. She said another way to ensure psychotropic medication had an appropriate diagnosis was the facility should request medical records from the admitting facility on admission to get or add the appropriate diagnosis from the documentation received. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/17/24 at 6:00 p.m., the ADM said the DON and ADON should ensure residents had appropriate diagnoses for psychotropic medications. She said the DON should be monitoring the process to ensure it was being done. She said appropriate diagnoses were important to ensure the diagnosis fit the medication ordered. She said there were medications that were approved for off labeled use so making sure there was an appropriate diagnosis was important. She said the diagnosis needed to fit what it was manufactured for. Record review of a facility's Psychotherapeutic Drug Management policy revised 10/24/22, indicated .to ensure the resident receives only those medications, in dose and for duration clinically indicated to treat the resident's assessed condition(s) .to ensure that any potential contributions the medication regimen has to an unanticipated decline or newly emerging or worsening symptoms is recognized and evaluated .the Facility will make every effort to comply with state and federal regulations .side effects .psychotropic medications . are drugs that affect brain activities associated with mental processes and behavior .categories of medications which affect brain activity include antihistamines .and central nervous system agents used to treat conditions such as seizures, mood disorders, pseudobulbar affect .the requirement pertaining to psychotropic medications apply to these types of medications when their documented use appears to be substitution for another psychotropic medication rather than the original or approved indication .attending medical practitioner responsibility .the psychotherapeutic medication order will include the following . diagnosis for the medication .indications and manifestations of the disorder treated .nursing responsibilities . will monitor psychotropic drug use daily noting any adverse effects .monitoring should also include evaluation of the effectiveness of non-pharmacological approaches .will monitor the presences of target behaviors on a daily basis charting by exception .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 35295 Based on interview, and record review the facility failed to employ sufficient staff with the appropriate competencies, skills set and accreditations to carry out the functions of the food and nutrition service department for 1 of 7 (Dietary Aide A) reviewed for qualified dietary staff. The facility failed to ensure the DA A met the requirements for food handling by obtaining a food handler's certificate. This failure could place residents at risk of not having their nutritional needs met and placing them at risk for food born illnesses. Findings: During an interview and record review on 07/16/24 at 10:11 AM, the DM provided an undated Employee Demographics list that revealed DA A was hired 11/3/23. She said DA A did not have his food handler's certificate. She said he should have had it within 2 weeks of hire, but he did not get it. She said she talked to HR about it and let HR know he had not gotten it after she had reminded him numerous times. She said it was her responsibility and the responsibility of HR to make sure DA A got his food handler's certificate within 2 weeks of hire. She said she explained to DA A the importance of him getting the food handler's certificate and he still did not get it. During an interview on 07/16/24 at 11:13 AM, the Dietician said DA A did not have his food handler's certificate. She said if he hired on 11/3/23 he should have had it within 30 days. She said it was the DM's responsibility to make sure he had gotten it. She said she did not know who was responsible for making sure the DM had the food handler's certificates for the dietary staff. She said it was important for all staff to have the food handler's certificates so that they could handle food safely. During an interview on 07/16/24 at 1:16 PM, HR said the DM told her DA A did not have his food handler's certificate a week or so ago. She said they talked to the ADM, and they were supposed to get that done but they did not. She said it was a problem because DA A did not know the proper protocol for food safety. She said that could affect all residents that ate out of the kitchen. During an interview on 07/16/24 01:51 PM, the ADM said they did not have a policy regarding Food Handler's Certificates. During an interview on 07/16/24 at 4:02 PM, the DON said she was not aware DA A did not have a food handler certificate. She said if he was working in the kitchen, he should have one. She said it was important to learn how to handle food, prevent contamination, and food safely. She said that could affect all residents that ate from the kitchen which was every resident. She said it was the DM and HR's responsibility to make sure he had proper training. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/17/24, at 7:28 AM, DA A said he was hired 11/3/23 as a dishwasher. He said he was supposed to get a food handler's certificate right after he hired. He said he was reminded numerous times by the DM, but he was busy and never got it done. He showed this surveyor he was watching the videos now and said he would have it today. DA A said the food handler's certificate was important for food safety, learning about cross-contamination and keeping all residents safe and healthy. During an interview on 07/17/24 at 7:33 AM, the ADM said DA A was working on getting his food handler's certificate now. She said she was not sure what the holdup was or why he did not have it. She said it was the responsibility of the DM to make sure all her staff had training and were certified. The ADM said HR told her they were pressuring him to get the certificate. She said she oversaw all departments including HR and Dietary. She said she believed the ball dropped when the prior ADM left 1 week after she started, then the facility was sold. She said she took over the building on 4/1/24 and the facility was sold 7/1/24. She said there were too many things happening at once. The ADM said DA A not having his food handler's certificate could affect every resident in the building in that he would not be aware of food borne pathogens, required temperatures of food, and how things were reheated or stored. She said there was a potential for illness with all residents.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 44933 Based on interview and record review, the facility failed to ensure the resident's medical record included documentation that indicates the resident received education on the influenza and the pneumococcal immunizations of 19 of 74 residents (Residents #39, Resident #38, Resident #7, Resident #53, Resident #33, Resident #58, Resident #56, Resident #54, Resident #2, Resident #67, Resident #68, Resident #60, Resident# 107, Resident #51, Resident #72, Resident #108, Resident #44, Resident# 109, and Resident #110) reviewed for immunizations. The facility failed to offer and administer the influenza and pneumococcal vaccination to Residents #39, Resident #38, Resident #7, Resident #53, Resident #33, Resident #58, Resident #56, Resident #54, Resident #2, Resident #67, Resident #68, Resident #60. The facility failed to offer and administer the pneumococcal vaccination to Resident# 107, Resident #51, Resident #72, Resident #108, Resident #44, Resident# 109, and Resident #110. The facility failed to offer and administer the influenza vaccination to Resident #67, Resident #68, Resident #60. These failures could place residents at risk for contracting a viral disease that could spread through the facility and cause respiratory complications, and potential adverse health outcomes. Findings included: Record review of a facility's Influenza and Pneumonia Vaccines list run date 05/30/34 was provided on 07/16/24. The list indicated Residents #39, Resident #38, Resident #7, Resident #53, Resident #33, Resident #58, Resident #56, Resident #54, Resident #2, Resident #67, Resident #68, Resident #60 had not received or refused influenza or pneumococcal vaccinations. The list indicated Resident# 107, Resident #51, Resident #72, Resident #108, Resident #44, Resident# 109, and Resident #110 had not received or refused pneumococcal vaccinations. The list indicated Resident #67, Resident #68, Resident #60 had not received or refused influenza vaccination and was not admitted out of influenza season. During an interview on 07/17/24 at 5:07 p.m., the DON said the ADON was responsible for ensuring residents were offered and received vaccinations. She said the DON should be ensuring the ADON kept an accurate record of resident's vaccination status and administered vaccinations. She said she was not aware 19 out of 74 residents had not received the influenza and/or pneumonia vaccine. She said vaccination was important for prevention. She said vaccinations helped prevent the resident from getting sick and reduced the resident's symptoms if the virus was contracted. She said residents not receiving vaccinations place residents at risk for contracting the virus and spreading the virus. During an interview on 07/17/24 at 6:00 p.m., the ADM said the DON was responsible in ensuring the resident were offered and received the flu and pneumonia vaccine. She said being vaccinated helped the resident, if contracted the virus, decreased the severity of the illness. She said vaccinations were a protection against viruses. (continued on next page)

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	675379	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havencare Nursing and Rehabilitation Center LLC	111 Ruthlynn Dr Longview, TX 75601

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/22/24 at 2:28 p.m., the ADON said vaccines were offered to all residents during the admission process. He said he often had to reach out to families/PCPs to obtain prior vaccine information for residents. He said vaccines were an important prevention tool the facility used to decrease the risk of preventable infection for the resident. Record review of a facility's Influenza Prevention and Control policy revised 06/2020, indicated .to ensure that the Facility prevents and controls the spread of influenza in the Facility .influenza vaccinations of residents .residents are offered an influenza immunization during flu season annually, unless the immunization is medically contraindicated .the resident's medical record includes documentation that indicates, at a minimum .that the resident either received the influenza immunization or did not receive . Record review of a facility's Pneumococcal Disease Prevention policy revised 06/2020, indicated .to ensure that the Facility prevents and controls the spread of pneumococcal disease in the facility .the pneumococcal polysaccharide vaccine is recommended for the following .residents of nursing homes or long term care facilities . the resident's medical record includes documentation that indicates, at a minimum .that the resident either received the pneumococcal polysaccharide vaccine or did not receive .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observations, interviews, and record review, the facility failed to ensure all patient care equipment was in safe operating condition for 1 of 4 resident (Resident#31) reviewed safe, functional equipment. The facility failed to ensure Resident #31's wheelchair brake handle was not loose. This failure could place resident at risk for usage of unsafe equipment. Findings included: Record review of Resident #31's face sheet dated 07/16/24, indicated Resident #31 was an [AGE] year-old female admitted on [DATE] with diagnoses including Alzheimer's disease (is a progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment), muscle weakness, and abnormalities of gait and mobility. Record review of Resident #31's quarterly MDS assessment dated [DATE], indicated Resident #31 was sometimes understood and sometimes had the ability to understand others. Resident #31 was unable to complete the BIMS assessment. Resident #31 had short-and-long term memory recall problem and moderately impaired cognitive skills for daily decision making. Resident #31 used a wheelchair as a mobility device. Resident #31 required supervision for oral hygiene, maximal assistance for personal hygiene and putting on/taking off footwear, and dependence for toileting hygiene and dressing. Record review of Resident #31's care plan dated 12/28/23, edited 06/19/24, indicated Resident #31 was high risk for falls related to cognitive deficits with poor safety awareness, unaware of environmental obstacles, visual deficits, loses balance easily, and attempts to transfer/stand/ambulate but limited with unsteady gait. Intervention included lock all moveable equipment before transferring resident. During an observation on 07/16/24 at 9:00 a.m., Resident #31 was self-propelling herself aimlessly up and down the secured unit hallway. Resident #31's wheelchair wheels had moderate amount of dried substance splattered throughout both wheels. Resident #31's wheelchair had a moderate amount of hair tangled where the wheels and the frame connected. During an interview and observation on 07/17/24 at 3:48 p.m., CNA J said Resident #31 used her wheelchair to get around. She said maintenance was responsible for the upkeep of resident's wheelchairs. CNA J entered Resident #31's room and inspected her wheelchair. She said Resident #31's right wheelchair brake handle was loose. She said if a resident's wheelchair brake did not work, she would not put the resident in the chair and notify maintenance. She said if a resident's wheelchair brake was loose or did not work, the resident could fall. She said if the resident fell , they could get bruises and fractures. She said she had not noticed Resident #31's loose brake handle. CNA J said she would take the wheelchair out of Resident #31's room so maintenance could look at it. CNA J left the secured unit to locate the maintenance supervisor. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 07/17/24 at 4:07 p.m., the maintenance supervisor arrived on the secured unit and inspected Resident #31's wheelchair. He said Resident #31's wheelchair handle was loose, and he would take care of it. He said he was responsible for the maintenance of resident's wheelchairs. He said CNAs needed to let him know when resident's wheelchairs needed maintenance. He said he fixed wheelchairs when he was notified of an issue. He said once he was notified, he fixed the issue immediately. He said if a resident's wheelchair brake handle was loose, it placed resident at risks for falls. During an interview on 07/17/24 at 4:10 p.m., LPN M said whoever put the resident in their wheelchair should assess the brakes. She said if a resident stood up and the brake was not working, then the resident could fall and hurt themselves. She said maintenance was responsible for fixing wheelchairs. She said if something needed fix, she called maintenance and placed it on the 24-hour report. During an interview on 07/17/24 at 5:07 p.m., the DON said maintenance was responsible for the upkeep of resident's wheelchairs, but staff had to inform him of the issue. She said all staff should be inspecting resident's wheelchair. She said if a resident's wheelchair had a loose brake handle, it was a safety risk, and the resident could fall and sustain an injury. During an interview on 07/17/24 at 6:00 p.m., the ADM said the maintenance supervisor was responsible for wheelchair brakes and parts. She said the ADM was involved in ordering parts for wheelchairs. She said staff needed to communicate to the maintenance supervisor any malfunctions or issues with resident's equipment. She said staff verbally told the maintenance supervisor issues but there was a maintenance book also. She said if the resident could stand, the resident could fall and injury themselves or break a bone. She said ultimately it was maintenance responsibility to maintain resident's wheelchairs. A policy on maintenance responsibility regarding resident equipment was requested at this time. On 07/18/24 at 4:44 p.m., the ADM sent an email with some requested facility policies to this surveyor. The requested policy for Maintenance was not received in the email received on 07/18/24 at 4:44 p.m. On 07/18/24 at 4:48 p.m., Another email was sent requesting a policy on maintenance responsibility regarding resident equipment. The requested policy for Maintenance was not received after the email sent on 07/18/24 at 4:48 p.m.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 44933 ased on interview and record review, the facility failed to maintain ensure the required in-service trainings were sufficient for the continuing competencies of nurse aides but must be no less than 12 hours per year for 5 of 5 staff, (CNA F, CNA G, CNA H, CNA J, and CNA K) records reviewed for staff training. The facility failed to provide CNA F, CNA G, CNA H, CNA J, and CNA K 12 hours of training per year. This failure could place residents at risk of being cared for by untrained staff. Findings included: Record review of the Personnel File Review completed on 07/16/24, indicated CNA J, CNA F, CNA H, CNA K, and CNA G did not have 12 hours of training per year on file. The Personnel File Review indicated CNA J's date of hire was 03/07/17, CNA F 04/27/10, CNA H 01/22/02, CNA K 06/17/02, and CNA G 08/06/13. During an interview on 07/17/24 at 4:59 p.m., the HR Payroll said she had been at the facility for 4 months. She said she was responsible for training records, background checks, EMR and OIG results. She said she was responsible to notify the DON about training that needed to be completed. She said if trainings were not done, staff would not know the facility's protocols and procedures. During an interview on 07/17/24 at 5:07 p.m., the DON said she did not know the process or who was responsible for ensuring employees files were up to date. She said the staffing coordinator was responsible for the CNA trainings and competency evaluations. She said CNAs evaluation were supposed to be done annually. She said when trainings and evaluations were not done, CNAs were working but not trained correctly. She said this risked the residents not getting the care they needed, and it being done incorrectly. During an interview on 07/17/24 at 6:00 p.m., the ADM said HR was responsible for personnel files. She said records should be kept on want was completed upon hire and annually. She said if CNAs were not trained properly or evaluated, CNAs may not be aware of changes, informed of new processes, and new information the facility wanted them to know. She said staff would be working with a lack of knowledge which placed residents at risk. A policy regarding staff development and training was requested at this time. On 07/18/24 at 4:29 p.m., the ADM sent an email stating the facility did not have a policy for staff development and training to this surveyor. The employee handbook was requested at this time. Record review of the facility's 2024 Employee Handbook dated 11/2020, indicated .orientation& in-service training .ongoing training is necessary to provide the highest level of quality care to our resident/patients .you will be responsible for participating in orientation and training related to your position .your supervisor and/or Human Resources will communicate those requirements to you .