STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675387	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Panola County Nursing & Rehabilitation	501 Cottage Rd Carthage, TX 75633

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 44933 Based on observation, interview, and record review, the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality for 2 of 17 residents reviewed for dignity. (Resident #31, Resident #49) The facility to ensure CNA H did not push Resident #31 backwards in his wheelchair from his room to the dining room. The facility failed to ensure LVN D did not stand up while assisting Resident #49 with his lunch meal. These failures placed residents at risk for diminished quality of life, loss of dignity and self-worth. Findings included: 1. Record review of a face sheet printed 06/03/24 indicated Resident #31 was an [AGE] year-old male and was admitted on [DATE] with diagnoses including metabolic encephalopathy (as an alteration in consciousness caused due to brain dysfunction (due to impaired cerebral metabolism)) and Parkinson's disease (is a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #31 was understood and understood others. The MDS indicated Resident #31 had a BIMS score of 07 which indicated severe cognitive impairment. The MDS indicated Resident #31 was dependent for eating, oral, toilet, and personal hygiene, shower/bathe self, and dressing. Record review of a care plan dated 01/30/23, revised 01/31/24 indicated Resident #31 had an ADL self-care performance deficit related to previous stroke, Parkinson's disease, history of cancer, muscle wasting and atrophy (shortening), abnormalities of gait and mobility, and muscle weakness. Intervention included encourage resident to participant to the fullest extent possible with each interaction. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/03/24 at 10:04 a.m., revealed CNA H pushed Resident #31, in his wheelchair, out of his bathroom then out into the hall. CNA H was in front of Resident #31 pushing his wheelchair backwards towards the dining area on the secured unit. 2. Record review of a face sheet printed 06/05/24 indicated Resident #49 was a [AGE] year-old, male and was 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), severe, with agitation and dysphagia (is when you can't swallow correctly, leading to problems eating and drinking). Record review of an annual assessment dated [DATE] indicated Resident #49 was sometimes understood and sometimes understood others with unclear speech. The MDS indicated Resident #49 had a BIMS of 99 which indicated he was unable to complete the interview process to measure his cognition. The MDS indicated Resident #49 had short-and-long term memory recall problems. The MDS indicated Resident #49 required setup assistance for eating. Record review of a care plan dated 05/17/23, revised on 11/24/23 indicated Resident #49 had an ADL self-care performance deficit related to dementia, impaired balance, unsteadiness on feet, muscle weakness generalized, abnormalities of gait and mobility. Intervention included Resident #49 required partial to moderate assist of staff participation to eat. During an observation on 06/03/24 at 12:29 p.m., revealed Resident #49 was sitting on the sofa with a bedside table in front of him. LVN D stood in front of him feeding Resident #49 his lunch meal. During an interview on 06/05/24 at 11:45 a.m., CNA H said pushing a resident backwards in a wheelchair was not allowed. She said she knew she was not supposed to do it. She said she did recall pushing Resident #31 backwards in the wheelchair on Monday, 06/03/24. She said pushing a resident backwards in a wheelchair could make the resident feel degraded. She said staff were supposed to feed a resident sitting down. She said staff should be eye level with the resident when feeding them. She said feeding the resident standing up could make them feel like a baby. During an interview on 06/05/24 at 12:10 p.m., LVN D said she did feed Resident #49 standing up on Monday, 06/03/24. She said she knew residents were supposed to be fed at their level. She said it was hard to feed Resident #49 at his level because he liked to grab at the food. She said she knew it was better to still sit. She said it was a dignity issues to stand over a resident while feeding them. During an interview on 06/05/24 at 1:54 p.m., the DON said she expected the nursing staff to sit at the resident's level when feeding them. She said sitting at the resident's level made sure the staff were feeding the resident correctly and for the resident's dignity. She said it was inappropriate to push a resident backwards in a wheelchair. She said it was a dignity issue and could upset the resident. She said staff were aware to sit down when feeding residents and not to push residents backwards. During an interview on 06/05/24 at 2:45 p.m., the ADM said she expected staff to feed a resident at eye level. She said it could make the resident feel useless or like a special needs person. She said the resident should feel as an equal to the staff. (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's Resident Rights policy revised 02/2021 indicated .employees shall treat all residents with kindness, respect, and dignity .resident's right to .a dignified existence .be treated with respect, kindness, and dignity .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48958 Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 5 of 17 residents reviewed for environment. (Residents #9, #35, #36, #16, and #7) The facility failed to ensure Resident #35 and Resident #36 had a clean room free from dust and dead roaches. The facility failed to repair Resident #9 ceiling tiles in room with water spots, due to water damage. The facility failed to ensure Resident #16's room was free of roaches. The facility failed to ensure Resident #7's room was free of water bugs. The facility failed to repair the ceiling in hall by the dining area. The facility had a trash can catching rainwater. These failures could place residents at risk of an unsafe or uncomfortable environment and a decrease in quality of life and self-worth. Findings included: Record review of Resident #35's face sheet indicated she was an [AGE] year-old female initially admitted to the facility on [DATE] with a diagnosis included: unspecified dementia (dementia without a specific diagnosis), restlessness and agitation (agitation is a normal emotion) and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #35 rarely understood others and was rarely understood by others. The MDS BIMS assessment was not completed for Resident #35. The MDS indicated Resident #35 was dependent with ADL's. Record review of an undated care plan indicated Resident #35 had impaired cognitive function dementia or impaired thought processes related to diagnoses of dementia severe and Alzheimer's disease. Record review of Resident #36's face sheet indicated she was a [AGE] year-old female initially admitted to the facility on [DATE] with a diagnoses included: unspecified dementia (dementia without a specific diagnosis), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and Parkinson's disease (a disorder of the central nervous system that effects movement). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #36 was usually understood and usually understood others. Resident #36 was not able to complete the BIMS assessment. The MDS indicated Resident #35 was dependent with ADL's. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of undated care plan indicated Resident #36 was monitored for signs and symptoms of acute respiratory insufficiency: anxiety, confusion, restlessness, shortness of breath at rest, cyanosis (is a condition that causes the skin, lips or nails to turn blue or purple due to low oxygen levels in the blood)and somnolence (drowsiness). Make sure call light was within reach and encourage the resident to use for assistance as needed. During observations on 06/04/24 at 8:47 AM in Resident #35's room, the resident was lying in bed looking around. Two dead roaches were next to Resident #35's fall mat that was beside the bed. When exiting the resident's room observed Resident #36's bed faced toward the opened closet. On the closet floor were two dead roaches on their backs surrounded by hair and dust. Record review of Resident #9's face sheet indicated she was an [AGE] year-old female initially admitted to the facility on [DATE] with a diagnoses included: multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), paranoid schizophrenia (a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly) and unspecified disorder of nose and nasal sinuses (diseases of the respiratory system). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #9 was understood by others and understood others. The MDS assessment indicated Resident #9 had a BIMS score of 15 which indicated her cognition was intact. The MDS indicated Resident #9 was independent with ADL's. Record review of undated care plan indicated Resident #9 found these measures to be calming and to relieve risk of re-trauma: speak in a calm, non-threatening manner while working with resident. Establish and maintain a trusting relationship by listening to the client. She likes to be in her room alone at times where it is quiet. She voices that she does not have any lingering trauma from previous traumas. During observation and interview on 06/03/24 at 10:53 AM revealed in Resident #9 room there were dark and light brown water spots on the resident's ceiling tiles. The spots were noted in Resident #9's room and in bathroom. Resident #9 said the spots had been there for a while and when she complained about them the facility would paint over them with some white paint, but when it rained the spots showed up in different areas. Resident #9 said she did not like the spots on the ceiling and with tiles getting wet by rain that could cause mold and respiratory issues. During an interview on 6/05/2024 at 11:20 AM CNA I said the water spots on the facility's ceiling was a concern, because with the ceiling getting wet could cause the pieces to fall and hit someone. During observation and interview on 6/05/2024 at 11:48 AM with Resident #9 she said she told management of the facility that fungus grew in wet areas and it could cause health issues, due to the ceiling tiles getting wet when it rained. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/05/2024 at 11:55 AM with the Maintenance man he said pest control came and sprayed last 5/30/24. He said the chemical pest control spray brought the bugs out, that was why the roaches were observed dead on the floors. He said pest control came once a month to spray the facility. He said he expected for housekeeping to disinfect the front lobby, the dining area, then they should clean the resident's room. He said housekeeping should ask permission to enter a resident's room and notify the resident what they were in the room for. He said he did feel like the roof leak was a hazardous issue. He said the facility was in the process of getting a new roof. He said the facility had already gotten the roof approved. He said when it rained the roof leaked and got the tile pieces in the ceiling wet. He said since the ceiling pieces got wet they could get heavy, and fall and hit someone. Review of an invoice from the local pest control company dated 5/30/2024 revealed services were rendered. During an interview on 6/05/2024 at 11:30 AM Resident #16 said he saw roaches all the time in his room and all over the bathroom. Resident #16 said the roaches would be on the walls and carried germs. Resident #16 said those roaches can bite and they are very nasty. Resident #16 said the raining in the facility was dangerous, because the sheet rock crumbling and falling was dangerous. He said the tile pieces in the ceiling could fall and hurt someone also. During an interview on 6/05/2024 at 12:22 PM with Resident #7 he said he had water bugs in his room all the time. He said the water bugs came out at night. He said water bugs were all in the hallways. He said he thought the water bugs were very nasty. He said he did not like seeing the bugs and he tried to kill them. During an interview on 6/05/2024 at 12:24 PM with Resident #27, she said she saw roaches running around the facility all the time. She said she tried to kill them. She said roaches were not very sanitary. She said she did not like the roaches running around the facility. Resident #27 said she had a lot of water spots in her room and they moved her into another room while they fixed the roof. She said a piece of the ceiling fell and hit her while she was lying in bed. She said she did not get hurt and it just felt like a wet sponge hit her. She said it happened a while back. During an interview on 6/05/2024 at 1:33 PM with Housekeeper K, she said yes, she had seen a lot of cockroaches when cleaning that hall . She said she did not hear the residents complain about the roaches. She said she would not want the roaches running around in her house. She said she did not think it was sanitary for the roaches to be running around the facility. She said the tiles in the top of the ceiling have fallen down when it rained. She said she felt like wet tiles in the ceiling were a hazard, because anyone could get hit on the head from the pieces if they fell . She said a resident had been hit by wet tiles from the ceiling before. During an interview on 6/05/2024 at 1:50 PM with LVN G, she said she seen a lot of water bugs in the resident's room. She said she had seen the exterminator at the facility, but she did not think the chemical they used worked well. She said it would not make her feel good if she had lived in the facility with bugs and it needed to be taken care of. She said the ceiling leaked all the time. She said a roof guy came a couple months ago and did some repairs to the roof. She said the roof leaks could cause all kind of health conditions; such as respiratory issues and someone can get hurt with the roof leaks. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/05/2024 at 2:58 PM with the DON, she said she had witnessed the roaches, but thought they came out when it rained. She said pest control came and sprayed monthly, but if staff or residents saw an increase in bugs they would notify Maintenance and he would notify pest control and had them come out and spray. She said the facility had had roof leaks and they came and did roof repairs throughout the building. She said the roof leaking was hazardous because the tiles could potentially fall and injure someone. During an interview on 6/05/2024 at 3:18 PM with the ADM, she said the exterminators just came last 5/30/2024 or 5/31/2024 and sprayed the facility. The bugs have come out. She said she was sure that it made the residents uncomfortable to see the roaches, but the facility was doing what they could to eliminate the bugs. She said she expected the housekeepers to keep this facility clean like it was the President's house. She said not cleaning thoroughly was not acceptable. She said the facility was working on the leaks and would get the rest of the ceiling tiles changed out that has water damage. She said the roof leaks could be a potential hazard due to mold and the tiles in the ceilings could fall and hit a resident. Record review of the facility Homelike Environment Policy, dated February 2021 revealed . Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. Record review of the facility Resident Rights Under Federal Law Policy undated, revealed . the resident has the right to reasonable accommodation of individual needs and preferences except where the health and safety of the resident or other residents would be endangered.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review, the facility failed to ensure the right to be free from any physical restraints imposed for purposes of convenience and not required to treat medical symptoms for 1 of 16 residents reviewed for restraint use (Resident #30). The facility failed to ensure Resident #30 was free from physical restraints in the form of CNA A locking her wheelchair which did not allow her to move freely around the secured unit. This failure could place residents at risk for a decreased quality of life, a decline in physical functioning and injury. Findings included: Record review of a face sheet printed on 06/05/24 indicated Resident #30 was a [AGE] year-old, female and was 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), 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 cerebral infarction (stroke). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #30 was understood and usually understood others. The MDS indicated Resident #30 had a BIMS score of 03 which indicated severe cognitive impairment. The MDS indicated Resident #30 wandered. The MDS indicated Resident #30 normally used a wheelchair in last 7 days of the assessment period for a mobility device. The MDS indicated Resident #30 required setup for oral hygiene and eating, substantial assistance for lower body dressing and putting on/taking off footwear, partial assistance for upper body dressing, and dependent for toileting and personal hygiene, and shower/bathe self. The MDS indicated physical restraints were not used for Resident #30. Record review of a care plan dated 05/03/23, revised 02/08/24 indicated Resident #30 was at risk for falls related to Alzheimer's disease and no safety awareness. Intervention included Resident #30 needed prompt response to all request for assistance. Record review of a care plan dated 08/01/23 indicated Resident #30 was an elopement risk/wanderer as evidence by disoriented to place, history of attempts to leave facility unattended, impaired safety awareness, and wanders aimlessly-placement on secured unit. Intervention included distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, and book. During an observation on 06/04/24 at 1:32 p.m., revealed CNA A pushed, in her wheelchair, Resident #30 out of the dining area on the secured unit towards the nursing station. CNA A locked Resident #30's wheelchair brakes then walked away from Resident #30. Resident #30 started trying to self-propel herself in the wheelchair, but it only moved a little. The MDS Coordinator noticed Resident #30 trying to self-propel herself and unlocked the wheelchair brakes. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/04/24 at 1:36 p.m., Resident #30 was wandering in front of the nursing station in her wheelchair. CNA A pushed Resident #30 towards the front side of the nursing station then locked her wheelchair brakes. During an observation on 06/04/24 at 1:49 p.m., revealed Resident #30's wheelchair brakes were still locked. During an interview on 06/05/24 at 11:05 a.m., the MDS Coordinator said locking the brakes on a resident's wheelchair when not transferring them, could be considered a restraint. She said she did recall Resident #30 trying to move in her wheelchair and the brakes being locked. She said she had to release the brake on Resident #30's wheelchair, but she thought it was only one brake. She said she did not see CNA A lock the brakes on Resident #30's wheelchair the second time. She said the facility did not use restraints. She said inappropriate use of restraints could cause injury to the resident. During an interview on 06/05/24 at 11:45 a.m., CNA H said locking a resident's wheelchair who could not unlock it, could be considered a restraint. She said the facility did not use restraints. She said Resident #30 could sometimes unlock her brakes but Resident #30 would not understand if they were locked and she wanted to move, she would need to unlock the brakes. She said Resident #30 wandered the unit in her wheelchair. She said using a restraint could cause the resident to tip over and did not let the resident do want they wanted to do. On 06/05/24 at 12:00 p.m., called CNA A for a phone interview. A voice message was left regarding the reason for the call and a call back phone number. No call back received before or after exit. During an interview on 06/05/24 at 1:35 p.m., LVN G said locking a resident's wheelchair brakes, who could self-propel themselves, could be considered a physical restraint. She said a resident's movement could not be restricted. She said the facility did not use physical restraints. She said inappropriate use of restraints could cause injury, harm, or falls to the resident. During an interview on 06/05/24 at 1:54 p.m., the DON said putting the brakes on a resident's wheelchair when not transferring them, could be considered a restraint. She said the facility was a restraint free facility. She said inappropriate use of restraints had the potential for injury to the resident. She said staff knew not to use restraints on residents. During an interview on 06/05/24 at 2:45 p.m., the ADM said locking a resident's wheelchair who could not unlock it, could be considered a restraint. She said the facility did not use restraints. She said restraints were not appropriate to use because the resident could not be mobile as they wished. Record review of a facility's Use of Restraints policy revised 04/2017 indicated .restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully .restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the preventions of falls .physical restraints are defined as any manual method or physical or mechanical device .which restricts freedom of movement .the definition of a restraint is based on the functional status of the resident .practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted .

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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** 44596 Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care within 48 hours of a resident's admission including the minimum healthcare information necessary to properly care for 2 of 7 residents reviewed for new admissions. (Resident #110 and Resident #111) The facility failed to develop a baseline care plan within 48 hours of admission for Residents #110 and #111. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: 1. Record review of an undated face sheet revealed Resident #110 was an [AGE] year-old male admitted [DATE] with the diagnoses of cellulitis to lower extremities (skin infection to legs), diabetes mellitus (disease that affects blood sugar levels), and hypertension (high blood pressure). Record review of an incomplete admission MDS assessment dated [DATE], revealed Resident #110 had a BIMS of 09, which indicated moderate cognitive impairment. The MDS revealed Resident #110 was supervision assistance for transfer, bathing, and toileting. The MDS revealed the discharge plan to return to the community. Record review of the EHR for Resident #110 revealed no baseline care plan was initiated prior to survey intervention. Record review of the EHR for Resident #110 revealed no comprehensive care plan was initiated. During an interview on 06/03/2024 at 9:50 a.m., Resident #110 stated he had plans to return home and was unsure why he could not go now. Resident #110 stated no one had discussed his medications or discharge plan with him. Resident #110 stated it would make his stay more pleasant if he had a goal of the date he was getting released. 2. Record review of an undated face sheet revealed Resident #111 was a [AGE] year-old male admitted on [DATE] with the diagnoses of right lower extremity deep vein thrombosis (blood clot in the right leg), anxiety (uncontrolled feelings of anxiousness), and hyperlipidemia (build-up of fat in blood that can lead to clogged arteries). Record review of an incomplete admission MDS assessment dated [DATE], revealed Resident #111 had a BIMS of 04, which indicated a severe cognitive deficit. The MDS revealed Resident #111 was dependent for bathing, transfer, and toileting, Record review of the EHR for Resident #111 revealed no baseline care plan was initiated prior to surveyor intervention. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the EHR for Resident #111 revealed no comprehensive care plan was created prior to surveyor intervention. During an interview on 06/04/2024 at 10:20 a.m., the DON stated no baseline care plans had been completed on new admits in the last 4-6 weeks. The DON stated it was her job to initiate and complete the baseline care plans, but she had been working the floor as a night CNA and had not done any baseline care plans. The DON stated baseline care plans were important because they acted as the map of directions for care for each of the residents. The DON stated without the baseline care plan as a guide the resident could receive the wrong care or miss the care they need. During an interview on 06/05/2024 at 12:45 p.m., the ADM stated she expected the staff members to do their part to complete the baseline care plans. She felt baseline care plans were important information to help the staff care for each resident. The ADM stated it was hard to care for new residents without having an outline of their needs and the baseline care plan gave the staff an outline until the MDS was completed and the comprehensive care plan was created to guide resident care. Record review of a facility policy dated 11/08/2023 titled Baseline Care Plan, indicated the baseline care plan was developed and implemented within 48 hours of a resident's new admission Baseline care plans are developed by the Registered Nurses and other healthcare team members.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675387	A. Building B. Wing	06/05/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 3 of 17 residents reviewed for care plans. (Resident #28, Resident #47, Resident #50) 1. The facility failed to provide Resident #28 with scheduled smoke breaks. Resident #28's care plan indicated he wished to smoke. 2. The facility failed to develop a care plan for Resident #47's ADL dependence, dietary needs, vision impairment, bowel/bladder status, and diagnoses of anemia (is when you have low levels of healthy red blood cells to carry oxygen throughout your body), constipation, insomnia, and gastroesophageal reflux disease (is a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach, called the esophagus). 3. The facility failed to ensure Resident #50's contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) were care planned. 4. The facility failed to ensure Resident #50's care plan fall intervention of fall mats (are made of high-density foam and covered with a non-slip material to keep them in place; is used to cushion falls and minimize the risk of injury) were in place when she was placed in bed by CNA A and had a fall on [DATE]. 5. The facility failed to ensure the DON placed Resident #50's fall mat on the floor when she exited the room during incontinent care on [DATE]. Resident #50 had a fall with injury. These failures could place residents at risk of not having individual needs met and cause residents not to receive needed services. Findings included: 1. Record review of a face sheet printed [DATE] indicated Resident #28 was a [AGE] year-old male and was admitted [DATE] with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (is one-sided muscle weakness) following cerebral infarction (stroke) affecting right dominant side, 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 restlessness and agitation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a significant change in status MDS assessment dated [DATE] indicated Resident #28 was sometimes understood and sometimes understood others with unclear speech. The MDS indicated Resident #28 had a BIMS score of 99 which indicated he was unable to complete the interview to measure his cognition. The MDS indicated Resident #28 had short-and-long term memory recall problem but was able to recall location of his room. The MDS indicated Resident #28 had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident #28 did not wander. The MDS indicated Resident #28 required substantial assistance for eating, oral, toilet, and personal hygiene and dependent for shower/bathe self. The MDS indicated Resident #28 used tobacco. Record review of a care plan dated [DATE], revised [DATE], indicated Resident #28 wished to smoke. Interventions included smoking assessment every month and as needed and monitor for any decline in ability for smoking. Record review of Resident #28's safe smoking assessment dated [DATE] indicated .Does the resident know the location(s) of the designated areas for smoking? .Yes .this resident requires direct supervision while smoking . Record review of an undated facility's Residents Who Smoke indicated .[Resident #28] . Record review of an undated facility's Smoking Schedule indicated .8:30 am .10:30 am .1:30 pm .3:00 pm . 4:30 pm .6:30 pm .8:00 pm .Unit Smoking area: the end of the secure unit facing the hospital . During an observation on [DATE] at 3:01 p.m., revealed Resident #28 was not outside in the designated smoking area on the secured unit. No staff or other residents were outside either. During an observation on [DATE] at 3:15 p.m., revealed Resident #28 was in his wheelchair sitting at the exit door near the designated smoking area on the secured unit. Resident #28 was looking at the nursing station. During an interview on [DATE] at 9:15 a.m., attempted to interview Resident #28 but his speech was unclear with vocal noises. During an observation and interview on [DATE] at 9:35 a.m., revealed Resident #28 was not outside in the designated smoking area on the secured unit. CNA A said Resident #28 was the only smoker on the secured unit. During an observation on [DATE] at 1:30 p.m., revealed Resident #28 was not outside in the designated smoking area on the secured unit. No staff or other residents were outside either. During an observation on [DATE] at 1:12 p.m., revealed Resident #28 was in his wheelchair sitting at the exit door near the designated smoking area on the secured unit. Resident #28 was looking at the nursing station. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of face sheet printed [DATE] indicated Resident #47 was [AGE] year-old, male and was admitted on [DATE] with diagnoses including iron (a condition in which blood lacks adequate healthy red blood cells), vitamin B12 (is a condition in which your body does not have enough healthy red blood cells, due to a lack (deficiency) of vitamin B12), and folate (is the lack of folic acid in the blood) deficiency anemia, 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 gastro-esophageal reflux disease. Record review of Resident #47's consolidated physician order, active as of [DATE] indicated regular diet, mechanical soft texture, regular consistency related to dementia, ordered on [DATE] with no end date. Record review of an admission MDS assessment dated [DATE] indicated Resident #47 was sometimes understood and sometimes understood others. The MDS indicated Resident #47 had unclear speech, adequate hearing, and impaired vision without corrective lenses. The MDS indicated Resident #47 had a BIMS score of 99 which indicated he was unable to complete the interview to measure his cognition. The MDS indicated Resident #47 had short-and-long term memory recall problem but was able to recall staff names and faces. The MDS indicated Resident #28 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident #28 required supervision for eating, oral hygiene, toileting hygiene, partial assistance for shower/bathe self and personal hygiene, substantial assistance for dressing and putting on/taking off footwear. The MDS indicated Resident #47 was frequently incontinent of urine and bowel. The MDS indicated Resident #47 had diagnoses including anemia, constipation, insomnia, and gastro-esophageal reflux disease. The MDS indicated Resident had a mechanically altered diet. Record review of a care plan dated [DATE] indicated Resident #47 had the potential for adjustment issues related to admission, hearing/processing deficit, elopement risk/wanderer as evidence by impaired safety awareness, required psychotropic medication, full code CPR, impaired cognitive/dementia or impaired thought process related to diagnosis of severe dementia. The care plan did not reveal a care plan for ADL dependence, dietary needs, vision impairment, bowel/bladder status, and diagnoses of anemia, constipation, insomnia, and gastroesophageal reflux disease. During an observation on [DATE] at 10:02 a.m., Resident #47 was lying in his bed. Resident #47 did not respond when greeted or to questions asked. During an observation on [DATE] at 1:08 p.m., Resident #47 was sitting at the dining room table eating lunch. During an observation on [DATE] at 1:34 p.m., Resident #47 was the last one at the dining room table. He finished eating his lunch meal. 3. Record review of a face sheet printed [DATE] indicated Resident #50 was [AGE] year-old, male and was admitted [DATE] with diagnoses including contracture of muscle (is the stiffening of muscles due to disease or lack of use), 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), limitation of activities due disability, and history of falling. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a quarterly MDS assessment dated [DATE] indicated Resident #50 was rarely/never understood and rarely/never understood others. The MDS indicated unclear speech, adequate hearing, and vision. The MDS indicated Resident #50 had short-and-long term memory recall problem. The MDS indicated Resident #50 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident #50 had limitation in range of motion on both sides of her body and upper and lower extremities. The MDS indicated Resident #50 was dependent for eating, oral, toileting, and personal hygiene, shower/bathe self, dressing, and putting on/taking off footwear. The MDS indicated Resident #50 required dependent (helper does all of the effort, resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) assistance to roll left and right, sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, and tub/shower transfer. The MDS indicated Resident #50 had falls since admission/entry, reentry, or the prior assessment which was one with no injury. The MDS indicated Resident #50 had skin tears with application of nonsurgical dressings. Record review of a care plan dated [DATE], revised [DATE], indicated Resident #50 was at risk for falling due to co-morbid conditions, history of falling, lack of coordination, muscle weakness, unsteadiness on feet, abnormalities of gait and mobility and impaired mobility. Intervention included beveled fall mats to bedside related to fall risk and resident's preference to scoot on floor. The care plan did not reveal Resident #50 muscle contracture or limited range of motion to upper and lower extremities on both sided of the body. Record review of an incident report completed by LVN D, dated [DATE], indicated . [Resident #50] was found on the floor bedside her bed .floor mat was not in place at bedside .this was an unwitnessed fall .no injures noted . Record review of Resident #50's incident report completed by the DON, dated [DATE], indicated .resident's room .witnessed fall .Resident #50 was transferred to bed by staff .RN [DON] observed resident's brief was wet and she needed to be changed .bed was in low position and RN [DON] exited room to get a brief for resident [Resident #50] .when RN [DON] was entering resident's room, resident was actively rolling out of low bed with scoop mattress with knees in the air .[Resident #50] was assessed for injury with laceration to right eyebrow measuring 2.5cm in length and 0.2 cm width and was bleeding .Res [Resident #50] also had a purple area approximately 1.5x1.5 cm forming on her cheek .neuro checks initiated .[Resident #50] assisted to bed and changed .mental status: impulsiveness, lack of safety awareness, forgetful .witnesses: DON .staff to ensure fall mat in place anytime resident is in bed . During an observation on [DATE] at 9:32 a.m., Resident #50 was in the dining room, in a reclining wheelchair. Resident #50's elbows and knees were contracted. Resident #50 was not interviewable. In Resident #50's room, 2 fall mats were folded and placed beside a recliner. During an interview on [DATE] at 11:05 a.m., the MDS Coordinator said she was responsible for care plans. She said she did care plan daily with order changes, when MDSs were due, and at care plan meetings. She said she normally care planned a resident's diagnoses, medications, and personal preference. She said Resident #47's care plan was incomplete and care areas were missing. She said she updated Resident #47's care plan today. She said Resident #50's contractures should also be care planned. She said care plans were important to understand the resident's needs. She said if the care plan was not developed the staff may not know the resident's care, assistance and needs of the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:00 p.m., called CNA A for a phone interview regarding fall on [DATE]. A voice message was left regarding reason for call and call back phone number. No call back received before or after exit. During an interview on [DATE] at 12:10 p.m., LVN D said Resident #28 smoked. She said she tried to take Resident #28 to smoke if time and staffing allowed. She said there was no designated staff to take Resident #28 to smoke. She said she did not know about a smoke schedule for the secured unit. She said Resident #28 could not verbally express when he wanted to take a smoke break but if he sat by the designated smoke area door, he wanted to smoke. She said it probably made Resident #28 upset no one took him to smoke when he wanted to. LVN D said CNA A forgot to place Resident #50's fall mats down after she put her back to bed. LVN D said she was off the secured unit and came back and CNA A was at the nursing station near Resident #50's room. She said she heard noises and walked towards Resident #50's room. She said she noticed Resident #50 on the floor with no floor mats underneath her. She said the incident made her upset. She said CNA A was aware Resident #50's fall mats belonged on the floor when she was in the bed. She said fall mats were one of Resident #50's fall interventions. She said if the care planned fall interventions were not followed falls happened. During an interview on [DATE] at 1:30 p.m., CNA H said Resident #28 was a smoker. She said she had not offered or taken Resident #28 to smoke today. She said Resident #28 was supposed to be taken at the smoke schedule times. She said the nurse, aides, and sometimes housekeeping staff took Resident #28 to smoke. She said Resident #28 would sometimes gesture smoking a cigarette with his hands when he wanted to smoke. She said Resident #28 should be taken to smoke at the smoke schedule times, but sometimes it was not possible with what was going on the unit. She said it probably would upset Resident #28 if he wanted to smoke and no one took him. CNA H said care plan interventions should be followed. She said fall mats should be placed at the resident's bedside to prevent injury if the resident falls. She said Resident #50 was supposed to have two fall mats at her bedside. She said Resident #50 had a lot of falls. She said not following fall interventions could result in falls, injury, and skin tears. She said Resident #50 was one person assist for incontinent care. She said she did not leave Resident #50 unsupervised during changing because she rolled out of the bed. She said she made sure to bring all her supplies in the room for incontinent care. She said leaving a resident unsupervised during changing could cause falls or injuries. During an interview on [DATE] at 1:54 p.m., the DON said she expected staff to follow the resident's care plan. She said all staff had access to a resident's care plan. She said the MDS Coordinator was responsible for care plans with the help of the nursing staff. She said care plans were important to ensure proper care and know the needs of the resident. She said if care plans were not followed or developed, the resident had the potential to not receive proper care. The DON said CNAs, LVNs and housekeeping were responsible for taking residents to smoke. She said residents should be taken to smoke at the scheduled smoke times and as needed. She said Resident #28 went to back door when he wanted to smoke. She said not taking Resident #28 could cause him to have behaviors. The DON said on [DATE], she was working as a CNA on the secured unit. She said she transferred Resident #50 to bed and noticed her brief was wet. She said Resident #50's bed was in a low position, but the floor mats were not down yet after transferring her. She said she left Resident #50's room to go get a brief to change her. She said as she was entering the room, Resident #50 was lifting her knees in the air and rolled out of the bed. She said she should not have left the room without putting the floor mats down. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:45 p.m., the ADM said nurses, aides, and department were responsible for taking resident to smoke. She said resident on the secured unit should be taken on the same schedule as the non-secure unit residents. She said residents needed to be taken to smoke by staff for their safety and it was the resident's right. She said she could not speak in great depths about care plans, but she expected nursing staff to follow the resident's care plan. Record review of a facility's Care Plans, Comprehensive Person- Centered policy revised ,d+[DATE] indicated .a comprehensive, person centered care plan .meet the resident's physical, psychosocial and functional needs is developed and implemented .the Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive .care plan for each resident .the comprehensive, person-centered care plan will .describe the services that are to be furnished .incorporate identified problem areas .aid in preventing or reducing decline in the resident's functional status .reflect currently recognized standards of practice for problems areas and conditions .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure each resident's person-centered comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 of 17 residents (Residents #50), reviewed for care plans. The facility failed to revise and update Resident #50's comprehensive care plan to reflect change in diet order from regular to pureed. The facility failed to revise and update Resident #50's comprehensive care plan to reflect swallowing disorder of coughing or choking during meals or when swallowing medications. The facility failed to ensure Resident #50's care plan for ADL dependence was updated to reflect a change from substantial-maximal assist to dependent assist with transfer per the MDS. These deficient practices could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. Findings included: Record review of a face sheet printed 06/03/24 indicated Resident #50 was [AGE] year-old, male and was admitted [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) and dysphagia (difficulty swallowing). Record review of Resident #50's consolidated physician orders active as of 06/03/24 indicated regular diet, pureed texture, regular consistency, divided plate for all meals for pocketing. Start date 12/03/23, no end date. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #50 was rarely/never understood and rarely/never understood others. The MDS indicated unclear speech, adequate hearing, and vision. The MDS indicated Resident #50 had short-and-long term memory recall problem. The MDS indicated Resident #50 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident #50 was dependent for eating, oral, toileting, and personal hygiene, shower/bathe self, dressing, and putting on/taking off footwear. The MDS indicated Resident #50 required dependent (helper does all of the effort, resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) assistance to roll left and right, sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, and tub/shower transfer. The MDS indicated Resident #50 had a swallowing disorder of coughing or choking during meals or when swallowing medications. The MDS indicated Resident #50 required a mechanically altered diet. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a care plan dated 11/17/23 indicated Resident #50 had a potential nutritional problem related to mild protein calorie malnutrition (is the state of inadequate intake of food (as a source of protein, calories, and other essential nutrients)) and anorexia (is an eating disorder characterized by an abnormally low body weight, an intense fear of gaining weight and a distorted perception of weight). Diet: Regular, Regular, Regular, divided plate for meals, health shakes three times a day with meals for 60 days. Intervention included provide, serve diet as ordered, monitor intake, and record every meal. The care plan did not indicate Resident #50's pureed texture diet and coughing or choking during meals. Record review of a care plan dated 11/17/23 indicated Resident #50 had an ADL self-care performance deficit related to dementia, comorbid conditions, history of falling, lack of coordination, muscle weakness, unsteadiness on feet, abnormalities of gait and mobility, muscle wasting and atrophy (shortening) of multiples sites, and impaired mobility. Intervention included transfer: required substantial to maximal assist with transfers. Record review of Resident #50's ADL Transferring: Self Performance dated June 2024 indicated: *06/01/24: 1:27 p.m.-Total dependence (full staff performance), 9:14 p.m.- Total dependence *06/02/24: 1:56 p.m.- Total dependence *06/03/24: 1:29 p.m.- Total dependence, 8:24 p.m.- Total dependence *06/04/24: 1:58 p.m.- Total dependence Record review of Resident #50's ADL Transferring: Support Provided dated June 2024 indicated: *06/01/24: 1:27 p.m.- One-person physical assist, 9:14 p.m.- One-person physical assist *06/02/24: 1:56 p.m.- One-person physical assist *06/03/24: 1:29 p.m.- One-person physical assist, 8:24 p.m.- Two plus person physical assist *06/04/24: 1:58 p.m.- One-person physical assist During an interview on 06/05/24 at 11:05 a.m., the MDS Coordinator said she updated the care plans daily. She said she looked at new orders and they were discussed in morning meeting. She said the ADON/DON also did acute care changes, but she primarily did those too. She said Resident #50's diet should have been updated from regular to pureed. She said she had actually feed Resident #50, and she had a pureed diet. She said she did not normally care plan if the resident had choking or coughing with meals. She said but that was not a bad idea to start adding it to the care plan. She said if care plans were not updated then staff did not know if there were changes in the resident's care. During an interview on 06/05/24 at 1:30 p.m., CNA H said Resident #50 was a one person transfer but should have been a two-person transfer. She said she had been telling the nurses and DON that Resident #50 needed two-person assist for transfers. She said Resident #50 did not follow commands and was not weight bearing. She said Resident #50 did not assist with transfers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/05/24 at 1:54 a.m., the DON said the MDS Coordinator was responsible for updating care plans. She said she expected care plans to be updated with changes and with MDS assessment. She said Resident #50 had been a one-person transfer but should have been a two-person person. She said she was going to change her to a mechanical lift also. She said Resident #50 had lost trunk control in March 2024 and did not follow commands. She said care plans needed to be updated to ensure proper care was being provided to the resident. She said if the care plans were not updated there was a potential the resident's needs could be unmet. During an interview on 06/05/24 at 2:45 p.m., the ADM said the nursing department was responsible for care plans revision and updating. Record review of a facility's Care Plans, Comprehensive Person-Centered revised 12/2016 indicated . assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .the interdisciplinary team must review and update the care plan .when the resident has been readmitted to the facility from a hospital stay .when there has been a significant change in the resident's condition .at least quarterly, in conjunction with the required quarterly MDS assessment .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 44933 Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities in accordance with the comprehensive assessment to meet the interests and the physical, mental, and psychosocial well-being for 1 of 1 memory care unit reviewed for activities. The facility failed to provide meaningful activities for dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) residents on the memory care unit. This failure could place residents at risk for not having activities to meet their interests or needs and a decline in their physical, mental, and psychosocial well-being. Findings included: During an observation on 06/03/24 at 9:32 a.m., the AD had a large television playing music in the dining area of the memory care unit. Approximately 8 residents were in the dining area. During an observation on 06/03/24 at 10:21 a.m.-12:00 p.m., the dining and sitting area nor hallways had any memory care/dementia focused activities. Television on in dining area but residents did not show interest. During an observation on 06/03/24 at 3:01 p.m.-3:30 p.m., 5-8 residents in sitting area and dining area no meaningful activities offered to residents. During an observation on 06/04/24 at 9:09 a.m.-10:15 a.m., 5-8 residents in sitting area and dining area no meaningful activities offered to residents. During an observation on 06/04/24 at 1:08 p.m.- 2:00 p.m., 5-8 residents in sitting area and dining area no meaningful activities offered to residents. Record review of the June 2024 Activity schedule indicated: *06/03/24: 8am- Daily Chronicles, 10am- Music Monday, 11am- Karaoke, 1pm- Sit and Get Fit, 2pm- Bingo, 4pm- One on Ones *06/04/24: no scheduled activities due to senior games. *06/05/24: 8am- Daily Chronicles, 10am- Coffee and Chat, 11am- Craft, 1pm- Helping Hands, 2om- Bingo, 4pm- One on Ones *10am and 1pm- Memory Care, 11am and 2pm- Main Dining (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Panola County Nursing & Rehabilitation	501 Cottage Rd Carthage, TX 75633

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/05/2024 at 9:00 a.m., the AD stated she tried to do one structured activity on the secured unit each day. She stated it was up to the staff on the unit to provide the other activities because she was responsible for the activities on the outside of the unit. She stated she had 2-3 residents on the unit that she did one on one activities with because they did not always come out of their rooms, and she did those 3 days per week. She stated it would be helpful to have an assistant that could provide more structured activities to the residents on the unit, so they did not just sit around all day. During an interview on 06/05/24 at 11:45 a.m., CNA H said she had received dementia care training through a company the facility used. She said activities were done with the resident at 10 a.m. and 2 p.m. She said the unit had baby dolls and stuffed animals, but a resident was hoarding them all in her room. She said there was not enough staff to do sensory stuff with the residents. She said a lot of the behaviors the residents had were from boredom. During an interview on 06/05/24 at 1:35 p.m., LVN G said she felt the facility provided dementia centered care to the secured unit residents. She said the facility could provide more dementia centered activities. She said providing the resident with dementia centered activities was a team effort. She said the secured unit had good family support and they could help the activities be more individualized. She said several of the women on the secured unit were homemakers so activities geared towards homemaking would be good for them. She said more individualized, structured activities helped with memory recall and behaviors. She said the residents would not be so bored if there were more individualized, structured activities. She said the facility had activities like a lap blanket (is a unique weighted lap pad/weighted blanket designed specifically to engage people with dementia including Alzheimer's), but they were not being used. During an interview on 06/05/24 at 1:54 p.m., the DON said staff received annual training on dementia centered care. She said all staff should providing person centered care to the memory care resident. She said the facility interviewed the resident's family to get input on activities that interested their family member before admission. She said the facility did have some activities available for the residents, but she understood there needed to be more structured activities. She said trying to find activities that all the residents would be interested in, it be safe, and not be an infection control risk could be challenging. She said not providing residents individualized, structured activities had the potential for increased behaviors and falls. During an interview on 06/05/24 at 2:45 p.m., the ADM said it was the IDT responsibility to provide the residents on secured unit dementia centered care. She said the facility should be using the resident's care plan to find activities to meet their needs. She said the activities should be at their level and staff assisting with activities. She said the secured unit needed a timeline or structured activities, things to keep them busy. She said when residents were not provided activities throughout the day, they could become agitated, altercations, and falls happened. Record review of a facility's Dementia policy dated 11/2018 indicated .direct care staff will support the resident in initiating and completing activities .therapeutic and recreational activities will be supervised and supported throughout the day as needed .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review, the facility has failed to ensure that the resident environment remains as free of accident hazards as possible and provide supervision to prevent avoidable accidents for 3 of 16 residents (Resident #30, Resident #31, Resident #50) and 3 of 5 staff (CNA A, CNA H, DON) reviewed for transfer and supervision. The facility failed to ensure CNA A did not leave the secure unit unsupervised on 06/04/24 which resulted in Resident #30 ambulating without her wheelchair and with no supervision. The facility failed to ensure CNA H performed a safe 1 person transfer which resulted in Resident #31 obtaining a skin tear to his forearm on 05/28/24. The facility failed to ensure CNA H did not transfer Resident #50 without another staff assistance on 04/07/24. During one person transfer, Resident #50 obtained a skin tear during transfer. The facility failed to ensure the DON did not provide incontinent care without another staff assistance on 05/08/24. The DON left Resident #50 unsupervised during incontinent care which resulted in a fall with no fall mats on the floor. The facility failed to ensure Resident #50's care plan fall intervention of fall mats (are made of high-density foam and covered with a non-slip material to keep them in place; is used to cushion falls and minimize the risk of injury) were in place when she was placed in bed by CNA A and had a fall on 04/13/24. These failures could place residents at risk of injury from accident and supervision. Findings included: 1. Record review of a face sheet printed on 06/05/24 indicated Resident #30 was a [AGE] year-old, female and was 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), 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 cerebral infarction (stroke). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #30 was understood and usually understood others. The MDS indicated Resident #30 had a BIMS score of 03 which indicated severe cognitive impairment. The MDS indicated Resident #30 wandered. The MDS indicated Resident #30 normally used a wheelchair in last 7 days of the assessment period for a mobility device. The MDS indicated Resident #30 required setup for oral hygiene and eating, substantial assistance for lower body dressing and putting on/taking off footwear, partial assistance for upper body dressing, and dependent for toileting and personal hygiene, and shower/bathe self. The MDS indicated Resident #30 required partial/moderate assistance for sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a care plan dated 08/12/22 indicated Resident #30 had an ADL self-care performance deficit related to intertrochanter fracture of right femur (is a type of hip fracture or broken hip), muscle wasting to right and left shoulder, pain, dementia, and depression (is a common and serious medical illness that negatively affects how you feel, the way you think and how you act). Intervention included ambulation: required partial to moderate assist of one staff member at times with ambulation of short distance, and substantial to maximal assist with ambulation of longer distance. And locomotion: required supervision or touching assist with locomotion at times. Record review of a care plan dated 05/03/23, revised 02/08/24 indicated: *Resident #30 was at risk for falls related to Alzheimer's disease and no safety awareness. Intervention included Resident #30 needed prompt response to all request for assistance. *Resident #30 was at risk for falls related to Alzheimer's disease and no safety awareness. Fall with injury on 02/07/24. Intervention included follow facility fall protocol. Record review of Resident #30's fall risk assessment completed by the DON, dated 05/04/24, indicated intermittent confusion, 1-2 falls in past 3 months, ambulatory/incontinent, adequate vision, balance problem while standing and walking, decreased muscular coordination, takes 1-2 of listed high risk medications, and 1-2 present predisposing conditions. Score 17= High risk. Record review of the facility's nursing schedule dated 06/04/24, indicated .Nurse aide .CNA A .6A-6P .North Unit .CNA M .6A-6P .South Unit .LVN D .6A-6P .South Unit . During an observation on 06/04/24 at 9:09 a.m., revealed CNA A walked towards the secure unit and opened the door. CNA A and I both entered at the same time. Resident #30 was walking around the corner of the dining room towards the entrance of the secured unit. CNA A hurried to the dining room and grabbed Resident #30's wheelchair. CNA A helped Resident #30 back into her wheelchair. There was no other staff visualized on the unit. During an interview on 06/04/24 at 2:00 p.m., LVN D said she had just returned to the facility. She said she had left earlier this morning for a family emergency. On 06/05/24 at 12:00 p.m., called CNA A for a phone interview. A voice message was left regarding reason for call and call back phone number. No call back received before or after exit. 2. Record review of a face sheet printed 06/03/24 indicated Resident #31 was an [AGE] year-old, male and was admitted on [DATE] with diagnoses including metabolic encephalopathy (as an alteration in consciousness caused due to brain dysfunction (due to impaired cerebral metabolism)) and Parkinson's disease (is a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a quarterly MDS assessment dated [DATE] indicated Resident #31 was understood and understood others. The MDS indicated Resident #31 had a BIMS score of 07 which indicated severe cognitive impairment. The MDS indicated Resident #31 rejected care which included ADL assistance. The MDS indicated Resident #31 used a wheelchair for a mobility device. The MDS indicated Resident #31 was dependent for eating, oral, toilet, and personal hygiene, shower/bathe self, and dressing. The MDS indicated Resident #31 was dependent for sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. Record review of a care plan dated 01/30/23, revised 01/31/24 indicated Resident #31 had an ADL self-care performance deficit related to previous stroke, Parkinson's disease, history of cancer, muscle wasting and atrophy (shortening), abnormalities of gait and mobility, and muscle weakness. Intervention included transfer: required partial to moderate assist with sit to stand, chair/bed-to-chair, tub/shower transfers and substantial to maximal assist with toilet transfers. Record review of a care plan dated 05/28/24, revised 05/30/24, indicated Resident #31 had a skin tear/potential for skin tear of the left forearm. Intervention included use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Record review of an incident report by LVN G, dated 05/28/24, indicated, .[Resident #31] had a skin tear in resident's room .CNA was assisting resident to stand patient pulled arm away and patient obtained a 3 cm skin tear at this time cleansed with wound cleaner, pat dry applied steri strips without further incident . Resident description: I [Resident #31] was trying to pull away.skin tear .left forearm .mental status: impulsiveness, lack of safety awareness, oriented to person, forgetful .predisposing situation factors: during transfer . During an observation and interview on 06/03/24 at 9:40 a.m., revealed Resident #31 was sitting in the hallway near the resident's room with a soft helmet on his head. Resident #31 was in a wheelchair slowly propelling himself into the room. Resident #31's left forearm had several scattered bruises and steri-strips noted. Resident #31 knew his name but then started complaining about being cold. Unable to perform interview due to inattentiveness. 3. Record review of a face sheet printed 06/03/24 indicated Resident #50 was [AGE] year-old, male and was admitted [DATE] with diagnoses including contracture of muscle (is the stiffening of muscles due to disease or lack of use), 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), limitation of activities due disability, and history of falling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a quarterly MDS assessment dated [DATE] indicated Resident #50 was rarely/never understood and rarely/never understood others. The MDS indicated unclear speech, adequate hearing, and vision. The MDS indicated Resident #50 had short-and-long term memory recall problem. The MDS indicated Resident #50 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident #50 had limitation in range of motion on both sides of her body and upper and lower extremities. The MDS indicated Resident #50 was dependent for eating, oral, toileting, and personal hygiene, shower/bathe self, dressing, and putting on/taking off footwear. The MDS indicated Resident #50 required dependent (helper does all of the effort, resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) assistance to roll left and right, sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, and tub/shower transfer. The MDS indicated Resident #50 had falls since admission/entry, reentry, or the prior assessment which was one with no injury. The MDS indicated Resident #50 had skin tears with application of nonsurgical dressings. Record review of a care plan dated 11/15/23 indicated Resident #50 was prone to skin tears and bruising of unknown origin related to thin/fragile skin, impaired nutritional status, and osteoporosis (is a bone disease that develops when bone mineral density and bone mass decreases, or when the quality or structure of bone changes). Intervention reflected to identify potential causative factors and eliminate/resolve when possible. Record review of a care plan dated 11/15/23, revised 06/03/24, indicated Resident #50 was at risk for falling due to co-morbid conditions, history of falling, lack of coordination, muscle weakness, unsteadiness on feet, abnormalities of gait and mobility and impaired mobility. Falls: 11/20/23 (no injuries), 02/06/24 (with injury), 02/19/24 (no injury), 04/13/24 (no injury), 05/08/24 (with injury), 05/27/24 (with injury). Intervention included beveled fall mats to bedside related to fall risk and resident's preference to scoot on floor. Record review of a care plan dated 11/17/23 indicated Resident #50 had an ADL self-care performance deficit related to dementia, comorbid conditions, history of falling, lack of coordination, muscle weakness, unsteadiness on feet, abnormalities of gait and mobility, muscle wasting and atrophy (shortening) of multiples sites, and impaired mobility. Intervention included transfer: required substantial to maximal assist with transfers. Record review of Resident #50's incident report completed by LVN G, dated 04/07/24, indicated .skin tear . resident's room .patient obtained skin tear to right forearm during transfer .predisposing situation factors: during transfer .other: thin/fragile skin .witness: [CNA H] .Statement: [Resident #50] was transferred from bed to chair .when resident was in her chair .I [CNA H] saw a skin tear to right forearm .chair was checked for sharp areas with none noted .[Resident #50] has thin/fragile skin and frequently moves arms all about . Record review of an incident report completed by LVN D, dated 04/13/24, indicated . [Resident #50] was found on the floor bedside her bed .floor mat was not in place at bedside .this was an unwitnessed fall .no injures noted . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #50's incident report completed by the DON, dated 05/08/24, indicated .resident's room .witnessed fall .Resident #50 was transferred to bed by staff .RN [DON] observed resident's brief was wet and she needed to be changed .bed was in low position and RN [DON] exited room to get a brief for resident [Resident #50] .when RN [DON] was entering resident's room, resident was actively rolling out of low bed with scoop mattress with knees in the air .[Resident #50] was assessed for injury with laceration to right eyebrow measuring 2.5cm in length and 0.2 cm width and was bleeding .Res [Resident #50] also had a purple area approximately 1.5x1.5 cm forming on her cheek .neuro checks initiated .[Resident #50] assisted to bed and changed .mental status: impulsiveness, lack of safety awareness, forgetful .witnesses: DON .staff to ensure fall mat in place anytime resident is in bed . Record review of Resident #50's ADL Transferring: Self Performance dated June 2024 indicated: *06/01/24: 1:27 p.m.-Total dependence (full staff performance), 9:14 p.m.- Total dependence *06/02/24: 1:56 p.m.- Total dependence *06/03/24: 1:29 p.m.- Total dependence, 8:24 p.m.- Total dependence *06/04/24: 1:58 p.m.- Total dependence Record review of Resident #50's ADL Transferring: Support Provided dated June 2024 indicated: *06/01/24: 1:27 p.m.- One-person physical assist, 9:14 p.m.- One-person physical assist *06/02/24: 1:56 p.m.- One-person physical assist *06/03/24: 1:29 p.m.- One-person physical assist, 8:24 p.m.- Two plus person physical assist *06/04/24: 1:58 p.m.- One-person physical assist During an observation on 06/03/24 at 9:32 a.m., revealed Resident #50 was in the secured unit dining room. Resident #50 was in a Broda chair (is a chair or wheelchair that provides comfort, support, and mobility throughout the day) with a bruise and steri-strips to right cheek and eye. Resident #50 made random noise and had restless legs. On 06/05/24 at 12:00 p.m., called CNA A for a phone interview regarding fall on 04/13/24. A voice message was left regarding reason for call and call back phone number. No call back received before or after exit. During an interview on 06/05/24 at 12:10 p.m., LVN D said CNA A forgot to place Resident #50's fall mats down after she put her back to bed. LVN D said she was off the secured unit and came back and CNA A was at the nursing station near Resident #50's room. She said she heard noises and walked towards Resident #50's room. She said she noticed Resident #50 on the floor with no floor mats underneath her. She said the incident made her upset. She said CNA A was aware Resident #50's fall mats belonged on the floor when she was in the bed. She said fall mats were one of Resident #50's fall interventions. She said if the care planned fall interventions were not followed falls happened. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/05/24 at 1:30 p.m., CNA H said on 04/07/24, she transferred Resident #50 from the wheelchair to the bed. She said she used a gait belt for the transfer. She said at the time, Resident #50 was a one person transfer but should have been a two-person transfer. She said she had been telling the nurses and DON that Resident #50 needed two-person assist for transfers. She said Resident #50 did not follow commands and was not weight bearing. She said Resident #50 did not assist with transfers. She said she could change Resident #50 by herself. She said Resident #50 was one person assist for incontinent care. She said she did not leave Resident #50 unsupervised during changing because she rolled out of the bed. She said she made sure to bring all her supplies in the room for incontinent care. She said leaving a resident unsupervised during changing could cause falls or injuries. She said she did not recall causing Resident #31's skin tear during a transfer. She said Resident #31 was a one person transfer but they used two-person assistance today (06/05/24). She said Resident #31 had days he needed a lot of assistance but occasionally like on Monday (06/03/24), he self-propelled himself and stood up without assistance. She said gait belts were supposed to be used for one person transfers. She said not using the correct amount of assistance could cause skin tears and falls. She said someone was supposed to be always on the secured unit. She said residents on the secured unit needed supervision. She said all types of things could happen if resident were left alone on the secured unit. She said falls and fights could happen when resident were left alone. She said Resident #30 did stand unassisted, but her knees gave out sometimes. She said Resident #30 should use her wheelchair to get around the unit. She said Resident #30 should not be ambulating on the unit without supervision. She said if Resident #30 ambulated without supervision or her wheelchair, she could fall and hurt herself. CNA H said care plan interventions should be followed. She said fall mats should be placed at the resident's bedside to prevent injury if the resident falls. She said Resident #50 was supposed to have two fall mats at her bedside. She said Resident #50 had a lot of falls. She said not following fall interventions could result in falls, injury, and skin tears. During an interview on 06/05/24 at 1:35 p.m., LVN G said she worked the day Resident #31 got a skin tear during transfer. She said CNA H was the CNA who transferred the resident. She said Resident #31 had a decline in ADL's especially after his recent surgery. She said Resident #31's physical and mental condition was labile. She said Resident #31 was a one-person assist transfer. She said gait belts were supposed to use for transfers. She said she did not think CNA H used a gait belt during Resident #31's transfer on 04/07/24. She said CNA H's hands would have been on the gait belt, not Resident #31's arms, for him to pull away. She said use of gait belts on the secured unit was challenging sometimes because the residents were impatient and did not follow directions. She said improper transferring could cause skin tears and falls. She said the secured unit should always have supervision. She said a CNA or LVN should be on the unit. She said the residents on the secured unit were unpredictable and so many things could happen if they are left unsupervised. She said Resident #30 should not be ambulating without supervision. She said residents unsupervised potentially could have falls, resident to resident altercation, and other injuries. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/05/24 at 1:54 p.m., the DON said on 05/08/24, she was working as a CNA on the secured unit. She said she transferred Resident #50 to bed and noticed her brief was wet. She said Resident #50's bed was in a low position, but the floor mats were not down yet after transferring her. She said she left Resident #50's room to go get a brief to change her. She said as she was entering the room, Resident #50 was lifting her knees in the air and rolled out of the bed. She said she should not have left the room without putting the floor mats down. She said Resident #50 had been a one-person transfer but should have been a two-person person. She said she was going to change her to a mechanical lift also. She said Resident #50 had lost trunk control in March 2024 and did not follow commands. She said gait belts were supposed to be used for one and two-persons transfer assists. She said Resident #31 was a one-person transfer assist. She said staff hands should be on the gait belt during the transfer not the resident's arms. She said transferring without a gait belt or improperly potential could cause falls and injuries. She said the secured unit should always have supervision. She said CNA A and LVN D, who were assigned to the unit, had not returned her phone call to question them about the secured unit residents being unsupervised. She said altercations and falls could happen if secured resident were unsupervised. She said Resident #30 could stand up and walk short distances. She said Resident #30's knees did give out on her without warning. She said Resident #30 should be using her wheelchair primarily for getting around. She said Resident #30 should not be standing or walking with no supervision. During an interview on 06/05/24 at 2:45 p.m., the ADM said she expected staff to use the appropriate amount of assistance for transfers and gait belts. She said she expected staff to stay on the secured and the residents to be supervised. She said it was important for the resident safety to prevent falls and elopements. Record review of CNA H's CNA Proficiency dated 04/30/24 indicated .transfers .1 person assist .satisfactory . 2 person assist .satisfactory .uses gait belt with transfers .satisfactory . Record review of a Care Plans, Comprehensive Person-Centered policy revised 12/2016, indicated . assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .the Interdisciplinary Team must review and update the care plan . Record review of a Safe Lifting and Movement of Residents policy revised 07/2017 indicated .in order to protect the safety and wellbeing of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents .resident safety .medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents .nursing staff .shall assess individual residents' needs for transfer assistance on an going basis .manual lifting of residents shall be eliminated when feasible .staff responsible for direct resident care will be trained in the use of manual (gait/transfer) . Record review of a Fall policy revised 03/2018 indicated .based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling .

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	675387	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Panola County Nursing & Rehabilitation	501 Cottage Rd Carthage, TX 75633

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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 4 residents reviewed for respiratory care. (Resident #39) The facility failed to ensure Resident #39's nebulizer mask (provide vaporized medicine into the airway) was stored in a bag after use. The facility failed to ensure Resident #39's nebulizer mask was labeled and dated. These failures could place residents at risk of respiratory infections. Findings included: Record review of a face sheet printed 06/05/24 indicated Resident #39 was a [AGE] year-old, male and admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (is a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and emphysema (is a lung disease that results from damage to the walls of the alveoli in your lungs). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #39 was usually understood and usually understood. The MDS indicated Resident #39 had a BIMS score of 06 which indicated severe cognitive impairment. Record review of a care plan dated 11/02/23, revised 02/21/24, indicated Resident #39 had a history of emphysema/ COPD and a history of anaphylaxis (is a common medical emergency and a life-threatening acute hypersensitivity reaction). Intervention included change respiratory tubing and mask every 7 days. Record review of Resident #39's consolidated physician orders active as of 06/05/24 did not reveal an order regarding frequency of changing oxygen equipment. Record review of Resident #39's consolidated physician orders active as of 06/05/24 indicated Ipratropium-Albuterol Inhalation Solution 0.5-2.5, 1 vial inhale orally every 4 hours as needed for cough/congestion and shortness of breath related to COPD and emphysema via nebulizer, start date 06/02/24, no end date. Record review of Resident #39's MAR dated 06/01/24-06/30/24 indicated: *Ipratropium-Albuterol Inhalation Solution 0.5-2.5, 1 vial inhale orally via nebulizer three times a day related to COPD and emphysema. Discontinued date 06/01/24 at 7:45 p.m. * Ipratropium-Albuterol Inhalation Solution 0.5-2.5, 1 vial inhale orally every 4 hours as needed for cough/congestion and shortness of breath related to COPD and emphysema via nebulizer, start date 06/02/24, no end date. (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 observation on 06/03/24 at 10:02 a.m., revealed Resident #39's nebulizer mask was on his bedside table connected to the nebulizer machine. Resident #39's nebulizer mask was not stored in bag and was not labeled with the resident's name or dated when lasted changed. During an observation on 06/04/24 at 9:09 a.m., revealed Resident #39's nebulizer mask was on the floor wrapped around the bed controller. Resident #39's nebulizer mask was not stored in bag and was not labeled with the resident's name or dated when lasted changed. During an interview on 06/05/24 at 12:10 p.m., LVN D said Resident #39 got nebulizer treatments as needed. She said Resident #39's nebulizer mask was not stored correctly or labeled/dated on Monday (06/03/24) and Tuesday (06/04/24). She said night shift LVNs on Sundays were responsible for labeling and dating. She said if resident's nebulizer masks were not stored correct and labeled/dated, the resident could get an infection. During an interview on 06/05/24 at 1:54 p.m., the DON said the nebulizer mask should be stored in bag when not in use. She said the nebulizer masks should be changed weekly and at that time, labeled and dated. She said Sunday night LVNs were responsible for the weekly changes. She said the nebulizer masks needed to be changed weekly and stored in bag for infection control. During an interview on 06/05/24 at 2:45 p.m., the ADM said the nursing department was responsible for respiratory equipment. Record review of a facility's Departmental (Respiratory Therapy)-Prevention of Infection policy revised 11/2011 indicated .the purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment .infection control consideration related to medication nebulizers . store circuit in plastic bag, marked with date and resident's name, between uses .discard the administration set-up every seven 7 days .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on observations, interviews, and record reviews, the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population for 3 (Resident #50,#32, and #31) of 16 residents residing on the secured unit. The facility failed to have sufficient staff available to provide resident care and supervision to prevent falls with injury on the secured unit for 3 of 3 months reviewed for staffing (March 2024-May2024). This failure could put residents at risk of not receiving necessary care and supervision to maintain their highest practicable physical, mental, and psychosocial wellbeing. Findings Included: 1. Record review of an undated face sheet revealed Resident #50 was a [AGE] year-old female admitted [DATE] with the diagnoses of dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), anxiety (uncontrolled feeling of anxiousness), and depression (group of conditions associated with the elevation or lowering of a person's mood). Record review of a quarterly MDS assessment dated [DATE], revealed Resident #50 had a BIMS of 00, which indicated severe cognitive impairment. The MDS revealed Resident #50 was dependent assistance for transfer, bathing, and toileting. The MDS revealed Resident #50 had falls in the past 90 days. Record review of a comprehensive care plan dated 11/23/2023 indicated an intervention for frequent visual checks related to fall risk. Record review of a progress noted dated 05/08/2024 written by the DON indicated the DON left Resident #50 unattended during incontinent care and Resident #50 fell while unsupervised and obtained a laceration to her right eyebrow and a hematoma to her cheek. Record review of a progress note dated 05/27/2024 written by LVN F indicated, Resident #50 was found on the floor by CNA B. She had laceration to the right side of the chin and her cheek. During an interview on 06/04/2024 at 10:30 a.m., the DON stated she was working the night shift (05/08/2024) as a CNA when Resident #50 fell from her bed, and she was working the secured unit alone. She stated she left the resident unattended to get a brief to change her and when she returned, she had fallen from the bed that was in the low position. The DON stated she felt having another aide on the unit would help with the supervision of the residents and was needed because of their acuity level. The DON stated that corporate directed the staffing ratio at the facility and they were not permitted to have two CNAs on the unit per shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/04/2024 at 11:45 a.m., CNA B stated she recalled when (05/27/2024) Resident #50 was found on the floor and that she had a laceration to her chin and there was blood everywhere. CNA B stated she was just one person assist and she did her best to keep an eye on everyone. CNA B stated she honestly did not know when Resident #50 fell . She stated she was doing her rounds changing people and walked into her on the floor. CNA B stated she had to call the nurse from her cell phone to come down and look at Resident #50 because she was out giving medications on south hall. CNA B stated on bad days when the residents were acting really wild it was impossible to get all the documentation and care done like you were supposed to, but if you had a routine, you could get most of the care for the resident's done. 2. Record review of an undated face sheet revealed Resident #32 was an [AGE] year-old male admitted [DATE] with the diagnoses of dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), hypertension (high blood pressure), and hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles). Record review of a care plan dated 11/24/2023 revealed Resident #32 had an intervention for falls of answering the call light promptly and frequent visual checks. Record review of a quarterly MDS assessment dated [DATE], revealed Resident #32 had a BIMS of 00, which indicated severe cognitive impairment. The MDS revealed Resident #32 was extensive to dependent assistance for transfer, bathing, and toileting. The MDS revealed Resident #32 had multiple falls with injuries in the past 90 days. The MDS revealed Resident #32 had physical and verbal behaviors towards others 4-6 days per week. Record review of a progress noted dated 03/05/2024 written by LVN H indicated Resident #32 was found on the floor after an unwitnessed fall and he sustained skin tears to his left hand from the fall. Record review of a progress note dated 03/11/2024 written by LVN F indicated Resident #32 has found on the floor during rounds and was noted to have redness and bruising to his left outer knee and left hip. 3. Record review of an undated face sheet revealed Resident #31 was an [AGE] year-old male, admitted on [DATE] with the diagnoses of anemia (lack of blood), hypertension (high blood pressure), and renal failure (a condition in which the kidneys lose the ability to remove waste and balance fluid). Record review of the quarterly MDS dated [DATE] revealed Resident # 31 had a BIMS of 07, which indicated a moderate cognitive deficit. The MDS indicated Resident #31 was dependent with ADLs and had no falls since the most recent admit. Record review of the care plan dated 05/25/2024 revealed Resident #31 had 9 falls since 01/19/2024. Interventions for the falls were listed as staff reorientation, ensuring proper footwear, answering call lights promptly, and reminding Resident #31 to use his wheelchair. The falls were listed as follows: 01/19/2024-witnessed; 01/25/2024-unwitnessed; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/27/2024-unwitnessed; 02/04/2024-witnessed; 02/07/2024-witnessed; 02/06/2024-unwitnessed; 03/26/2024-witnessted; 05/09/2024-unwitnessed 05/11/2024-unwitnessed- with injury. Record review of progress notes dated 03/01/2024 to 06/01/2024 reveal no progress note documentation related to falls. Record review of the PBJ staffing Data Report dated 01/01/2024 to 03/31/2024 indicated the facility triggered for one star staff rating. Record review of the daily staff sign in sheets from 03/01/2024 to 06/04/2024 indicate one CNA assigned to the secured unit with an average census of 16-20 residents. During a general observation of the secured unit on 06/03/2024 at 9:35 a.m., there was (1) CNA providing ADL care and supervision for 16 resident's residing on the secured unit. No other staff was on the secured unit from 9:35 a.m. to 10:00 a.m. During the 10 minutes CNA A was providing incontinent care to a dependent resident the other residents were moving around throughout the unit, into other resident's rooms, attempting to stand up and walking unassisted with no supervision. The nurse assigned to the secured unit was outside of the unit passing medication to residents on another hall. During an observation and interview of the secured unit on 06/04/2024 at 9:08 a.m., CNA A was outside of the secured unit for approximately 10 minutes and the assigned nurse (LVN D) had to leave for a family emergency. There was no staff on the unit when the surveyor and CNA A arrived at the locked door outside of the secured unit together and CNA A let the surveyor into the unit. CNA stated she was taking a 10-minute break and that LVN D left the facility and the ADON was supposed to take over as the nurse. CNA A stated the ADON told her to call her if she needed any help and she would come back to the unit. No falls were noted during the absence of staff. CNA A stated she could do all the tasks assigned to her if she really hustled. She stated she was responsible for meals, bathing, toileting, dressing, and grooming all 16 residents. She stated the nurse had to pass meds in the unit and out on the south hall. She stated the nurse was probably assisting on the unit about 2-3 hours a day because of all the other things she had to do. She said during that time she could go and take her lunch break and that left the nurse on the unit by herself. CNA A stated there was not time to do things with the residents other than the basics needs because she spent a lot of time redirecting them. CNA A stated sometimes they turned on music back there, but they did not do much else because there was no time with one person back there. CNA A stated other people would come back to help on occasion but only if something serious was going on like state being in the building or someone passing away. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/04/2024 at 8:50 a.m., LVN D stated it was a lot of work to pass pills to the residents on the unit and south hall, but she got it done. LVN D stated she spent about half the shift out of the unit passing medications and seeing about the residents on south hall because they all had unique issues that needed to be dealt with each day. LVN D stated it would be very helpful to have another staff member on the secured unit to assist in monitoring the residents back there because they were all fall risks and most of them had behavior problems that needed to be monitored continuously. LVN D stated it would probably cut down on the falls and other behavioral issues if they had more staff to spend more one-on-one time with the residents back there. During an interview on 06/05/2024 at 2:30 p.m., the DON stated the staffing pattern for the building was one CNA on the secured unit and one CNA on south hall each, and one nurse that worked both the secured unit and south hall each shift. The DON stated when the census was up more, they were able to run two CNAs or one CNA and a medication aide. But they are unable to do that when their census was so low. The DON stated she was aware there had been a large number of unwitnessed falls with injury on the secured unit. The DON stated in a perfect world there would be two CNAs on the secured unit so that no one was ever left unattended in a common area. The DON stated not having two staff members on the secured unit at all times was a risk to the residents that reside on the unit because they are unsupervised for periods of time throughout the day and night when care was being given to others. During an interview on 06/05/2024 at 3:00 p.m., the ADM stated she understood it was not ideal to have only one staff member on the secured unit and it left the residents unattended while care was being done. She stated it would make it easier for the staff if they had two staff members back there at all times. The ADM stated corporate comes up with the PPD and that was how the facility staffs the building. During an interview with the Administrator on 06/05/2024 at 4:20PM, she stated the facility did not have any written policies or procedures related to staffing levels or staffing of the secured units.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 44596 Based on observation and interview, the facility failed to post the daily nurse staffing information with the current date, resident census, and numbers of staff actual hours worked at the beginning of each shift for 3 of 3 days reviewed, in a place readily accessible to residents and visitors, in that: The facility failed to update and post the daily nurse staffing information (current date, resident census, and numbers of staff actual hours worked) on 06/03/2024,06/04/2024, and 06/05/2024. This failure could affect residents, their families, and facility visitors by placing them at risk of not having access to information regarding the numbers of staff caring for the residents each shift and facility census. The findings included: An observation on 06/03/2024 at 9:30 a.m. revealed the daily staffing pattern (number of nurses and CNAs working with each resident each shift) posted was from 05/30/2024. An observation on 06/04/2024 at 10:45 a.m. revealed the daily nurse staffing pattern posted was from 06/03/2024. An observation on 06/05/2024 at 2:00 p.m. revealed the daily nurse staffing pattern posted was from 06/03/2024. During an interview on 06/05/2024 at 2:45 p.m., the DON stated she was responsible for changing the staffing posting each day and it would become the ADON's responsibility once she was trained. She stated not changing it each day was an oversight on her part. She stated failure to post the staffing numbers could give the public inaccurate information on the staffing of the building that was caring for their loved ones. During an interview on 06/05/2024 at 3:00 p.m., the ADM stated, the facility had no policy on nurse staff posting but the staff posting was posted daily by the DON or ADON. The ADM stated not posting the information would give the public inaccurate information.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility failed to ensure each residents' drug regimen was free from unnecessary psychotropic drugs (without adequate behavior monitoring) for 1 (Resident # 47) of 5 residents whose medications were reviewed in that: 1. The facility failed to ensure Resident #47 had an appropriate diagnosis for his prescribed Seroquel (Quetiapine; 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)) 2.The facility failed to ensure Resident #47 had behavior monitoring (monitor activities and mood) for his prescribed Seroquel. 3.The facility failed to ensure Resident #47 had side effects monitoring (are defined as unintended responses to approved pharmaceuticals (is any kind of drug used for medicinal purposes) given in appropriate dosages) for his prescribed Seroquel. These deficient practices could place residents at risk of not receiving the intended therapeutic benefits of their psychotropic medications. Findings included: Record review of face sheet printed 06/04/24 indicated Resident #47 was [AGE] year-old, male and was 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), severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and insomnia (is a common sleep disorder that can make it hard to fall asleep or stay asleep). Record review of an admission MDS assessment dated [DATE] indicated Resident #47 was sometimes understood and sometimes understood others. The MDS indicated Resident #47 had unclear speech, adequate hearing, and impaired vision without corrective lenses. The MDS indicated Resident #47 had a BIMS score of 99 which indicated he was unable to complete the interview to measure his cognition. The MDS indicated Resident #47 had short-and-long term memory recall problem but was able to recall staff names and faces. The MDS indicated Resident #47 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident #47 required supervision for eating, oral hygiene, toileting hygiene, partial assistance for shower/bathe self and personal hygiene, substantial assistance for dressing and putting on/taking off footwear. The MDS indicated Resident #47 was prescribed an antipsychotic and on a routine basis. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a care plan dated 05/22/24 indicated Resident #47 required psychotropic medication of Seroquel. Interventions included consult with pharmacy and medical doctor to consider dosage reduction when clinically appropriate and discuss with medical doctor and family ongoing need for use of medication. Record review of Resident #47's consolidated physician orders dated active as of 06/04/24 indicated: 1Quetiapine Fumarate Oral Tablet 25 MG, give 1 tablet by mouth at bedtime related to unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance. Start date 05/15/24, no end date. No order for antipsychotic behavioral and side effect monitoring noted. 2*Melatonin Oral Tablet 5 MG, give 1 tablet by mouth at bedtime related to insomnia. Start dated 05/15/24, no end date. Record review of Resident #47's MAR dated 06/01/24-06/30/24 indicated: 2Quetiapine Fumarate Oral Tablet 25 MG, give 1 tablet by mouth at bedtime related to unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance. Start date 05/15/24, no end date. No order for antipsychotic behavioral and side effect monitoring noted. 2Melatonin Oral Tablet 5 MG, give 1 tablet by mouth at bedtime related to insomnia. Start dated 05/15/24, no end date. Record review of Resident #47's Office Visit Disease Management Note by MD L dated 05/07/24 indicated . primary diagnosis: severe dementia, without behavioral disturbance, psychotic disturbance, mood disturbance, unspecified dementia type .no violent behavior .dementia seems to have worsened after starting Megace .Seroquel 25mg daily prescribed at bedtime which along with melatonin has helped with his sleep . he still occasionally awakens and wanders in the house at night .the patient is not nervous/anxious .negative for confusion and suicidal ideas .mood and affect: mood normal . During an interview on 06/05/24 at 12:10 p.m., LVN D said behavior and side effect monitoring was ordered on admission or when the medication was ordered. She said the admission nurse or the nurse who received the medication order was responsible for ordering behavior and side effect monitoring. She said monitoring was important to make sure the resident was not experiencing side effects and to know if the residents needed the medication. During an interview on 06/05/24 at 1:54 p.m., the DON said she was responsible for ensuring psychotropic medication had appropriate diagnosis. She said Resident #47 admitted on [DATE], from the community on Seroquel. She said the facility had planned to discontinue the medication soon. She said she had recently returned from vacation, and she also wanted Resident #47 to get settled in. She said she had not documented the medication review or facility plan but it was going to get done soon. She said she also wanted to get an order for Resident #47's insomnia before she discontinued the Seroquel. She said she felt like the outside physician [MD L] placed Resident #47 on Seroquel for his nighttime wandering. She said Resident #47 should have orders for antipsychotic behavior and side effect monitoring. She said the LVNs, or DON should put the order in for antipsychotic behavior and side effect monitoring. She said monitoring was important for medications to ensure it was needed, working effectively, and no side effects were experienced. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/05/24 at 2:45 p.m., the ADM said antipsychotic medication use was more of nursing department question than administration. She said she would rather not comment. Record review of a facility's Psychotropic Drug Use policy revised 01/2001 indicated .psychotropic drug therapy shall be used only when it is necessary to treat a specific condition .the attending physician must include a reason or symptoms with any order psychotropic drug therapy .nursing documentation must include a description of target symptom(s), their frequency and expected outcomes so that the attending physician can determine if the medication are working effectively .unless the resident's medical record clearly indicates that the resident has one or more of the following specific conditions, psychotropic drugs should not be used .schizophrenia, schizo-affective disorder, delusional disorder, psychotic mood disorder .

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observations, interviews, and record reviews the facility failed to provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals for 1 (Resident #19) of 3 residents reviewed for special eating equipment and assistance when consuming meals, in that: The failed to assess and provide Resident #19 with an assistive device to helps prevent food from accidently being pushed off the plate while eating during meal service to minimize food spillage. This failure could place residents at risk for harm by weight loss, diminished independence, and self-esteem. The findings included: Record review of a face sheet dated 06/03/24 indicated Resident #19 was an [AGE] year-old, male and 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) and mild protein-calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition). Record review of Resident #19's consolidated physician order dated active as of 06/05/24 did not reveal an order for assistive eating device. Record review of an annual MDS assessment dated [DATE] indicated Resident #19 was sometimes understood and sometimes understood others. The MDS indicated Resident #19 had a BIMS of 99 which indicated he was unable to complete the interview process to measure his cognition. The MDS indicated Resident #19 had short-and-long term memory recall problems. The MDS indicated Resident #19 was severely impaired for cognitive skills for daily decisions making. The MDS indicated Resident #19 required setup assistance for eating. The MDS indicated Resident #19 required a mechanically altered diet. Record review of a care plan dated 06/15/22, revised 03/31/23 indicated Resident #19 had potential nutritional problem related to diet of mechanical soft and diagnosis of mild protein calorie malnutrition. Intervention included provide verbal assistance and cues during meals. Record review of Resident #19's ADL Eating Percentage dated 06/2024 indicated: *06/01/24: Breakfast-76-100%, Lunch- 76-100%, Dinner 76-100% *06/02/24: Breakfast- 76-100%, Lunch- 51-75%, Dinner-51-75% *06/03/24: Breakfast- 76-100%, Lunch 76-100%, Dinner 76-100% *06/04/24: Breakfast- 76-100%, Lunch 51-75%, Dinner 76-100% (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*06/05/24: Breakfast 76-100%, Lunch 76-100% Record review of Resident #19's ADL Eating Assistance Requirement dated 06/2024 indicated: *06/01/24- Lunch: supervision, Dinner: supervision *06/02/24- Lunch: limited assistance, Dinner: independent *06/03/24- Lunch: limited assistance, Dinner: supervision *06/04/24- Lunch: independent, Dinner: supervision *06/05/24- Lunch: limited assistance During an observation on 06/03/24 at 12:08 p.m., Resident #19 was eating his lunch meal on a flat plate. Resident #19 attempted to scoop his chopped meat with a fork, but the meat fell on to his pants. Resident #19 switched utensils to a spoon and attempted to scoop his chopped meat, but the meat fell on the ground. Resident #19 eventually got a few pieces of his chopped meat into his mouth. During an observation on 06/04/24 at 1:25 p.m., Resident #19 was still sitting at dining room table eating his lunch. Underneath Resident #19 was food particle and plastic spoon. MDS Coordinator cleaned the sides of Resident #19's wheelchair of food particles. During an observation on 06/05/24 at 12:35 p.m., Resident #19 was sitting at the dining room table eating his lunch on a flat plate. Resident #19 struggled to scoop his food on his utensil. Resident #19 noted with hand tremors. Food particles noted on the floor. During an interview on 06/05/24 at 12:10 p.m., LVN D said Resident #19 fed himself. She said Resident #19 did not like assistance with meals. She said Resident #19 fed himself good one day then the next day he was messy. She said she did not know if an assistive device would help him during meals. She said the dietary department provided the resident with assistive devices like scooped plates. During an interview on 06/05/24 at 1:30 p.m., CNA H said Resident #19 needed cueing when he ate but did not want assistance. She said she sometimes had to put one food item on his plate for him to finish the meal. She said Resident #19 would benefit from a scoop plate. She said Resident #19 did have trouble scooping up his food during meals. She said it took Resident #19 a long time to eat his meals. She said if a resident needed an assistive feeding device, she would notify the nurse and they would let the dietary manager know. She said not providing a resident an assistive device could cause them to not eat good. She said if the resident did not eat good, they could lose weight. During an interview on 06/05/24 at 1:35 p.m., LVN G said the nurse, CNA, or DON assessed the resident during meals to see if an assistive device would be beneficial. She said Resident #19 recently had a decline in last 2-3 weeks. She said Resident #19 had some recent medications and behavior changes. She said Resident #19 preferred to feed himself but sometimes he did have hand tremors. She said Resident #19 probably should have been assessed for an assistive device due to his decline. She said it was important to provided residents needed assistive devices to maintain their independence and help with weight. She said not providing a resident with an assistive device during meals placed residents at risk for weight loss and increase need for assistance. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/05/24 at 1:54 p.m., the DON said it was the responsibility of the IDT which included the nurse, CNA, dietary, and DON to assess resident for assistive device during meals. She said Resident #19 would benefit from a scooped plate being used during meals. She said he had declined in last couple of weeks. She said Resident #19 would be getting a scoop plate right now. She said Resident #19 got agitated when staff tried to help me during meals. She said a resident not getting an assistive device could affect their intake and nutritional status. During an interview on 06/05/24 at 2:45 p.m., the ADM said the nursing department was responsible for assessing residents for assistive devices used during meals. Record review of a facility's Assistive Devices and Equipment policy revised 01/2020 indicated .our facility maintains and supervises the use of assistive devices and equipment for residents .certain devices and equipment that assist with resident .independence are provided for residents .specialized eating utensils and equipment .recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident care plan .

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643 Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 1 of 12 resident personal refrigerators reviewed for food safety (Resident #26). The facility failed to ensure the refrigerator for Resident #26 did not contain a decomposing banana, watermelon, and expired meat. This failure could place resident at risk for food borne illnesses. Findings included: Record review of a face sheet dated [DATE] indicated Resident #26 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses including Parkinson's Disease (A disorder of the central nervous system that affects movement, often including tremors), Hypomagnesemia (happens when you have a lower-than-normal level of magnesium in your blood), Dysphagia (a medical term for difficulty swallowing). Record review of a quarterly MDS dated [DATE] indicated Resident #26 usually understood others and usually made himself understood. The MDS indicated Resident #26 had moderately impaired cognition with a BIMS score of 10. The MDS indicated Resident #26 did not reject evaluation or care. Record review of a care plan for Resident #26 dated [DATE] revealed Resident #26 was to be monitored for any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. During an observation on [DATE] at 9:32 a.m., in Resident #26's personal refrigerator it was observed that a pack of bologna lunch meat was expired in May of 2024, a banana that had turned completely black, and a container of watermelon that had an unidentifiable clear white slime. During an interview on [DATE] at 10:05 a.m., with Resident #26 he said he did not know if staff cleaned out his refrigerator. He said he eats whatever was in the refrigerator when he got hungry. He said he would eat the banana as it was. He said he doesn't normally check for expiration dates. He said he cannot remember the last time someone cleaned out his refrigerator of old food. During an observation on [DATE] at 12:46 p.m., in Resident # 26's personal refrigerator it was observed that a pack of bologna lunch meat was expired in May of 2024, a banana that had turned completely black, and a container of watermelon that had an unidentifiable clear white slime. During an interview on [DATE] at 09:37 a.m., with Housekeeper J she said no one told her she needed to clean out the refrigerators in resident's rooms. She said she was unsure who was responsible to ensure the resident's refrigerators did not have spoiled food. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:10 a.m., with the DON, she said it was the responsibility of housekeeping staff to clean out the resident's refrigerators. She said residents could be placed at risk for foodborne illness if they consume expired or old food. During an interview on [DATE] at 1:20 p.m., with the Administrator she said it is the responsibility of all staff to clean out the resident's refrigerators. She said she will be implementing a new system to assign rooms to staff to look for problems such as expired food in personal refrigerators. She said residents can be placed at risk for foodborne illness if they consume expired or old food. During an interview on [DATE] at 1:28 p.m. with the Administrator he said that the facility did not have a policy regarding personal refrigerators.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 4 of 14 residents (#35, #36, #3 and #6) reviewed for infection control practices. 1.The Facility failed to ensure Resident #35 and #36 had wash basins stored properly with names and in bags. 2. The facility failed to ensure wipes with feces were properly discarded and were left on Resident #3 and #6's bedroom floor. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: Record review of Resident #35's face sheet indicated she was an [AGE] year-old female initially admitted to the facility on [DATE] with a diagnosis included: unspecified dementia (dementia without a specific diagnosis), restlessness and agitation (agitation is a normal emotion) and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #35 rarely understood and rarely understands others. The MDS indicated the BIMS assessment was not completed for Resident #35, due to cognitive function. The MDS indicated Resident #35 was dependent with ADL's. Record review of undated care plan indicated Resident #35 had impaired cognitive function dementia or impaired thought processes related to diagnoses of dementia severe and Alzheimer's disease. Record review of Resident #36's face sheet indicated she was a [AGE] year-old female initially admitted to the facility on [DATE] with a diagnosis included: unspecified dementia (dementia without a specific diagnosis), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and Parkinson's disease (a disorder of the central nervous system that effects movement). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #36 was usually understood and usually understands others. Resident #36 was not able to complete the MDS assessment. The MDS indicated Resident #35 was dependent with ADL's. Record review of undated care plan indicated Resident #36 was monitored for signs and symptoms of acute respiratory insufficiency: anxiety, confusion, restlessness, shortness of breath at rest, cyanosis and somnolence. Make sure call light was within reach and encourage the resident to use for assistance as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations on 06/04/24 at 3:01 PM in Resident #35 and Resident #36's bathroom was three wash basins in the bathtub without names and not in bags. Record review of Resident #3's face sheet indicated she was a [AGE] year-old male initially admitted to the facility on [DATE] with a diagnosis included: moderate protein-calorie malnutrition (protein-energy undernutrition), muscle weakness (a lack of strength in the muscles) and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #3 was sometimes understood and sometimes understands others. The MDS assessment was not completed for Resident #3. The MDS indicated Resident #3 was dependent with ADL's. Record review of undated care plan indicated Resident #3 prefers to crawl on the floor in his room for mobility (per sister-this is what he did at home when he wanted to be in the floor recently, staff will monitor for signs and symptoms that he wants down on the floor). Ensure fall mat is in place on the floor for resident to crawl on to prevent injuries. Staff to assist resident as needed. Record review of Resident #6's face sheet indicated she was a [AGE] year-old male initially admitted to the facility on [DATE] with a diagnosis included: vascular dementia (brain damage caused by multiple strokes), paraplegia (paralysis of the legs and lower body) and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #6 sometimes make self-understood and usually understands others. The MDS revealed Resident #6 had BIMS score of 11, which indicated moderate cognitive impairment. The MDS indicated Resident #6 was dependent with ADL's. Record review of undated care plan indicated Resident #6 revealed: Toileting: provide incontinent care with each episode and as needed. Toileting use: Resident is dependent on staff with toileting. Toileting: May use perineal wipes. Toileting: Resident is totally incontinent of his bowels and needs to be checked every 2 hours and as needed. Toileting: Resident requires assistance from 1 staff to toilet. He is bed bound and all care is anticipated and provided per staff. During observations on 06/05/24 at 9:17 AM in Resident #3 and Resident #6 room there were dirty wipes on the floor with brown feces on them. The odor from the wipes was foul with Resident #3 and Resident #6 in their room lying in bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/05/2024 at 11:20 AM with CNA I said she had witnessed a lot of the residents did not have their names on their wash basins in their bathrooms and the basins were not in bags. She said most of the time she tried to put the wash basins in bags and put their names on them. She said she really could not say what it can cause, because she did not use them. She said she only gave showers. She said using the same wash pan on a different residents could be an infection control issue. During observations and interview on 6/05/2024 at 11:55 AM the Maintenance man observed wipes with feces on Resident #3 and Resident #6's floor in bedroom. Resident # 6 was sitting up in bed eating lunch. The wipes with feces had a foul odor in the room. Maintenance man said that was unacceptable. He said expected for housekeeping to disinfect the front lobby, the dining area, then they should be cleaning the resident's room. He said housekeeping should ask permission to enter the resident's room and notify the resident what they were in the room for. He said had three housekeepers; 2 on a shift; one does the North end and the other does the South end of the facility. During an interview on 6/05/2024 at 2:58 PM with DON she said the CNA's know they are supposed to be labeling the resident's wash basins with their names and placing them in bags. She said using the same wash basins with residents was cross contamination and could cause a major infection control issue. She said she expect when the CNA's performed incontinent care on residents the trash should be properly disposed of and wipes with feces should not be left on resident's floor. The DON said that the wipes were left on the floor was unacceptable. During an interview on 6/05/2024 at 3:18 PM with the Administrator she said except the CNA's to do their jobs and dispose of trash in the correct manner. She said she expected the housekeepers to keep this facility clean like it was the President's house. She said everyone had a job to do and not keeping facility cleaned thoroughly was not acceptable. Record review of the facility Infection Prevention and Control Program Policy, date October 2018, revealed . an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The infection prevention and control program developed to address the facility-specific infection control needs and requirements identified in the facility assessment and the infection control risk assessment. The program is reviewed annually and updated as necessary. Record review of the facility Homelike Environment Policy, dated February 2021 revealed .Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. Record review of the facility Resident Rights Under Federal Law Policy undated, revealed . the resident has the right to reasonable accommodation of individual needs and preferences except where the health and safety of the resident or other residents would be endangered.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 44596 Based on interview and record review, the facility failed to implement an antibiotic stewardship program that included antibiotic use protocols for 6 of 6 months (January 2024 through June 2024) reviewed for Infection Control Tracking and Trending. -The facility did not implement the antibiotic orders protocol in their Antibiotic Stewardship policy. -The facility had missing information on the Tracking and Trending Logs as to the outcome of the antibiotic use (if the infections were resolved or not). -The facility did not implement the 72-hour Antibiotic Time Out protocol in their Antibiotic Stewardship program. These failures could place residents with infections at risk for unnecessary antibiotic use and increased infections that are resistant to antibiotics. Findings included: Record review of the Antibiotic Stewardship Policy revised 02/2022 indicated Goals: Prescribers will document a dose, duration, and indication for all antibiotic usage. Policy: Antibiotic Stewardship Program (ASP) Core Elements: 5. Tracking: The Facility monitors at least one process measure of antibiotic use and at least one outcome or training in antibiotic use: a. Process Measure: Medical records are reviewed when a new antibiotic is started to determine whether the clinical assessment, prescription documentation, and antibiotic selection were in accordance with facility antibiotic use policies and practices Antibiotic Stewardship Protocols: 4. Antibiotic Time Out: d. Infection Preventionist or other designated member of the Facility nursing staff notifies the ordering provider of the 3-day expiration and requirement for Antibiotic Time Out: 1. Provider may consult Infectious Disease provider and eliminate need for the Time Out Process. ii. Provider may complete Antibiotic Time Out telephonically with member of the Antibiotic Stewardship Team or clinical designee. iii. If provider fails to complete the Antibiotic Time Out on or prior to Day 3 of treatment, the Antibiotic Stewardship Team in collaboration with Pharmacy Consultant and Medical Director, may complete the process and determine the appropriateness and effectiveness of continuing or discontinuing the medication. Any actions require a valid and complete physician's order. Record review of the Infection Control Tracking and Trending Log for January 2024 to June 2024 indicated the following: -January 2024- 1. Log had no indication of 72-hour time out review and no indication of infection resolution. 2. A physician order for antibiotics prior to culture on 01/12/2024. -February 2024 (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.Log had no indication of 72-hour time out review and no indication of infection resolution. 2. Log has no indication of cultures for infections. -March 2024- 1. There was no indication of 72-hour time out review and no indication of infection resolution. 2. Logs were missing information about antibiotic indications (signs and symptoms of infection) and cultures. -April 2024- 1. There was no indication of 72-hour time out review and no indication of infection resolution. 2. Logs were missing information about antibiotic indications and cultures. -May 2024- 1. There was no indication of 72-hour time out review and no indication of infection resolution. 2. Logs were missing information about antibiotic indications and cultures. -June 2024- 1. There was no indication of 72-hour time out review and no indication of if infections were resolved. During an interview on 06/05/2024 at 10:20 a.m., the IP stated she would bring the tracking and trending for infection control, but it was not completed, and it was behind several months. The IP stated she had been working the floor as a CNA on the secured unit at night and had not had time to keep it up. The IP stated it was the duty of IP to keep up with the tracking and trending on a weekly basis to ensure it was done. The IP stated it was important for antibiotic usage to be kept at a minimum to decrease resistance. The IP stated she would add the 72-hour antibiotic time out to the tracking log and she would continue to encourage the MD to follow the antibiotic stewardship guidelines of culturing and not prescribing broad spectrum antibiotics prior to the culture if symptoms are mild. The IP stated overuse of antibiotics can cause superbugs and resistant strands of common bacteria which are harder for the elderly population to fight off and could lead to illness and even death. During an interview on 06/05/2024 at 2:30 p.m., the ADM stated it was the nursing department's job to ensure all the antibiotic stewardship program was being conducted correctly. The ADM stated the IP had been stretched thin by having to work the floor several shifts over the last several months, but it was ultimately their responsibility to ensure it was complete and correct. The ADM stated not following the facility policy and state guidelines for antibiotic stewardship could lead to more serious infections for the residents that are already susceptible to infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675387	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Panola County Nursing & Rehabilitation	501 Cottage Rd Carthage, TX 75633

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the CDC's Core Elements of Antibiotic Stewardship for Nursing Homes Appendix A: Policy and practice actions to improve antibiotic use accessed on 06/06/2024 at https://www.cdc.gov/antibiotic-use/core-elements/nursing-homes.html. Antibiotic prescribing and use policies: Documentation of dose, duration, and indication. Specify the dose (including route), duration (i.e., start date, end date, and planned days of therapy), and indication, which includes both rationale (i.e., prophylaxis vs. therapeutic) and treatment site (i.e., urinary tract, respiratory tract), for every course of antibiotics. This bundle of antibiotic prescribing elements should be documented for both nursing home-initiated antibiotic courses as well as courses continued in the nursing home which were initiated by a transferring facility or emergency department. Documenting and making this information accessible (e.g., verifying indication and planned duration is documented on transfer paperwork) helps ensure that antibiotics can be modified as needed based on additional laboratory and clinical data and/or discontinued in a timely manner Broad interventions to improve antibiotic use: Perform antibiotic time outs. Antibiotics are often started empirically in nursing home residents when the resident has a change in physical or mental status while diagnostic information is being obtained. However, providers often do not revisit the selection of the antibiotic after more clinical and laboratory data (including culture results) become available. An antibiotic time out is a formal process designed to prompt a reassessment of the ongoing need for and choice of an antibiotic once more data is available including: the clinical response, additional diagnostic information, and alternate explanations for the status change which prompted the antibiotic start. Nursing homes should have a process in place for a review of antibiotics by the clinical team two to three days after antibiotics are initiated to answer these key questions: o Does this resident have a bacterial infection that will respond to antibiotics? o If so, is the resident on the most appropriate antibiotic(s), dose, and route of administration? o Can the spectrum of the antibiotic be narrowed or the duration of therapy shortened (i.e., de-escalation)? o Would the resident benefit from additional infectious disease/ antibiotic expertise to ensure optimal treatment of the suspected or confirmed infection?