STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675444	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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** 46929 Based on interview, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 1 resident (Resident #57) reviewed for resident rights. The facility failed to ensure CNA S treated Resident #57 with respect and dignity when CNA S left Resident #57 exposed to the hallway after leaving her room. These failures could place residents at risk for diminished quality of life, loss of dignity, and self-worth. Findings included: Record review of Resident #57's face sheet, dated 12/05/24, indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included dementia (the loss of cognitive functioning to such an extent that it interferes with a person's daily life and activities), and anxiety disorder (a mental health condition that causes uncontrollable and excessive feelings of fear or anxiety that can significantly impair a person's daily life). Record review of Resident #57's quarterly MDS assessment, dated 10/22/24, indicated she had a BIMS score of 10, which indicated moderate cognitive impairment. She was able to make herself understood and she was able to understand others. During an interview on 12/02/24 at 09:38 AM, Resident #57 said she asked CNA S to leave her room and CNA S left her brief halfway off of her when she left the room. She said the sheet was left off of her, the bedside table was out of reach, and the door was left open. She said she was exposed to the hallway. She said this made her feel upset and she was worried someone down the hall may see her exposed. During an interview on 12/05/24 at 7:45AM, Resident #57 said after CNA S left her uncovered she was upset and the nurse working that night came in and fixed her brief and covered her back up. This surveyor attempted to call the nurse named by the resident two times. This surveyor did not receive a return call. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/24 at 8:45AM, CNA S said she was taking care of Resident #57 on 10/08/24. She said the resident refused care from her and asked her to leave her room. She said she left the sheet and blanket pulled back and the resident had a brief on and was exposed to the hallway when she left the room. She said she did not close the door. She said she notified the nurse that Resident #57 refused care and the nurse completed the care of the resident. During an interview on 12/05/24 at 9:18AM, the Activity Director said Resident #57 reported to her the morning of 10/08/24 that during the early morning hours she asked CNA S to leave her room and the aide left her sheet pulled back and she was left exposed to the hallway with her brief halfway on. During an interview on 12/05/24 at 1:44PM, the ADON said she expected the resident to have been covered and the door to be closed so the resident was not exposed to the hallway. During an interview on 12/05/24 at 1:54PM, the DON said the Activity Director reported to her that the resident had reported to the Activity Director about the incident that had occurred between Resident #57 and CNA S. She said she interviewed the resident and the resident reported to her that CNA S left her exposed to the hallway. She said she expected the aide to cover the resident and shut the door to provide privacy. She said the risk was embarrassment or a dignity issue to the resident. During an interview on 12/05/24 at 2:10PM, the Administrator said he expected the aide to maintain the resident's dignity. He said the risk was lack of dignity to the resident. Record review of the facility's policy, Perineal Care, last revised 04/10/23, stated: .4. Perineal care for Female: . .b. Drape resident with linens to provide privacy. Keep resident covered throughout procedure, exposing areas as needed . Record review of the facility's policy and procedure, revised 08/14/2022, titled, Resident Rights reflected The staff will abide by and protect resident rights in accordance with state and federal guidelines.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observation, interview and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or others for 1 of 6 residents (Resident #35) reviewed for reasonable accommodations of needs. The facility failed to ensure Resident #35 had a call light within reach. This failure could place residents at risk of possible falls, major injuries, hospitalization , and unmet needs. Findings include: Record review of Resident #35's face sheet dated 12/05/24 reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #35 had diagnoses which included: legal blindness, glaucoma secondary to other eye disorders, left eye, severe stage (a group of eye conditions that can cause blindness) and fracture of unspecified part of neck of right femur. Record review of Resident #35's MDS, dated [DATE], reflected Resident #35 was sometimes understood and sometimes understood others. Resident #35's BIMs score was a 4, which indicated severe impaired cognition. Resident #35 required substantial or maximal assistance with all ADLs. Record review of Resident #35's care plan dated 7/10/24 reflected Resident #35 was a high fall risk and had impaired physical mobility. The interventions included encourage her to call for assistance and provide appropriate level of assistance to promote safety of resident. During observations of Resident #35's call light not within reach were made in room at the following times: -12/02/24 at 9:49 A.M. Call light hanging in headboard of bed and bed mattress elevated from headboard. -12/02/24 at 10:15 A.M. Call light hanging in headboard of bed and bed mattress elevated from headboard. -12/02/24 at 11:42 A.M. Call light hanging in headboard of bed and bed mattress elevated from headboard. -12/02/24 at 2:12 P.M. Call light hanging in headboard of bed and bed mattress elevated from headboard. -12/02/24 at 3:22 P.M. Call light hanging in headboard of bed and bed mattress elevated from headboard. -12/03/24 at 9:30 A.M. Call light on floor beside bed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/03/24 at 2:23 P.M. Call light on floor beside bed. -12/03/24 at 3:47 P.M. Call light on floor beside bed. -12/04/24 at 10:36 A.M. Call light on floor beside bed. -12/04/24 at 1:47 P.M. Call light on floor beside bed. During an interview on 12/5/2024 at 8:34 A.M., CNA O said the aides are responsible for ensuring the resident call light was within reach. She said Resident #35 was able to use her call light. She said anything could happen to her and she always need her call light. She said Resident #35 could fall, choke or anything and she would not be able to call for help. During an interview on 2/5/2024 at 8:39 A.M., CNA GG said everyone was responsible for ensuring residents call lights are assessable. She said Resident #35 could use her call light She said negative effects of her not having her call light assessable was if she needed help, she could not call for help. She said call lights needed to be always assessable for residents. During an interview on 12/5/2024 at 8:45 A.M., LVN D said anyone walks in a resident's room was responsible for ensuring the resident call light are assessable to them. She said she had never seen Resident #35 use her call light, but it should still be available to her. She said the negative effects of Resident #35 not having her call light assessable was staff will not know her needs. During an interview on 12/5/2024 at 10:23 A.M., the ADON said the aides are responsible for ensuring that the call lights assessable for the residents. She said the nurse should follow-up with ensuring the call light was accessible for the resident. She said Resident #35's call light should be accessible for her to use. She said the negative effects of Resident #35 not having her call light within reach would be she could not stress her need help. During an interview on 12/5/2024 at 12:55 P.M., the DON said Resident #35 was not going to use her call light. She said the CNA, Charge Nurse, anybody walking by the resident's room, or any staff members can make sure a resident had a call light within reach. She said the negative effects of a resident not to have a call light within reach would be they could not call for help. She said the resident could fall and hurt themselves. During an interview on 12/5/2024 at 2:41 P.M., the ADM said Resident #35 call light should be on her bed. He said all staff were responsible to ensure that the resident's call lights were within reach. He said the negative effects of a resident not having a call light within reach they would not be able to alert us of their needs. Record review of facility's Call Lights Answering Policy, revised 01/19/2023, reflected The staff will provide an environment that helps meet the resident's needs by answering call lights appropriately . When leaving the room, be sure the call light is placed within the resident's reach.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 46929 Based on interview, and record review the facility failed to post in a place readily accessible to residents, and family members and legal representative of residents, the results of the most recent survey including any plans of correction without identifying information about complainants or residents for 2 of 2 survey results binders reviewed. The facility failed to ensure the most recent abbreviated standard survey results, exit date 08/15/24, was posted in the survey results book. This failure could place residents at risk of not being aware of past and current violation findings from state surveys and investigations conducted in the facility. Findings included: During a record review on 12/03/24 at 11:23 AM, this surveyor reviewed the survey/inspection results book in the lobby of the facility. The most recent state visit result in both binders was dated 12/01/23. During a record review on 12/04/24 at 08:28 AM, this surveyor reviewed the survey/inspection results book in the lobby of the facility. The most recent state visit result in both binders was dated 12/01/23. During an interview on 12/04/24 at 04:25 PM, RNC R said they do not have a policy related to the survey results book being updated. She said the book should have the inspection and survey results including those that have citations. During an interview on 12/05/24 at 01:29 PM, RNC R said the Administrator was responsible for updating the survey results book. She said she was unsure how many visits were missed but the books were updated after this surveyor's last interview. During a record review on 12/05/24 at 01:32 PM, this surveyor reviewed the survey/inspection results books. They were updated and included the previously missing 8/15/24 visit. During an interview on 12/05/24 at 2:10PM, the Administrator said he was responsible for ensuring the survey results books were up to date in the lobby. He said there was not a risk to the resident because of the books not being completely up to date.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview, and record review, the facility failed to ensure individuals with mental health disorders were provided an accurate Preadmission Screening and Resident Review (PASRR) Screenings for 1 of 4 residents (Resident #76) reviewed for PASRR. The facility failed to refer Resident #76 for PASRR review following new mental illness diagnosis of major depression disorder (mood disorder that causes persistent sadness and loss of interest) on 05/13/24. This failure could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs. Findings included: Record review of Resident #76's face sheet dated 12/03/24, indicated a 64-years-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #76 had diagnoses including cerebral infarction (is a serious condition that occurs when blood flow to the brain is blocked, resulting in brain tissue death), brief psychotic disorder (severe mental illnesses that cause a person to lose touch with reality and have abnormal thinking and perceptions), and psychoactive substance use. Record review of Resident #76 Diagnosis Report dated 12/04/24 indicated Major depressive disorder, recurrent. Start date 05/17/24. Record review of Resident #76's quarterly MDS assessment dated [DATE] indicated Resident #76 was sometimes understood and usually understood others. Resident #76 had unclear speech. Resident #76 was rarely/never understood so a BIMS was unable to be completed. Resident #76 had short-and-long term memory recall problems. Resident #76 had severely impaired cognitive skills for daily decision making. Resident #76 had an active diagnosis of depression. Record review of Resident #76's care plan dated 10/03/24 indicated antidepressant related to diagnosis of major depressive disorder (07/17/24) as evidence by Sertraline (is a medication used to manage and treat the major depressive disorder) and Bupropion (is an antidepressant medication used to treat depression). Intervention included in house psych services as needed. Record review of Resident #76's undated Mental Illness/Dementia Resident Review, Form 1012, completed by the previous MDS Coordinator, MDS RN K, indicated Resident #76 had a diagnosis of mental illness that met the Code of Federal Regulations definition. Resident #76 mental diagnosis was a new diagnosis as of 05/13/24. MDS RN K indicated Resident #76 had a primary diagnosis of dementia assigned on 05/13/24. Resident #76 Form 1012 was not signed by the nursing facility physician or local mental health authority/local behavioral health authority. Resident #76's Form 1012 did not indicate if a new PASRR Level 1 was submitted. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/24 at 3:11 p.m., MDS LPN J said she could not find a diagnosis of dementia for Resident #76. She said she did not know why MDS RN K filled out Resident #76's Form 1012 with a primary diagnosis of dementia. She said Resident #76's Form 1012 was never completed or submitted. She said Resident #76 had a new diagnosis of major depressive disorder added 05/13/24. She said a new PASRR Level 1 should have been submitted to the Local Intellectual and Developmental Disability Authority. She said the Local Intellectual and Developmental Disability Authority then would have completed a PASRR evaluation to determine if the resident qualified for mental illness. She said Resident #76's not having another PASRR Level 1 submitted after her new mental illness diagnosis, would not have been found unless the facility had done an audit. She said failure to complete a form 1012 on Resident #76 resulted in her not receiving the proper evaluation from PASRR services or receiving additional services. She said Resident #76 was receiving in house psych service and was seen last on 10/11/24. She said she was responsible for ensuring all PASRR level 1 were completed and completing the Form 1012 when a resident had a new mental illness. During an interview on 12/05/24 at 2:42 p.m., the Director of Nursing said she had been in her current position since September 2024. She said she did not have a lot of knowledge yet about the PASRR process. She said major depressive disorder was a mental illness. She said she believed the social worker was responsible for completing PASRR Level 1s when a resident had a new mental illness. During an interview on 12/05/24 at 3:32 p.m., the Administrator said if a resident had a new mental illness diagnosis, he would hope the local mental authority submitted a new PASRR Level 1. He said once the facility was notified of the new mental illness diagnosis, the MDS Coordinator and Social Worker would coordinate with the local mental authority to provide the services the resident needed. He said if a PASRR Level 1 was not completed then a resident could not receive services they needed. Record review of an undated facility's PASRR Pre-Admission Process Flow policy indicated .when to utilize Form 1012 (This form is to be completed by MDS) .a determination that the PL1 was filled out incorrectly after patient admitted .an individual's diagnosis is changed .a survey determines the PL1 is incorrect or needs review . The policy did not address updating the PASRR Level 1 after a new mental illness diagnosis.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interviews and records reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident to ensure the comprehensive care plan described the services and interventions to be used to attain and maintain the resident's practicable physical, mental, and psychosocial well-being for 2 (Resident #63 and Resident #80) of 18 residents reviewed for care plans. The facility failed to ensure Resident #63, per her care plan intervention, had a pillow placed in her wheelchair due to leaning on 12/02/24 and 12/03/24. The facility failed to document/monitor Resident #80's oral intake per her care plan intervention due to her altered nutritional status in November 2024. These failures could place residents at risk of not having their individualized needs met, and a decline in their quality of care and life. Findings included: Record review of Resident #63's face sheet dated 12/02/24, indicated an 84-years-old female who admitted to the facility on [DATE]. Resident #63 had diagnoses including Alzheimer's disease (is a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to perform everyday tasks), muscle weakness, and pain. Record review of Resident #63's quarterly MDS assessment dated [DATE] indicated Resident #63 was rarely/never understood and rarely/never understood others. Resident #63 had unclear speech. Resident #63 could not complete the BIMS assessment due to being rarely/never understood. Resident #63 had short-and-long term memory recall problem. Resident #63 had severely impaired cognitive skills for daily decision making. Resident #63 used a wheelchair as a mobility device. Resident #63 required substantial/maximal assistance for chair/bed-to-chair transfer. Record review of Resident #63's care plan dated 10/20/24 indicated impaired physical mobility related to limited joint mobility causes resident to higher risk of falling as evidence by substantial/maximal assistance for chair/bed-to-chair transfer, left sided weakness, and uses wheelchair. Intervention included place pillow in resident's wheelchair for resident's comfort. Resident #63 leans in wheelchair. Record review of Resident #63's grievance dated 10/23/24, completed by a family/friend indicated .Resident #63 not positioned appropriately in wheelchair at times . During an observation on 12/02/24 at 4:30 p.m., Resident #63 was sitting in her wheelchair at the nursing station. Resident #63 was leaning to the right in her wheelchair. Resident #63 did not have a pillow on the right side of her wheelchair. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/03/24 at 5:08 p.m., Resident #63 was sitting in her wheelchair at the nursing station. Resident #63 was leaning to the right in her wheelchair with her feet crossed. Resident #63 did not have a pillow on the right side of her wheelchair. Record review of Resident #80's face sheet dated 12/02/24, indicated a 59-years-old female who admitted on [DATE] and readmitted on [DATE]. Resident #80 had diagnoses including cerebral infarction (is a serious condition that occurs when blood flow to the brain is blocked, resulting in brain tissue death), hemiplegia (is a condition that causes paralysis or weakness on one side of the body, usually due to brain or spinal cord injuries) and hemiparesis (is a condition that causes weakness or an inability to move on one side of the body) following cerebral infarction affecting unspecified side, gastrostomy status (is the placement of a feeding tube through the skin and the stomach wall), and dysphagia (difficulty swallowing). Record review of Resident #80's significant change in status MDS assessment dated [DATE] indicated Resident #80 was usually understood and usually understood others. Resident #80 had a BIMS score of 10 which indicated moderate cognitive impairment. Resident #80 required substantial/maximal assistance for eating. Resident #80 had a feeding tube while not and while a resident within the last 7 days. Resident #80 had a mechanically altered diet. Resident #80 received 25% or less of total calories through tube feeding. Record review of Resident #80's care plan dated 10/08/24 indicated altered nutritional status related to missing teeth as evidence by diet: regular, mechanical soft, and thin liquids. Intervention included monitor oral intake of food and fluid. Record review of Resident #80's ADL function report dated November 2024 indicated: *11/01/24-11/07/24: No documented breakfast, lunch, or dinner intake. *11/08/24: No documented breakfast or lunch. *11/09/24-11/12/24: No documented breakfast, lunch, or dinner intake. *11/13/24-11/14/24: No documented breakfast or lunch. *11/15/24-11/17/24: No documented breakfast, lunch, or dinner intake. *11/18/24: No documented breakfast or lunch. *11/19/24-11/23/24: No documented breakfast, lunch, or dinner intake. *11/24/24-11/26/24: No documented breakfast or lunch. *11/27/24-11/30/24: No documented breakfast, lunch, or dinner intake. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/24 at 11:57 a.m., LVN N said she had been working at the facility for a year. She said she worked the 200 and 100 halls. She said she had taken care of Resident #63 and Resident #80. She said the CNAs were responsible for documenting a resident's meal intake. She said the CNAs were supposed to document in the facility's electronic charting system in the ADL section. She said charting should be done after every meal. She said documenting a resident meal intake was important to keep tracking of how much the resident was eating. She said it was important to know a resident's intake for weight loss concerns and monitor the resident's nutritional status. She said the meal intake provided tracking and trending information for dietary. She said it also helped the facility or dietician know if the resident needed dietary supplements. She said the LVNs were supposed to ensure the CNAs documented the resident's oral intakes after meals. She said Resident #63 wiggled a lot in her chair. She said the facility had tried a different chair beside the wheelchair to help with her leaning and comfort. She said CNAs were supposed to put a pillow in Resident #63's wheelchair. She said the LVNs should be checking Resident #63's wheelchair to ensure she had a pillow in place. She said the pillow in Resident #63's wheelchair was for pressure relief and comfort. She said Resident #63's pillow was to prevent skin breakdown. She said care plans were to be followed by the CNAs and the nurses. She said the care plan was the facility's directions for individualized resident care. She said it was the responsibility of the LVNs to communicate all the needs of the residents to the CNAs. During an interview on 12/05/24 at 1:26 p.m., CNA O said CNAs were responsible for charting the resident's meals and snacks. She said she was supposed to document each meal in the facility's electronic charting system. She said the resident's care plan interventions were important to follow to take proper care of them. She said charting the resident's meal intakes were important to know how they ate and monitor their weight. She said not charting a resident's meal intakes could make the facility not know the resident was losing weight. During an interview on 12/05/24 at 2:42 p.m., the Director of Nursing said CNAs were responsible for charting all resident's meal intakes. She said the CNAs should be charting the meal intake amounts in the facility's electronic charting system. She said it was important to keep up with Resident #80's meal intakes. She said it was important to chart meal intake to monitor for weight loss per Resident #80's care plan intervention. She said the charge nurse should be ensuring the CNAs were charting meal intakes. She said Resident #63 had a high back wheelchair and the facility was trying to get her a different type of chair. She said Resident #63 pushed out the pillows staff placed in the wheelchair. She said the CNAs were supposed to place a pillow on her right side in the wheelchair. She said the pillow in Resident #63's wheelchair was to prevent skin breakdown and comfort. She said the charge nurses were supposed to ensure the CNAs placed a pillow in Resident #63's wheelchair per Resident #63's care plan intervention. She said the care plan and interventions were developed to identify the resident's needs and show how the facility was going to address the problem. During an interview on 12/05/24 at 3:32 p.m., the Administrator said the nursing department was responsible for following the resident's care plan interventions. He said the CNAs should be charting the resident's meal intakes before the end of their shift. He said it was important to monitor the resident's meal intake to monitor their appetite, intake, and decline. He said primarily the nursing staff were responsible for placing a pillow in Resident #63's wheelchair. He said but if any staff saw Resident #63's pillow not in place, they needed to notify the nursing staff. He said Resident #63's pillow was important for proper positioning. He said the facility needed to educate the staff on following the resident's plan of care and documenting. (continued on next page)

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	675444	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility's Care Plan-Process policy reviewed 02/12/2020, indicated .the team directs care planning towards attaining and maintaining the highest optimal physical, psychosocial, functional status .the plan of care identifies the .problem .interventions, discipline specific services, and frequency . Record review of a facility's Support Surfaces and Repositioning/Managing Tissue Loads-General Information policy revised 07/2018, indicated .Patients/Residents will be repositioned and/or placed on support surface selected in accordance with generally accepted guidelines .prevent direct contact between bony prominence and support surface .individualize the selection and periodic re-evaluation of a seating support and associated equipment for posture and pressure redistribution .inspect and maintain all aspect of a seating support surface to ensure proper functioning and meeting of the individual's needs . Record review of a facility's Meal Intake Documentation policy revised 01/12/2020, indicated .For resident whose nutritional status has been identified as inadequate, maintaining and/or improving the nutritional status, staff will monitor and document the amount of food the resident is consuming at each meal .meal intake of all residents will be monitored .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, personal and oral hygiene for 1 of 5 residents (Resident #80) reviewed for ADL (activities of daily living) care. The facility failed to ensure Resident #80 was gotten out of bed in November 2024. This failure could place residents who required assistance from staff for ADLs at risk of not receiving care and services to meet their needs which could result in feelings of poor self-esteem, decrease socialization and skin breakdown. Findings included: Record review of Resident #80's face sheet dated 12/02/24, indicated a 59-years-old female who admitted on [DATE] and readmitted on [DATE]. Resident #80 had diagnoses including cerebral infarction (is a serious condition that occurs when blood flow to the brain is blocked, resulting in brain tissue death), hemiplegia (is a condition that causes paralysis or weakness on one side of the body, usually due to brain or spinal cord injuries) and hemiparesis (is a condition that causes weakness or an inability to move on one side of the body) following cerebral infarction affecting unspecified side, gastrostomy status (is the placement of a feeding tube through the skin and the stomach wall), and dysphagia (difficulty swallowing). Record review of Resident #80's significant change in status MDS assessment dated [DATE] indicated Resident #80 was usually understood and usually understood others. Resident #80 had a BIMS score of 10 which indicated moderate cognitive impairment. Resident #80 did not reject care which included ADL assistance. Resident #80's MDS assessment indicated doing things with groups of people and going outside to get fresh air when the weather was good, was somewhat important to her. Resident #80's mobility device was a wheelchair. Resident #80 was dependent for chair/bed-to-chair transfer. Record review of Resident #80's care plan dated 10/08/24, indicated impaired physical mobility related to history hemiplegia or hemiparesis, stroke, and cardiovascular disease (is a term for a group of disorders that affect the heart and blood vessels) as evidence by left side weakness, left upper extremities weakness, left ankle joint pain, and left hip joint pain. Intervention included provide appropriate level of assistance to promote safety of resident. Record review of Resident #80's ADL function report dated November 2024 indicated: *11/01/24 at 3:46 p.m.: Transfer did not occur (CNA KK). *11/08/24 at 9:42 p.m.: Transfer did not occur (CNA NN). *11/12/24 at 6:55 p.m.: Transfer did not occur (CNA NN). *11/13/24 at 8:31 p.m.: Transfer did not occur (CNA NN). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*11/14/24 at 6:55 p.m.: Transfer did not occur (CNA NN). *11/17/24 at 5:38 a.m.: Transfer did not occur (CNA NN). *11/18/24 at 7:20 p.m.: Transfer did not occur (CNA LL). *11/24/24 at 9:01 p.m.: Transfer did not occur (CNA MM). *11/25/24 at 9:55 p.m. Independent with no setup or physical help from staff (CNA MM). *11/26/24 at 8:21 p.m.: Transfer did not occur (CNA MM). During an interview and observation on 12/02/24 at 10:43 a.m., Resident #80 was lying in her bed. Resident #80 said she wanted to get out of the bed. She started crying. Resident #80 said she had bed in her bed for a whole month. She said she ate, slept, and used the bathroom in her bed. She said she was missing her Geri-chair and the facility would not put her in a wheelchair. Resident #80 had a wheelchair at her bedside with the footrest and other items on the seat. Resident #80 said the wheelchair was another family member and the Geri-chair she used was taken from her. During an observation on 12/04/24 at 1:00 p.m., Resident #80 was lying in her bed. Observed CNA E and CNA L working the 100 hall. During an observation on 12/04/24 at 2:00 p.m., Resident #80 was lying in her bed. During an observation and interview on 12/04/24 at 4:05 p.m., Resident #80 was sitting at the nursing station. She said CNA F had just gotten her up and she was happy. She said she had asked staff this morning to get her up though. On 12/05/24 at 11:31 a.m., called CNA E and left voice mail. No return call before or after exit. On 12/05/24 at 11:32 a.m., called CNA L and unable to leave message. On 12/05/24 at 11:34 a.m., called CNA F and left voice mail. No return call before or after exit. During an interview on 12/05/24 at 11:57 a.m., LVN N said a resident should be gotten out of bed when they wanted. She said the residents should be asked daily if they wanted to be gotten up. She said if Resident #80 asked to be gotten up then accommodations should have been made for her. She said getting a resident out of the bed was important for socialization and skin integrity. She said not getting a resident out of the bed could cause depression, low self-esteem, and feeling neglected. She said CNAs should be getting the resident out of the bed. She said the nurses should be ensuring the residents who asked are gotten up and other residents were offered. She said the nurses should be ensuring this during rounding or med pass. During an interview on 12/05/24 at 1:26 p.m., CNA O said the resident should be gotten out of the bed every day or when they wanted to. She said CNAs should document the transfer on the facility's electronic charting system. She said getting the resident out of the bed was important to prevent breakdown, keep the bones active, and not be in the bed all day. She said when a resident stay in the bed, it could cause skin breakdown, loss of mobility, and depression. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/24 at 2:42 p.m., the Director of Nursing said CNAs were responsible for getting the residents out of the bed. She said the residents should be gotten out of the bed upon request. She said the CNAs should be charting the transfer in the facility's electronic charting system. She said the charge nurse should be ensuring the residents who requested to be gotten up, did indeed get up. She said Resident #80 did not like the Geri-chair but wanted to sit in a wheelchair. She said Resident #80 did like to get out of the bed. She said she did not feel the wheelchair was the safest option for Resident #80. She said her stroke had affected her posture and caused weakness. She said Resident #80 was placed at the nursing station to be monitored while in the wheelchair. She said staff members were afraid of Resident #80. She said staff members were reluctant to assist Resident #80 because of her previous abuse allegations towards staff. She said she had instructed staff to still assist Resident #80, but with a partner and she also had a camera in the room. During an interview on 12/05/24 at 3:32 p.m., the Administrator said the CNAs were responsible for getting the resident out of the bed. He said the charge nurse should be ensuring it was happening. He said it was important for the residents to get out of the bed for socialization, relieving pressure, and increases quality of life. Record review of a facility's ADL Care-Transfer Techniques policy reviewed 06/19/23, indicated .staff will provide safe and effective transfer technique for residents in accordance to standard practice guidelines .

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review, the facility failed to ensure residents received care, consistent with professional standards of practice, to prevent pressure ulcers based on the comprehensive assessment for 1 of 5 Residents (Resident #65) whose record were reviewed for skin integrity. The facility failed to ensure Resident #65's pressure-relieving mattress (is designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) was on the correct settings. This failure could place residents at risk for developing pressure ulcers and could contribute to developing avoidable pressure ulcers. Findings included: Record review of Resident #65 face sheet dated 12/02/24 indicated a 76-years-old female admitted to the facility on [DATE]. Resident #65 had diagnoses including metabolic encephalopathy (is a brain dysfunction caused by a chemical imbalance in the blood that affects the brain), urinary tract infection (is a common bacterial infection that occurs in the urinary tract, which includes the bladder, kidneys, and urethra), Type II diabetes (is a condition that occurs when the body doesn't use insulin properly, leading to high blood sugar levels), pressure ulcer of right bittock, unstageable (is a type of bed sore that occurs when too much pressure is applied to a specific area of the skin over a long period of time), and pressure ulcer of left buttock, stage 4 (is the most severe stage, characterized by full thickness tissue loss where the underlying muscle, tendon, or bone is exposed, often with significant damage to surrounding tissue, and a high risk of infection). Record review of Resident #65's significant change in status MDS assessment dated [DATE] indicated Resident #65 was usually understood and usually understood others. Resident #65's BIMS score was not completed. Resident #65 was dependent for roll left and right and lying to sitting on side of bed. Resident #65 weighed 155 pounds. Resident #65 had one stage 3 pressure ulcer and one stage 4 pressure ulcer. Resident #65 received turning/repositioning program, nutrition or hydration intervention, and pressure ulcer/injury care as skin and ulcer/injury treatment. Record review of Resident #65's care plan updated 12/02/24 indicated skin breakdown: at risk for/actual related to stage 4 pressure ulcer, history cardiovascular disease, and history of pressure injury (09/24/24) as evidence by pressure ulcer risk: severe, weight loss in the last month, confined to bed most of time, wound, and incontinent of bowel. Intervention included position resident properly; use pressure-reducing or pressure-relieving device if indicated. Record review of Resident #65's VOHRA Wound Evaluation and Management Summary dated 11/19/24, indicated .patient [Resident #65] has wounds on her left buttock .left heel .stage 4 pressure wound of the left buttock full thickness .duration: greater than 237 days .wound size (Length x Width x Depth) 4.9x7x1.5 centimeters .wound progress: improved evidence by decreased depth, decrease surface area .Unstageable Deep Tissue Injury .duration: greater than 14 days .wound size 1x1xnot measurable .wound progress: improved evidenced by decreased surface area . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility's wound report dated 11/25/24-12/02/24 indicated .Resident #65 .assessment date 11/26/24 .admitted with on 09/24/24 .stage 4 left buttock .improved .4.5x6.3x2.7 centimeters . assessment date 11/26/24 .facility acquired on 11/11/24 .unstageable left heel .resolved 11/26/24 . Record review of Resident #65's weight record dated 12/04/24 indicated: *11/07/24 145 pounds *10/07/24 149.4 pounds *09/24/24 154.8 pounds During an observation on 12/02/24 at 9:50 a.m., Resident #65 was lying in bed with a friend at the bedside. Resident #65 spoke on and off then closed eyes as if falling asleep. Resident #65 words were unclear and garbled. Resident #65's pressure relieving mattress weight setting was 250 pounds. During an observation on 12/03/24 at 3:17 p.m., Resident #65 was lying in her bed asleep. Resident #65's pressure relieving mattress weight setting was 250 pounds. During an observation on 12/04/24 at 2:14 p.m., Resident #65 was lying in her bed. Resident #65's pressure relieving mattress weight setting was 250 pounds. During an interview on 12/05/24 at 12:35 p.m., WCLVN G said Resident Service and the LVNs were responsible for the resident's pressure relieving weight settings. She said she was responsible for ensuring the resident who needed a pressure relieving mattress had one or addressed any issues with it. She said she did not know if the Resident Service and LVNs were supposed to check the setting every shift or every morning. She said it was important for the weight settings to be correct to prevent or prevent further deterioration of a pressure wound. She said she did not know Resident #65's weight setting was not correct on her pressure relieving mattress. During an interview on 12/05/24 at 1:07 p.m., the Resident Service said she was only responsible for making sure the residents had a pressure relieving mattress. She said she had nothing to do with the bed setting. During an interview on 12/05/24 at 2:42 p.m., the Director of Nursing said the Resident Service was responsible for the weight settings on the pressure relieving mattress. She said the wound care nurse and LVNs should ensure the weight settings are correct. She said if the weight settings were not correct, the mattress would not do its job. She said when the bed weight settings were not correct, it could cause skin issues, breakdown, and new or worse skin breakdown. During an interview on 12/05/24 at 3:32 p.m., the Administrator said the charge nurses or nurse manager were responsible for the pressure relieving mattress settings. He said too much, or not enough pressure would cause the resident to not lay right. He said incorrect settings could cause pressure areas. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/24 at 4:28 p.m., LVN D said the wound care nurse was responsible for the bed setting on the pressure relieving mattresses. She said the wound care nurse was supposed to check the bed setting every day. She said some residents had an order on the treatment administration record. She said the correct bed settings were important for skin integrity. She said when the bed settings were not correct then it placed the resident at risk for skin breakdown. She said she was taking care of Resident #65. She said she had not noticed Resident #65's bed weight setting was on 250 pounds. Record review of a facility's Support Surface and Repositioning/Managing Tissue Loads-General Information policy revised 07/2018, indicated .support surface will be chosen to meet the individual's needs .pressure redistributing support surface are designed to either increase the body surface area that comes in contact with the support surface or to sequentially alter the parts of the body that bear load, thus reducing the duration of loading at any given anatomical site . Record review of a facility's An Overview of Wound Care policy dated 07/2018, indicated .to provide guidance to clinicians for educational purpose about skin and wound care with an emphasis on pressure ulcers/injuries and other common wounds .prevention and treatment strategies .provide appropriate, pressure-distribution, support surfaces .the effectiveness of pressure redistribution devices is based on their potential to address the individual resident's risk, the resident's response to the product, and the characteristics and condition of the product .these products are more likely to reduce pressure effectively if they are used in accord with the manufacturer's instructions .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 48958 Based on interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 2 of 3 residents reviewed for quality of care (Resident #289 and Resident #290). 1. The facility failed to ensure Resident #289 did not elope from the facility on [DATE]. 2. The facility failed to ensure Resident #290 did not elope from the facility on [DATE] and [DATE] . The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for injury or harm. The findings included: 1.Record review of Resident #289's face sheet dated [DATE] revealed he was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of neurocognitive disorder with Lewy bodies (a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function) and Parkinson disease (a disorder of the central nervous system that affects movement, often including tremors). Record review of Resident #289's quarterly MDS assessment dated [DATE] revealed a BIMS of 06 which indicated severe cognitive impairment. Resident #289 required clean-up assistance for eating, showering and toileting. Resident #289 required moderate assistance to walk 10 feet. Record review of Resident #289's care plan revealed a care plan dated [DATE] titled cognitive deficit. Decision making monitor for any changes or decline in cognitive as evidenced by short-term memory loss and long-term memory loss. Resident #289 was a fall risk related to fall on [DATE] and a history of Parkinson's disease as evidenced by tremors, generalized weakness, left sided weakness, right sided weakness, and left upper extremities weakness. Resident #289 had behavioral changes dated [DATE] due to neurocognitive disorder. Record review of Resident #289's elopement risk assessment [DATE] revealed resident was a moderate elopement risk. Record review on 15 minute watch on Resident #289 dated [DATE]-[DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #289's incident accident report dated [DATE] 6:29 P.M., revealed Resident typically leaves on pass with [Family Member #1] on Thursdays for the weekend and returns on Monday. Resident stated to staff on ,d+[DATE] that he was getting ready to leave and he would see her on Monday which was not abnormal for this resident. Resident was seen by staff at facility at 6:00PM. Resident noted to be at a local restaurant at 6:29PM by facility staff. Upon interview resident stated that he was going to his family member #1's house . Resident was in fact headed in correct direction to arrive at family member #1 house. Investigation revealed that resident is concerned about marital issues. Resident alert and oriented with BIMS of 13 at time of incident. Resident repeatedly expressed his apologies for leaving facility without signing out stating that it would not happen again. Resident voiced that he thought he could leave whenever he wanted. Resident does have some impulse control deficits and acknowledges this deficit. Resident acknowledges that he did not consider the risk of leaving the facility unannounced and ambulating off facility grounds. Record review of Resident #289's skin data dated [DATE] revealed he had a skin tear to left knee approximately the size of a half dollar and skin tear to left elbow approximately the size of a nickel. Resident #289 had bruising to the top of right buttocks and left arm. During an interview on [DATE] at 5:31 P.M., Family Member #1 said Resident #289 and her had some problems when he stayed the weekend with her. She said she tried to bring him back to the facility that Saturday, but she was unsuccessful. She said she brought him back to the facility that Wednesday on [DATE], and he did not want to go back. She said he had been telling the facility she was sick and he was at home taking care of her, but she was not aware of that at the time. She said he had told a family member he could leave the facility any time he wanted to. She said when she brought Resident #289 back to the facility on [DATE], she made the facility aware that they had an argument and the facility staff told her to turn off her phone or block him from calling her. She said she was told that another resident's family member from the facility called the facility and told them they seen Resident #289 at a local restaurant on the interstate. She said the facility did not know he had left the facility. She said he was trying to get a ride to her house. She said one of the nurses that knew him finally convinced him to get in the car with her and she brought him back to the facility. She said [DATE] was the only time he ever tried to leave the facility. She said the facility would let him sit outside all the time without staff, because he loved to be outside. She said the facility said he was last seen outside in front of the facility at 6:,d+[DATE]:15 P.M. and a resident's family member called the facility from a local restaurant at about 6:27 P.M. and said he was there. She said Resident #289 fell in a local restaurant parking lot and skinned his left knee and left elbow, but they were not major injuries. She said the next morning the facility called her and said he was going to be transferred to a behavioral Unit. The facility said the state had got involved in the incident and said he was a high-risk resident. She said he was in another facility that was a locked down facility at that time. The facility told her when Resident #289 got back to the facility he was coherent and was trying to come home to check on her, because they had a bad argument. She said Resident #289 was not in the mental state to cross over a major highway that was very dangerous. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:11 A.M., LVN DD said she had just got to work at 6:00 P.M. on [DATE] and Resident #289 was sitting outside on the front porch . She said Resident #289 said he was waiting on, and they were going on a date. She said shortly after that, the Activity Director called the facility and said he was in the parking lot at a local restaurant. LVN DD said they tried to get him to come back to the facility, but he was adamant about going to see family member #1. LVN DD said RN U and CNA V, convinced him to get in the car with them and returned to the facility. LVN DD said it was normal for Resident #289 to sit outside on the porch without staff even though he was an elopement risk. LVN DD said Resident #289 thought family member #1 was cheating on him, so he was agitated. She said he was adamant about not getting in the car and said if he would have gone another route, he would have missed us. She said she knew Resident #289 had on a red button-down long sleeve shirt, blue jeans, and a white cowboy hat on [DATE]. She said she did not remember the shoes he had on. LVN DD said when Resident #289 got back to the facility, he was upset. LVN DD said he said he had fell at a local restaurant before staff got there and he was not hurt. LVN DD said Resident #289 had some confusion, but he said he did not hit his head. LVN DD said he knew where he was going. LVN DD said the facility did 15-minute checks on Resident #289 until he left the facility, but she was not sure if they did neuro checks. LVN DD said the road he traveled was very busy, he crossed a street, and the other staff said he had tried to get a ride from a stranger. LVN DD said when they got him back to the facility, it took her and other staff members a while to get him to calm down, then a family member came and they got into an argument and he was even more upset. During an interview on [DATE] at 9:42 A.M., Activity Director W she said she was leaving the facility on her way home about 6:00 P.M. She said something told her to look at a local restaurant and she seen Resident #289 standing there. She said Resident #289 was tired and she offered him to sit in the car with her and he refused. She said she called the nurse at the facility and when the nurse LVN DD arrived, she tried to get him in the car, but he still refused. Activity Director W said RN U and CNA V came to the scene. She said Resident #289 proceeded to walk with an unsteady gait. Activity Director W said a gentleman came to help and Resident #289 said he wanted to go home to family member #1. She said Resident #289 continued to walk to the bank with the RN U under his arm walking with him. She said Resident #289 gave in and got in the car with RN U and CNA V, because he was tired. During an interview on [DATE] at 3:50 P.M., the DON said she received a couple calls that Resident #289 had been found at a local restaurant. She said Resident #289 had a plan to go home, because family member #1 did not live far away from the facility. She said Resident #289 was concerned about family member #1 was cheating on him. She said at first Resident #289 did not want to get into the car with the staff members, but eventually he got in the car and came back to the facility. She said he did not take his wheelchair when he left; he used wheelchair as a walker. She said he fell during the elopement and scrapped his left leg and left elbow. She said he did not show any signs that he wanted to leave the facility. She said family member #1 came to the facility and got him often. She said he was worried about family member #1 because she was not answering the phone. She said Resident #289 and family member #1 had an argument a day before the elopement, because he thought she was cheating with the neighbor. She said he sat outside on the bench every day. She said there were two different ways he could get to a local restaurant from the facility, they were not sure which route he took. She said Resident #289 was a moderate elopement risk . She said when he returned to the facility staff did every 15-minute checks on him, then the facility started discussing the next plan for him. She said the facility sent him to a behavior unit . She said then the facility decided to send him to their sister facility, because it was a locked facility. (continued on next page)

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	675444	A. Building B. Wing	12/05/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 4:18 P.M., CNA X said Resident #289 normally walked out of the facility and sat out on the front porch, but that day, he walked off the premises. She said usually he sat out there and came back in. She we got him back to the facility. She said when she last seen him, he was walking out the front door to sit on the porch. She said at supper time staff went to his room to pass his tray and he was not there; then we to the front porch and was not there. She said they expanded the search and she drove her personal car to a local restaurant after one of the staff members said he was going to meet family member #1; they had a dinner date. She said he did not look tired and did not appear to have had any injuries. CNA V was the aide that went to find them. He got in the car with the RN U and CNA U to go back to the facility. She said she wanted to say he was on one-on-one checks and the facility called family member # after the incident. She said Resident #289 had to crossed over 4 lanes of traffic before he made it to a local restaurant. During an interview on [DATE] at 5:18 P.M., the DON said since the elopement incident with Resident #289 the facility had put prevention steps in place . She said a licensed nurse did not complete the elopement risk assessment on [DATE] . She said an elopement risk assessment should be done on admission by a licensed nurse. She said previously nonclinical personnel completed elopement assessments. She said going forward nonclinical personnel was not someone that she would expect to complete an elopement assessment and the elopement assessments would to be filled out accurately under her management. 2. Record review of Resident #290's face sheet dated [DATE] revealed he was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of dementia (a group of thinking and social symptoms that interferes with daily function), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities), altered mental status (a change in how well the brain is working), violent behavior and delirium due to known physiological condition (disrupts brain function). Record review of Resident #290's care plan dated [DATE] revealed the resident was a high elopement risk. His cognition decision-making skills were severely impaired. Record review of Resident #290's incident reported dated [DATE] revealed the resident had a fall and elopement outside of the facility. During an interview on [DATE] at 5:02 P.M., Family Member #2 said Resident #290 believed he was going to meet someone at a local restaurant . She Resident #290 turned over in his wheelchair off the curb in the parking lot. She said he was at the facility, and he did not leave the property. She said she was not sure how far he was from the front door. She said he tried to leave the facility several times, so the facility told her he needed to be in a secured unit. She said she tried to find placement for him. She said it was hard to find placement for him, because he had a history of violent and inappropriate behaviors in the past, but she found placement for him . She said the facility tried everything they could to keep him from eloping, but he was very persistent and head strong. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:35 P.M., LVN B said she remembered Resident #290 was arguing with staff, because they were trying to redirect him. She said he was trying to leave out the front door, because he was going out the front door to meet with a deceased family member to go eat at a local restaurant. She said she was unable to redirect him, so she had another staff member to help me with him . She said she believed the former Administrator helped get him back into the facility. She said the facility put Resident #290 on 15 minutes checks and she gave him a PRN Ativan for anxiety. She said Resident #290 tried more than once to leave the facility, but he never left the premises. During an interview on [DATE] at 3:41 P.M., the DON said she got a phone call , and she called the former DON and then called the former Administrator about Resident #290's elopement and him falling. She said a family member found him outside. She stated she could not remember if he hit his head. She stated the nurse assessed him outside and he had some scraps on his left knee and left elbow as if he was trying to get up by himself off the concrete. Resident #290 was confused. She said before Resident #290 became confused it was common for him to sit outside. She said Resident #290 was in the curb of the front entrance of the facility. She said she did not remember the incident on [DATE] when Resident #290 eloped. She said the facility requested for him to transferred him to another facility . During an interview on [DATE] at 2:27 P.M., Marketing Z said she covered multiple facilities and the only facilities that could take an elopement risk resident was a memory care unit. She said if the patient was an elopement risk, the patient could not be considered for the facility. During an interview on [DATE] at 2:34 P.M., Admissions Coordinator Y said the facility could not take residents that were an elopement risk. During an interview on [DATE] at 4:55 P.M., the RDO informed surveyor that former ADM was terminated on [DATE] due to elopement of Resident #289. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Nurse Practitioner progress note dated [DATE] revealed Resident #289 had been seen on [DATE]. This is a [AGE] year-old male who is seen today after he was found to have left the facility unannounced and was walking to his former home. He was found by nursing staff to be down the road quite a ways in the parking lot of a gas station. Initially, he was irrational and agitated and would not get in the car with the nursing staff to go back to the facility. He apparently told nursing staff that he thought since he had Medicaid he could leave whenever he wanted, and he told one nursing staff member that he was on his way to take his wife to the rodeo. However come on today's examination he states that he left to go check on his wife as he had not heard from her and he got very worried about her well-being. He was able to verbalize exactly what he did and why he did it. I do not believe that he was confused in the moment when he made the decision to leave the facility and to go home as he was headed in the correct direction and was able to verbalize that he should have told someone that he was leaving. However, I do believe that the action was very impulsive, and he verbalized that he did not think about the risks or repercussions of leaving the facility unannounced in walking down a busy road by himself considering his impaired gate from his Parkinson's. He admits that he has difficulty with impulse control. He verbalizes that he will never do this again and he is apologetic. He states overall that he has been feeling ok but has been having some freeze spells secondary to his Parkinson's. He has been taking his breakthrough carbidopa levodopa prn dose On most days, but he does state that it seems to help get him back moving. He denies any additional issues or needs at the time of exam. I did explain to him that depending on what the facility protocols are he may not be able to stay in this facility as it is not a locked facility considering he has had a previous attempt of leaving the facility. Record review of the facility policy, Elopement Risk Assessment, revised [DATE] revealed the licensed nurse documents in the nurse's notes and behavior monitoring in the HBR; any exit seeking behavior on an on-going basis and interventions are adjusted as needed. Record review of the facility policy, Elopement Management, dated [DATE] revealed an immediate investigation and search will be conducted if a resident is considered missing. The resident will be located and returned to a safe environment within standard practice guidelines. `The facility corrected the noncompliance on [DATE] by the following: Record review of Training In-Service Form, Elopement Policy and Procedure, dated [DATE]. Record review of Training In-Service Form, Door Alarms, undated. Record review of Training In-Service Form, Managing elopement risk when resident stated they were leaving. They discussed how they could have handled that differently and watching for signs of confusion. They also discussed disease process dated [DATE]. During an interview on [DATE] at 2:28 PM., Housekeeping AA said she was in serviced over elopement and door alarms. She said the green code was for staff to check everywhere for the resident. She said after 30 minutes if the resident was not found staff should contact the police and the family. She said if the resident was found check them from head to toe. She said let the DON and ADM know as soon as possible once staff were aware the resident was missing. Door alarms you look if anyone got out , see if all residents were there, check outside, check everything , the DON, and ADM first. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:31 P.M., the ADON said she was in serviced over elopement and door alarms. She said the facility should call a code green for a missing resident. She said go to the nurse's station and get details on the missing resident, what they were wearing, last seen, and plan to find the resident. She said two people go together to find the resident. She said make sure the ADM, DON and all staff are aware . She said if the door alarm went off, she would go check and assess why the alarm was going off and check to see if all the residents are accounted for. During an interview on [DATE] at 2:34 P.M., LVN N said She was in serviced over elopement and door alarms. She said notify Administration and search every room. She said a code green should be called. She said two people together look everywhere and if resident was not found call the police and the family. She said if the door alarm goes off to check for residents inside and outside. She said a full head count for the entire building should be performed immediately of the residents. During an interview on [DATE] at 2:37 P.M., Floor Tech EE said he had in-services over elopement and door alarms. He said he would stop doing the floors and follow instructions on finding a missing resident, he would help to find them. He said if he saw a resident in the parking lot, he would bring them back in and tell the DON, ADM, and charge nurse. He said if a door alarm went off he would make sure no resident was near the door and he would alert staff immediately. During an interview on [DATE] at 2:39 P.M., Admissions Y said she was in serviced over elopement and door alarms. She said if a resident was missing would get their face sheet, search the inside perimeter, and slowly move outside. She said she would tell the ADM and DON and they would call a code green and meet at the nurse's station for a plan. She said two people were to search outside and staff would search indoor, then everyone would keep looking until resident was found. She said if a door alarm went off staff should instantly look to see if a resident was trying to get out, alert ADM, DON, do a head count and find out why the alarm went off. She said staff should check all showers and any place a resident could be. During an interview on [DATE] at 2:42 P.M., CNA FF said she was in serviced over elopement and door alarms. She said if a resident was missing, code green should be called, if a resident said they wanted to leave she would tell the ADM and DON immediately. She said if a resident was missing search where last seen and let everyone know you cannot find them. She said all staff should meet at the front nurse's station and everyone looks for the resident. She said door alarms staff should run to the alarm to see what was going on, to see if anyone escaped. During an interview on [DATE] at 2:45 P.M., CNA CC said she was in serviced over elopement and door alarms. She said if a resident eloped a code green should be called, notify ADM, DON, charge nurse, and let everyone know and find the resident. She said staff should search perimeters first then go from there. She said call police if not found in 30 minutes. She said if a door alarm goes off, do not just turn it off make sure no one has gotten out, if no resident was there, get help, search elsewhere, across the street, down the back and everywhere. She said all staff meet at the front nurse's station for an elopement plan. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:48 P.M., CNA E said she was in serviced over elopement and door alarms. She said if a resident got out of the code green. They have a book at the desk will tell you about the resident. Will tell the ADM and DON and ADM will call the police if not found in a certain period. Meet at the nurse's station for a plan to find the resident. Door alarm - check immediately could be someone escaping. Make sure every resident is safe and secure. Even if you don't see a resident still have to notify everyone and go check and do a head count to make sure. During an interview on [DATE] at 3:07 P.M., WCLVN G said she was in-serviced on elopement and door alarms. She said if a resident had eloped or she suspected to elope; staff should try to determine the last place the resident was seen, the closest exit, meet at the front nurse's station, a code green should be called and a plan should be made to find the resident. She said when a resident was unaccounted for first thing, she would do would be tell the DON, ADM, and SW. She said after 30 minutes of searching and resident not found call the police, med director, fire dept, and family. She said when a door alarm goes off check the exits for a resident and look in that area to make sure a resident had not exited. During an interview on [DATE] at 2:48 P.M., DON said she in serviced all staff over the Elopement policy and procedure and alarms. She said during an elopement, look for the resident first. She said she discussed what to look for in a resident that might elope, look for triggers in residents that might elope, what make you think of a resident might try to go to the door. She said she made sure staff understood the measures taken for a resident at risk for elopement. She said informed all staff if a resident was missing contact the DON; so, she could call a code green. She said during an elopement she meet with all staff at the front nursing station and the facility had a 30-minute window to look for a missing resident before the police were called. She said when the door alarm in service was performed we did a live demonstration we had someone stand at the door to activate the alarm, so staff knew how the alarm sounds. She said staff were informed that they need to check for the resident before they assumed a resident was missing and checked outside of the door before the door alarms were turned off. She said the smoking area alarms were different. She said the side door alarms went off by closing the door and the alarm would go off. During an interview on [DATE] at 3:05 P.M., LVN BB said she in serviced over elopement and alarms. She said when an elopement occurred or suspected the facility called a code green. She said if staff were not unable to locate the resident within 30 minutes, then the police were called, figure out where the resident was last seen, search the building and perimeters for the resident. She said there was an elopement book that verified higher elopement risk residents. She said after an elopement an incident report should be completed, an updated the elopement risk assessment on the resident. She said once a resident was found a nurse should do a head-to-toe assessment, notify the DON/ADM/ MD and 15-minute checks on the resident for 72 hrs. She said when alarms went off check outside to see if a resident left through the door and check the area before the alarm was turned off. During an interview on [DATE] at 3:11 P.M., CNA F said she was in serviced over elopements and alarms with elopements, she said if a resident eloped the staff gather in the front at the nurse's station and all staff in the facility would be notified of the elopement. She said staff should look inside the facility then look outside the facility. Notify the police after 30 minutes of searching for a resident if they are not found. When alarms were heard then run to the end of the hall and see what was going on and check to see if someone has left out the door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:41 P.M., ADM said the incident with Resident #289 was situational . He said the facility had guidelines in place to prevent this incident from reoccurring. He said he loved to see his residents sitting outside, but safety always came first. He said he was not working at the facility when the incident occurred. He said he did not have all the facts about the incident with the Resident #289 or Resident #290. He said safety would be an issue for a resident that eloped the facility and crossed 4 lanes of traffic. He said the risk for the Resident #289 and Resident #290 could have been anything from missing meds to an injury. The noncompliance was identified as PNC. The noncompliance began on [DATE] and ended on [DATE]. The facility corrected the noncompliance before the survey began.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review, the facility failed to ensure that each resident who was incontinent of bowel/bladder and each resident with an indwelling catheter received appropriate treatment and services to prevent urinary tract infections, for 2 of 5 residents (Resident #65 and Resident #63) reviewed for quality of care. The facility failed to ensure CNA E and CNA L provided peri care/catheter care per the facility's policy for Resident #65 on 12/04/24. The facility failed to ensure, on 12/04/24, Resident #63 did not have feces on her thigh and brown stained creases on the legs portion of her brief. These failures could place residents at risk for urinary tract infections. Findings included: Record review of Resident #65 face sheet dated 12/02/24 indicated a 76-years-old female admitted to the facility on [DATE]. Resident #65 had diagnoses including metabolic encephalopathy (is a brain dysfunction caused by a chemical imbalance in the blood that affects the brain), urinary tract infection (is a common bacterial infection that occurs in the urinary tract, which includes the bladder, kidneys, and urethra), Type II diabetes (is a condition that occurs when the body doesn't use insulin properly, leading to high blood sugar levels), pressure ulcer of right bittock, unstageable (is a type of bed sore that occurs when too much pressure is applied to a specific area of the skin over a long period of time), and pressure ulcer of left buttock, stage 4 (is the most severe stage, characterized by full thickness tissue loss where the underlying muscle, tendon, or bone is exposed, often with significant damage to surrounding tissue, and a high risk of infection). Record review of Resident #65's significant change in status MDS assessment dated [DATE] indicated Resident #65 was usually understood and usually understood others. Resident #65's BIMS was not completed. Resident #65 was dependent for toileting hygiene. Resident #65 had an indwelling catheter (is a thin, hollow tube that is inserted into the bladder to drain urine and is left in place for a period of time) and was always incontinent of bowel. Resident #65 had a multi-drug resistant organism (a bacterial infection caused by a microorganism that is resistant to multiple classes of antibiotics and antifungals), pneumonia (is a lung infection that causes the air sacs in the lungs to fill with fluid or pus, making it difficult to breathe), and septicemia (is a life-threatening infection that occurs when bacteria, viruses, or fungi enter the bloodstream). Record review of Resident #65's care plan dated 09/24/24 indicated urinary catheter related to anatomical or functional diagnosis as evidenced by foley catheter every 2 shift and change foley catheter every 30 days. An intervention included care and changing of urinary catheter as ordered. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #65's order summary report dated 11/01/24-12/04/24 indicated Foley Catheter 16 French every 2-shift, continuous gravity drainage and catheter care, Diagnosis: Retention of urine (is a condition that occurs when a person is unable to empty their bladder), start date 10/10/24. During an observation on 12/04/24 at 2:30 p.m., CNA E and CNA L provided Resident #65 with peri/catheter care. WCLVN G was also at the bedside. CNA E wiped Resident #65's catheter tubing with the disposable wipes four times. CNA E then wiped down Resident #65 perineum three times with disposable wipes. Resident #65's disposable wipes fell off the bedside table to the floor. Resident #65's disposable wipes fell open and the packaging was face down. WCLVN G picked up the disposable wipes and removed a few wipes from the package. WCLVN G then wiped the outside of the package with a sanitizing wipe, and then placed it back on Resident #65's bedside tray. CNA E wiped Resident #65's peri area two times with disposable wipes. CNA L slightly retracted Resident #65's labia majora (outer folds) and CNA E wiped down the middle three times with the disposable wipes. Record review of Resident #63's face sheet dated 12/02/24, indicated an 84-years-old female who admitted to the facility on [DATE]. Resident #63 had diagnoses including Alzheimer's disease (is a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to perform everyday tasks), muscle weakness, and pain. Record review of Resident #63's quarterly MDS assessment dated [DATE] indicated Resident #63 was rarely/never understood and rarely/never understood others. Resident #63 had unclear speech. Resident #63 could not complete the BIMS assessment due to being rarely/never understood. Resident #63 had short- and long-term memory recall problems. Resident #63 had severely impaired cognitive skills for daily decision making. Resident #63 was dependent for toileting hygiene. Resident #63 was always incontinent for urine and bowel. Record review of Resident #63's care plan dated 10/20/24 indicated self-care deficit related to end stage Alzheimer's, hospice services, and history of seizures as evidence by dependent with toileting hygiene. Intervention included hospice and facility staff to perform ADL's. During an observation and interview on 12/04/24 at 2:40 p.m., WCLVN G performed a skin assessment of Resident #63 with the assistance of CNA F. WCLVN G detached Resident #63's brief to inspect her skin. The leg creases on Resident #63's brief was light brown but only urine was noted in the brief. WCLVN G instructed CNA F to clean a dark brown substance on Resident #63's thigh/buttock area. WCLVN G said it looked like something was left from the prior changing. CNA F cleaned Resident #63 rectum area then wiped towards her vagina. On 12/05/24 at 8:55 a.m., the female catheter care policy was requested from the Administrator and RNC T by email. During an interview on 12/05/24 at 9:30 a.m., RNC T provided a hard copy of Perineal Care policy and said it covered the catheter care procedure. On 12/05/24 at 11:31 a.m., called CNA E and left voice mail. No returned call before or after exit. On 12/05/24 at 11:32 a.m., called CNA L and unable to leave message. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/24 at 11:34 a.m., called CNA F and left voice mail. No return call before or after exit. During an interview on 12/05/24 at 12:35 p.m., WCLVN G said CNA E and CNA L were assigned to Resident #63 on 12/04/24. She said Resident #63's brief had brown stuff on it and there was leftover feces on her vagina/buttock area. She said the brown stained brief and left over feces could indicate Resident #63 was not cleaned properly the time before. She said CNA F wiped towards Resident #63's vagina instead of away. She said not cleaning Resident #63 properly placed her at risk for a urinary tract infection. She said the residents had a weakened immune system so they were susceptible to any type of infections. She said CNA E and CNA L did not properly do catheter care on Resident #65. She said once Resident #65 was positioned correctly, a second CNA was not needed for catheter care. She said Resident #65's legs could have been placed wider to allow for better cleaning. She said Resident #65's labia were not separated and cleaned properly. She said it would have been better practiced getting Resident #65 another package of wipes when hers fell on the floor. She said improper catheter care placed resident at risk for urinary tract infections. During an interview on 12/05/24 at 2:42 p.m., the Director of Nursing said she expected staff to follow the facility's catheter care policy and procedure. She said she expected the residents to be clean after incontinent care was provided. She said she expected nursing staff to clean away from the vagina, always clean front to back. She said she expected basic infection control measures to be followed during catheter and incontinent care. She said improper catheter care or incontinent care placed the residents at risk for urinary tract infections. During an interview on 12/05/24 at 3:32 p.m., the Administrator said he expected the CNAs to provided proper care to the residents. He said Resident #63 should not have residual feces from the previous changing. He said not cleaning feces from a resident skin had the potential to cause skin breakdown. He said the lack of cleanliness was not proper technique. He said he expected the CNAs to provide catheter care per the facility's policy. Record review of the facility's Perineal Care policy dated 04/22/2024, indicated .Staff will provide perineal care in accordance with the standard of practice to prevent skin breakdown and infection. Procedure: 4. Perineal Care for Female: a. Assist resident to lie on their back with legs flexed at knees and spread apart. b. Drape resident with linens to provide privacy. Keep resident covered throughout procedure, exposing areas as needed. c. Wash and dry resident's upper thighs. d. Wash labia majora. Use nondominant hand to gently retract labia from thigh. Use dominant hand to wash carefully in skinfolds. Wipe in direction from perineum to rectum. Repeat on opposite side using separate section of washcloth or new wipe. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Gently separate labia with nondominant hand to expose urethral meatus and vaginal orifice. With dominant hand wash downward from pubic area toward rectum in one smooth stroke. Use a separate section of washcloth or new wipe for each stroke. Clean thoroughly over labia minora, clitoris, and vaginal orifice. Avoid tension on the urinary catheter if present and clean around it thoroughly . 8. Turn resident to clean all areas of buttocks with new wipe or section of washcloth wiping front to back to remove feces present. Observe for redness, bruising, open skin, rash, or other abnormalities .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35295 Based on observations, interviews, and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicated otherwise for 1 of 3 residents (Resident #81) reviewed for nutrition. 1. The facility failed to follow the dietician's recommended tube feeding for Resident #81 to receive Glucerna 1.5 at 60 ml/hr beginning 9/14/24. 2. The facility failed to follow the dietician's recommendation of weekly weights beginning 11/15/24 for Resident #81. 3. The facility did not follow up on Resident #81's 9.12% weight loss in 3 months. These failures could place residents at risk for malnourishment, weight loss, skin breakdown, and decreased quality of life. Findings included: Record review of Resident #81's face sheet dated 12/3/24 indicated Resident #81 was a [AGE] year-old male that admitted [DATE] with diagnoses that included: Dysphagia following cerebral infarction (difficulty swallowing after a stroke where part of the brain experiences a blockage of blood flow), cognitive communication deficit (difficulty communicating due to cognitive impairment), surgical aftercare on the digestive system (feeding tube placed in abdomen). Record review of Resident #81's quarterly MDS assessment dated [DATE] indicated Resident #81 had unclear speech, was sometimes understood by others, and usually understood others. He had a BIMS score of 0, indicating severe cognitive impairment. The MDS indicated he had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. He had a feeding tube. Record review of Resident #81's care plan updated 12/3/24 for Resident #81 revealed he had altered nutritional status with enteral feedings with Glucerna 1.5 cal 0.08 gram-1.5 kcal/ml oral liquid, 80 ml/hr every 24 hours 1 time per day. He had a 135 ml flush every 4 hours. The care plan indicated Resident #81 required weights to be taken monthly and weekly (dated 8/1/24). Resident #81 had a dietician referral on 7/31/24. The care plan indicated Resident #81 had trending weight loss since admission. He had cognitive deficits with long term memory loss and expressive speech deficit. Record review of Resident #81's physician's orders dated 7/31/24 - 12/3/24 indicated: 8/1/24 Peg (feeding tube inserted through the abdomen w all and into the stomach) tube flush 135 cc every 4 hours. 10/6/24 - 12/3/24 Glucerna 1.2 cal, 0.06 gram-1.2 kcal/ml oral liquid 60 ml/hr every 24 hours on 1 time per day. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/3/24 Glucerna 1.5 cal 0.08 gram-1.5 kcal/ml oral liquid 60 ml/hr peg tube every 24 hours 1 time per day. 12/3/24 Glucerna 1.5 cal 0.08 gram-1.5 kcal/ml oral liquid, 80 ml/hr every 2 shift for 21 hours. Record review of the electronic record indicated Resident #81 weights were: 11/3/24 152.8 lbs. 9/4/24 164.4 lbs. 8/9/24 176.6 lbs. Record review of the Nutrition Follow-up Note dated 9/14/24 indicated: [Resident #81] is followed regarding a 6.91% 30 day weight loss .He is NPO status and received Diabetisource AC at 65 mls every hour with 135 mls water every 4 hours .Goal to cease further 30 day significant weight loss. When available, D/C Diabetisource AC at 65 mls. Begin Glucerna 1.5 at 60 mls every hour .Weekly weights for monitoring. Record review of the Nutrition Follow-up Note dated 10/30/24 did not indicate type or amount of feeding. The note indicated Resident #81 weighed 164.4 lbs. and was NPO. Record review of a Nutrition Follow-up Note dated 11/15/24 indicated: [Resident #81] has experienced a significant weight loss NPO with enteral feeding of Glucerna 1.2. However, he should be on Glucerna 1.5 at 60 mls every hour .Please [hand] the correct formula. During an observation on 12/02/24 at 10:32 AM, Resident #81 was lying in a bariatric (heavy duty for larger patients) bed. He had Glucerna 1.2 60 ml/hr 135 ml flush every 4 hours . Feeding, water, and syringe was dated 12/2/24. The head of the bed was raised 30-45 degrees. He was on EBP. During an observation on 12/03/24 at 9:41 AM, Resident #81 was positioned on his left side with the head of the bed raised 30-45 degrees. His feeding tube was running. Glucerna 1.2 at 60 ml/hr with a 135 ml flush every 4 hours . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/03/24 at 9:43 AM, RN A said that was his second week working the hall. He looked at the electronic record and said [Resident #81]'s weights were: 11/3/24 152.8 lbs, 9/4/24 164.4 lbs, 8/9/24 176.6 lbs. He read the physician's orders aloud and said Glucerna 1.2 cal was ordered at 60 ml/hr with a 135 ml flush every 4 hours. RN A then went into Resident 81's room and said Yes, Glucerna 1.2 was running at 60 ml/hr with a 135 ml flush every 4 hours. He then went back to his computer and read the nutrition note for 11/15/24. He said Resident #81 should be on Glucerna 1.5 cal and they should have gotten an order from the doctor based on the dietary recommendations. He said the nutrition note from 11/15/24 indicated Resident #81 should be on weekly weights, but there were no weekly weights in the computer. He said according to the dietary note, they should have been getting weekly weights and they had not. He read the nutrition note from 10/30/34, then read the nutrition note from 9/14/24 and said Resident #81 should have been on Glucerna 1.5 cal since 9/14/24. RN said if dietary made a recommendation and they were not doing it, it was a problem. He said he would get a current weight for Resident #81 since the last weight was 11/3/24. During an interview and observation on 12/03/24 10:21 AM, RN A was pushing the mechanical lift out of Resident #81's room. He said Resident #81 weighed 149.4 lbs. He said he had just gotten his weight. During an interview on 12/03/24 at 11:33 AM, RN A said he did not know who was responsible for making sure dietary/nutritional recommendations were followed but thought it would be talked about in the care plan meetings. He said he would have never thought to look at the dietary recommendations because he looked at the MD orders. He said he did not know what nursing person was responsible to look at the dietary recommendations, but the process was, whomever saw the dietary recommendations would call the MD to get orders based on the dietary recommendations. RN A said he called the MD earlier and got orders for Resident #81 for Glucerna 1.5 cal. He said he was about to hang the Glucerna. He said the risk of not following the dietary recommendations was weight loss which Resident #81 had, and also poor nutrition. He said the risk of not following the recommendation of weekly weights was they would not know about changes with the resident. He said they did not know he had lost more weight until they weighed him that day. During a phone interview on 12/03/24 at 11:56 AM, Resident #81's MD said Resident #81's formula should have been addressed in September 2024 when the dietician ordered it. He was not aware of the significant weight loss. He said it was very important to know if Resident #81 was getting sufficient calories. He said the facility absolutely should have changed his Glucerna to 1.5 cal and done weekly weights when it was ordered by the dietician because he needed proper nutritional support. He said the 3-month 9.12% weight loss would not have a lasting impact on Resident #81 because he and the facility would work together to get his weight back up and on the right track. He expected to be notified of changes with residents. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on12/03/24 at 12:12 PM, the dietician looked at her computer and said she recommended Glucerna 1.5 cal on 9/14/24, and on 11/15/24 when they had not changed his formula to Glucerna 1.5 cal, she recommended it again along with weekly weights. She said the DON or designee should have acted on these recommendations when they received them. She said on 9/14/24, she recommended the Glucerna 1.5 because of weight loss and wanted to increase his nutrition. She showed this surveyor on her email (sent email) where she had sent her recommendations to: Nutrition Services, the DON, and the ADON on 9/14/24. She showed this surveyor where she emailed (sent email) her dietary recommendations on 11/15/24 to: Nutrition Services, the DON, and the ADON, and she included the Regional RN on that email. She said there was no October 2024 weight documented. She said she did not have a good percentage on his weight loss. She said the DON and ADON were responsible for making sure dietary recommendations were followed and the risk of not following them were malnutrition and weight loss. During an interview on12/03/24 at 3:27 PM, LVN B said she had worked at the facility for 5 years. She said she was not sure who acted on dietary recommendations. She said it was probably the ADON or DON. In the past, the old ADON and DON would alert her verbally to dietary recommendations then she would see the new orders in the electronic chart. She said if she got recommendations from the dietician, she would call the MD and get orders for the recommendations, put the new orders in the electronic record, then call the family to let them know. She said she was not sure who was responsible for dietary recommendations currently, because they had new staff. She said the process was that the dietician gave the recommendations to the DON, then the DON would give them to her, or to the nurse for that resident, then she or that nurse would call the MD for the orders and put the new orders in the electronic record. During an interview on 12/03/24 at 3:50 PM, LVN C said the charge nurse on the hall for that particular resident was responsible for making sure the dietary recommendations were followed up on. She said if the dietician gave recommendations to her, then she would call the MD and if he agreed, get orders, then let the DON know about it. She said she did not know if the dietician emailed or provided the ADON or DON dietary recommendations. She said, ultimately, the DON was responsible for making sure the dietary recommendations were followed up on. She said if the dietician had recommendations, she needed to tell the charge nurse or DON, otherwise the nurses would not know they were there. During an interview on 12/03/24 at 5:01 PM, the DON and ADON said the Regional Nurse consultant provided them with an action plan regarding weight loss. The DON said she just got it on that day. The DON said she and the ADON were new and trying to find their way. The DON said the policies she provided, Enteral and Weight policies, were all they had that addressed Resident #81's weight loss, dietary recommendations, and proper feeding. During an observation on 12/05/24 at 7:46 AM, Resident #81 was in a bariatric bed, positioned on his right side. The head of the bed was up 35-45 degrees. Glucerna 1.5 at 80 cc/hr with 135 ml flush every 4 hours was running. The Glucerna was dated 12/4/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/24 at 8:53 AM, the ADON said she started to work at the facility 9/14/24. She said Resident #81 had lost a severe amount of weight and the MD should have been notified immediately, as soon as they saw a weight loss. She said Resident #81's weight loss was not addressed, and it was the responsibility of her and the DON to make sure dietary recommendations were acted upon. She said it was her understanding there would be an email from the dietician that went to her, the DON and the regional consultant nurses. She said it was up to her, the DON, or the nurses to get the orders from the MD related to the dietary recommendations. The ADON said after looking at her email better, she found the emails the dietician had sent on 9/14/24 and 11/15/24. She said she did not see the emails prior to that day. She said she had been in-serviced along with the DON regarding the weight log, and dietary recommendations along with keeping up with it monthly. She said communication came from the dietician monthly. She said from then on, they would definitely look at the dietary recommendations, see the weight loss, maybe re-weigh them, reach out to the MD and let the MD know the dietician recommendations and see if the MD had any other recommendations. She said before then, she did not know what the process was regarding dietary recommendations and notifying the MD. She said whatever the process was, it failed everywhere. She said she did not know Resident #81 had such a significant weight loss, and did not know he was ordered weekly weights. She said the process for weight loss was to notify the MD immediately, but that did not happen because she did not know about it. The ADON said going forward, she would monitor all weekly weights by looking in the electronic record. If the weights were not there, she would get them herself or have someone get the resident's weight so she could follow it. She said moving forward, she would be responsible for all weight loss and it would be her responsibility to let the DON know, notify the MD, and document what the MD said along with any new orders. She said she would document everything in the nurse's notes. The ADON said things went wrong when she was not trained as to what to do with weight loss, dietary recommendations or any of that. During an interview on 12/05/24 at 1:20 PM, the DON said the nurses will tell the CNA's when to do weights. She said all residents were weighed monthly but if they were weekly weights, she would put it in the computer and it would prompt the nurse to enter the weight in, so either the nurse would weigh the resident or let the CNA know she/he needed to. During an interview on 12/05/24 at 1:24 PM, the DON said she agreed Resident #81 had lost a severe amount of weight. She said the MD should have been notified of weight loss of 5% in 30 days, 7.5% in 90 days, and 10% in 180 days. She said it was her responsibility to make sure the dietary recommendations were acted upon. She said before this survey it was the responsibility of the charge nurses and the DON to let the MD know about dietary recommendations. The DON said there was a lapse and it was the fault of the prior ADON, but ultimately it was her responsibility. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She said she saw the dietary recommendations the dietician emailed on 9/14/24 and 11/15/24. She said prior to the survey, she had another ADON that was responsible for the weights and dietary recommendations and that was not being done. She said the prior ADON had not been with them about 3 weeks but she was not taking care of things when she was here. She said she was ill and in and out of the facility in September 2024 and she was out for a week for DON orientation. She said she just missed the 11/15/24 email from the dietician. She said moving forward, she would automatically print out the dietary recommendations and verify that it was all done, by verifying it in the computer (orders the dietitian put in). If it was medication or something that had to be ordered by the MD, she said she would personally reach out to the MD to get the orders, or see if he had other orders. She said she would delegate that task to the ADON if she was not there. She said the weekly weights were not done that were ordered 11/15/24 for Resident #81 and that was part of the lapse. She said she had no excuse. The DON said moving forward, weights would be done at the beginning of every month. Dietary recommendations would be printed and kept in a binder that she would have. Weekly weights would be put in the computer by her, and she would monitor and let the nurses know of any changes. She said weekly weight was something in the dashboard in the computer and it would populate and the nurse would have to check off on it, to make sure it was done. She said the risk of not addressing weight loss could be malnutrition and/or malnourishment, more weight loss, muscle atrophy, and possible system failure. During an interview on 12/05/24 at 1:44 PM, the ADM said Resident #81's lost a severe amount of weight, and it was not addressed by the facility as it should have been. He said the DON and the IDT Team was responsible for making sure the dietary recommendations were acted upon. He said it was the responsibility of the DON to contact the MD and get orders. The ADM said he did not know how they got the dietary recommendations from the dietician. He said he did not know the process for dietary recommendations, contacting the MD, or weight loss. He said the whole process failed. He said for weight loss, the nurse should give the dietician recommendations and staff should immediately notify the MD and proceed with the orders that the MD and dietician gave. The ADM said he did not know why the weekly weights were not done or why the MD was not notified because the MD should have been notified as soon as weight loss was noticed. Record review of the facility's policy Enteral Nutrition for Closed System Nasogastric, Nasointestinal, Gastric and Jejunal Feeding Tubes, dated 1/12/2018 and revised 5/19/24, indicated: Policy: Enteral nutrition therapy will be performed in a safe manner by qualified licensed nurses according to standard practice guidelines. The policy did not address dietary recommendations or following MD orders. Record review of the facility's policy Weight Monitoring Policy, revised 1/12/20 and revised 5/19/23, indicated: Policy: Resident weights will be recorded and monitored at a minimum frequency monthly. 2.Monthly a)Monthly weights and re-weights results are to be recorded in the EHR: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i.EMR>Nurse>weight log by the seventh day of every calendar month. b)Unplanned and undesired weight variance will be evaluated for significance utilizing the Resident Assessment Instrument Guidelines (RAI) and will be reweighed according to RAI guidelines as followed: i.5% in thirty (30) days ii.7.5% in ninety (90) days iii.10% in one hundred-eighty (180) days . d)Usual weight is defined as weight below established CMS benchmarks as defined in section (b) above. e)If the monthly weight gain or loss shows significance as indicated in (b) above, the resident is reweighed within twenty-four (24) hours to assure accuracy of weight. f) If the reweigh identifies there is an actual weight gain or loss according to RAI guidelines outlined in (b), the resident/family, physician, and the Registered Dietician are notified by the Nursing Department. The physician and family are notified via phone, the Registered Dietician via email. The date of such notification is documented in the nurse's notes in the EHR. g)The Registered Dietitian reviews the resident's nutritional status and makes recommendations for intervention in the nutritional therapy assessment if significant weight change is noted. h)Significant, unplanned changes in weights are reviewed at the Standards of Care Committee meeting. The Committee will also identify and gradual weight loss.

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	675444	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate administering of all drugs and biologicals, to meet the needs of 1 of 18 residents (Residents #80) reviewed for pharmacy services. The facility failed to ensure Resident #80 had accurate and new readings for each administration of Hydralazine (is used to treat high blood pressure) on 11/01/24, 11/02/24, 11/06/24, 11/07/24, 11/11/24, 11/15/24, and 11/16/24. This failure could place residents at risk for inaccurate drug administration. Findings included: Record review of Resident #80's face sheet dated 12/02/24, indicated a 59-years-old female who admitted on [DATE] and readmitted on [DATE]. Resident #80 had diagnoses including cerebral infarction (is a serious condition that occurs when blood flow to the brain is blocked, resulting in brain tissue death) and hypertension (is a chronic condition where the pressure of blood in your arteries is consistently too high). Record review of Resident #80's significant change in status MDS assessment dated [DATE] indicated Resident #80 was usually understood and usually understood others. Resident #80 had a BIMS score of 10 which indicated moderate cognitive impairment. Record review of Resident #80's care plan dated 10/08/24 indicated the resident received antihypertensive as evidence by hydralazine 25 mg tablet and amlodipine (relaxes your blood vessels so that blood can move through them more easily and your heart does not have to work as hard) 10 mg tablet physician orders. Intervention included monitor blood pressure every shift. Record review of Resident #80's medication summary report dated 11/01/24-12/04/24 indicated hydralazine 25 mg tablet, 1 tablet by mouth 3 times per day. Hold if systolic blood pressure was less than 110. Hold if diastolic blood pressure less than 60. Hold if pulse less than 60. Diagnosis: acute kidney failure. Start date 10/08/24. Record review of Resident #80's medication administration record dated 11/01/24-11/30/24 indicated hydralazine 25 mg tablet, 1 tablet by mouth 3 times per day. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Hold if pulse less than 60. Diagnosis: acute kidney failure. Start date 10/08/24. Resident #80 vital signs indicated: *11/01/24 at 8:00 a.m.: Pulse 61, BP 135/82 *11/01/24 at 12:00 p.m.: Pulse 61, BP 135/82 *11/01/24 at 4:00 p.m.: Pulse 61, BP 135/82 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*11/02/24 at 8:00 a.m.: Pulse 84, BP 132/82 *11/02/24 at 12:00 p.m.: Pulse 84, BP 132/82 *11/02/24 at 4:00 p.m.: Pulse 84, BP 132/82 *11/06/24 at 8:00 a.m.: Pulse 68, BP 103/68 *11/06/24 at 12:00 p.m.: Pulse 68, BP 103/68 *11/07/24 at 8:00 a.m.: Pulse 62, BP 147/90 *11/07/24 at 12:00 p.m.: Pulse 62, BP 147/90 *11/07/24 at 4:00 p.m.: Pulse 62, BP 147/90 *11/11/24 at 8:00 a.m.: Pulse 61, BP 133/79 *11/11/24 at 12:00 p.m.: Pulse 61, BP 133/79 *11/15/24 at 8:00 a.m.: Pulse 68, BP 132/78 *11/15/24 at 12:00 p.m.: Pulse 68, BP 132/78 *11/16/24 at 8:00 a.m.: Pulse 82, BP 160/80 *11/16/24 at 12:00 p.m.: Pulse 82, BP 160/80 During an interview on 12/05/24 at 11:57 a.m., LVN N said she had been employed at the facility for a year. She said she had worked the night shift initially but currently was working day shift. She said she was working the 200 and 100 halls. She said she had taken care of Resident #80. She said a resident's blood pressure and pulse should be checked each time the blood pressure medication was due. She said a resident's blood pressure and pulse readings were normally not the same at each administration time. She said a charted exact same pulse and blood pressure readings could indicate falsification. She said Resident #80's blood pressure and pulse could be low and not need the medication. She said Resident #80's blood pressure and pulse could be high, and the physician needed to be notified if the dose was adjusted. She said not properly monitoring a resident's pulse and blood pressure before administering a blood pressure medication could harm the resident. During an interview on 12/05/24 at 2:42 p.m., the Director of Nursing said she expected the nursing staff to take the resident's blood pressure before each dose. She said that documenting the exact same pulse and blood pressure readings could indicate falsification. She said blood pressure and pulse readings were subjected to change all the time. She said if a resident's blood pressure was low and the blood pressure medication was administered, it could bottom out. She said the resident could experience syncope (fainting or passing out), confusion, and even death. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/24 at 3:32 p.m., the Administrator said a resident's blood pressure should be taken before a blood pressure medication was administered. He said the exact same blood pressure and pulse readings charted could have indicated a resident did not have a change or the nursing staff copy and pasted the reading. He said it was important to follow the physician orders according to the parameters. Record review of a facility's Medication Administration policy dated 01/2024 indicated .obtain and record any vital signs as necessary prior to medication administration .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications (is a medication used: In excessive doses (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indication for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued) for 3 of 5 residents (Resident #33, Resident #65, and Resident #80) reviewed for unnecessary medications. 1. The facility failed to ensure Resident #33 had the correct diagnoses on entered orders for the use of diabetes mellitus medications. 2. The facility failed to ensure Resident #65 had documented the correct diagnoses on entered orders for use of Acetaminophen 300 mg-codeine 30 mg (is used to help relieve mild to moderate pain), Lisinopril (is a medicine to treat high blood pressure (hypertension) and heart failure), Metoprolol (is used to treat angina (chest pain) and hypertension (high blood pressure)), Amlodipine (relaxes your blood vessels so that blood can move through them more easily and your heart does not have to work as hard), and Apixaban (used to reduce the risk of stroke and blood clots in people who have atrial fibrillation). 3. The facility failed to ensure Resident #80 had documented the correct diagnoses on entered orders for the use of Acetaminophen (is used to treat mild to moderate pain), Tramadol (is used to relieve moderate to moderately severe pain), Aspirin (is used to reduce fever and relieve mild to moderate pain), Hydralazine (is used to treat high blood pressure), Amlodipine (relaxes your blood vessels so that blood can move through them more easily and your heart does not have to work as hard), and Atorvastatin (is medication used to lower cholesterol and triglycerides (fats) levels to help prevent heart disease, angina (chest pain), strokes, and heart attacks). These failures could place residents at risk for adverse drug reactions (unintended, harmful events attributed to the use of medicines) and receiving unnecessary medications. Findings included: 1.Record review of Resident #33's face sheet dated 12/02/24 indicated Resident #66 was an 80-years-old male admitted on [DATE] with diagnoses including diabetes mellitus (a group of diseases that result in too much sugar in the blood (high blood glucose) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Record review of Resident #33's quarterly MDS assessment dated [DATE] indicated Resident #33 was understood and understood others. Resident #33 had clear speech, adequate hearing, and adequate vision. Resident #33 had an incomplete BIMS score. Resident #33 was dependent with ADL's. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #33's care plan dated 10/17/24 indicated Resident #33 had diabetes mellitus. Administer insulin and/or oral hypoglycemics as fasting blood sugar via glucometer as ordered. Observe for signs and symptoms of hyperglycemia such as blood sugar more than 180mg/dL, fatigue (weak, tired feeling), blurred vision, headaches, increased thirst, trouble concentrating, frequent urination, and weight loss. Notify provider per order. Observe for sign and symptoms of hypoglycemia such as shakiness, nervousness or anxiety, irritability or impatience, confusion, rapid heartbeat, lightheadedness or dizziness, nausea, sleepiness, blurred vision, tingling or numbness in lips or tongue, headaches, weakness or fatigue, lack of coordination, seizure, and unconsciousness. Treat per hypoglycemic protocol. Sliding scale insulin coverage as ordered. Therapeutic diet as ordered. Record review of Resident #33's consolidated physician order active as of 12/02/24 indicated: Glutose-15 40 % oral gel (DEXTROSE) 1 Gel by mouth As Needed LOW BS (BLOOD SUGAR) if FSBS is <60 and responsive, recheck FSBS in 15 min and call MD. If Blood sugar is < 60 and responsive give glucose 15 gm and call MD. Re check in 15 minutes Blood Glucose Check Dx: Heart failure, unspecified. Lantus Solostar U-100 Insulin 100 unit/mL (3 mL) subcutaneous pen (insulin glargine, human recombinant analog) 8 Units/Units Subcutaneous every morning HOLD IF BS < 100 and notify provider notify provider for >400 <60 Blood Glucose Check Site Location Dx: Heart failure, unspecified. During an interview on 12/05/24 at 9:03 A.M., LVN N said the nurse assigned to the resident was responsible for putting in the new orders and diagnosis for a resident chart. She said the diagnosis for the medication should be with the Dr. orders. She said an order for insulin should not be under a diagnosis of heart failure, it should be with diabetes mellitus. She said a negative effect of a resident not having the correct diagnosis with medications was miscommunication and misdiagnosing. During an interview on 12/05/24 at 9:45 A.M., LVN D said the nurse on duty for the admitting resident put in the resident orders on admission. She said the nurse was supposed to put the correct diagnosis for the medications. She said the oncoming nurse should check the orders behind the pervious nurse, but the facility had an ADON to check behind the nurses. She said a negative effect of not having the correct diagnosis for a resident medication was it could confuse the nurse. During an interview on 12/05/24 at 10:23 A.M., the ADON said she was responsible for ensuring that the medications were put in the system with the correct diagnosis. She said medications should be put in the system with the correct diagnosis. She said she did the chart audits now. She said she had only been doing it for about two weeks. She said the negative effects of a resident with the wrong diagnosis for a medication was a treatment could be missed and it did not make sense. 2. Record review of Resident #65's face sheet dated 12/02/24 indicated a 76-years-old female admitted to the facility on [DATE]. Resident #65 had diagnoses including metabolic encephalopathy (is a brain dysfunction caused by a chemical imbalance in the blood that affects the brain), type 2 diabetes (is a condition that occurs when the body doesn't use insulin properly, leading to high blood sugar levels), acute myocardial infarction (is a life-threatening medical emergency that occurs when blood flow to the heart is blocked), and atherosclerotic heart disease (is a group of conditions that occur when plaque builds up in your arteries, narrowing them and reducing blood flow) of native coronary artery with angina pectoris (is a type of chest pain or discomfort that occurs when the heart muscle doesn't receive enough oxygen-rich blood). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #65's significant change in status MDS assessment dated [DATE] indicated Resident #65 was usually understood and usually understood others. Resident #65's BIMS score was not completed. Resident #65 received an anticoagulant and opioid during the last 7 days of the assessment period. Record review of Resident #65's care plan dated 09/24/24 indicated: *Anticoagulant/Antiplatelet as evidenced by apixaban. Intervention included administer medications as ordered. *Antihypertensive as evidence by amlodipine, lisinopril, and metoprolol. Intervention included administer medications as ordered. *Opioid as evidence by acetaminophen 300 mg- codeine 30 mg. Intervention included ask physician to review medication for possible dose reduction every three months. Record review of Resident #65's medication summary report dated 11/01/24-12/04/24 indicated: *Acetaminophen 300 mg- Codeine 30 mg tablet, 1 tablet by mouth every 4 hours as needed for pain. Diagnosis: Type 2 diabetes. Start date 09/24/24. Entered by LVN C. *Lisinopril 40 mg, 1 tablet by mouth 1 time per day. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Hold if pulse less than 60. Diagnosis: Type 2 diabetes. Start date 09/24/24. Entered by LVN C. *Metoprolol tartrate 25 mg tablet, 1/2 tablet by mouth 2 times per day. Hold if pulse less than 60. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Diagnosis: Type 2 diabetes. Start date 09/24/24. Entered by LVN C. *Amlodipine 5 mg tablet, 1 tablet by mouth 1 time per day. Hold if pulse less than 60. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Diagnosis: Type 2 diabetes. Start date 09/24/24. Entered by LVN C. *Apixaban 5 mg tablet, 1 tablet by mouth 2 times per day. Diagnosis: Type 2 diabetes. Start date 09/24/24. Entered by LVN C. Record review of Resident #65's medication administration record dated 11/01/24-11/30/24 indicated: *Acetaminophen 300 mg- Codeine 30 mg tablet, 1 tablet by mouth every 4 hours as needed for pain. Diagnosis: Type 2 diabetes. Start date 09/24/24. Entered by LVN C. Received 29 times as needed. *Lisinopril 40 mg, 1 tablet by mouth 1 time per day. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Hold if pulse less than 60. Diagnosis: Type 2 diabetes. Start date 09/24/24. Entered by LVN C. Received 30 doses. *Metoprolol tartrate 25 mg tablet, 1/2 tablet by mouth 2 times per day. Hold if pulse less than 60. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Diagnosis: Type 2 diabetes. Start date 09/24/24. Entered by LVN C. Received 58 doses. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Amlodipine 5 mg tablet, 1 tablet by mouth 1 time per day. Hold if pulse less than 60. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Diagnosis: Type 2 diabetes. Start date 09/24/24. Entered by LVN C. Received 30 doses. *Apixaban 5 mg tablet, 1 tablet by mouth 2 times per day. Diagnosis: Type 2 diabetes. Start date 09/24/24. Entered by LVN C. Received 60 doses. 3. Record review of Resident #80's face sheet dated 12/02/24, indicated a 59-years-old female who admitted on [DATE] and readmitted on [DATE]. Resident #80 had diagnoses including cerebral infarction (is a serious condition that occurs when blood flow to the brain is blocked, resulting in brain tissue death), pain, hyperlipidemia (is a condition where there are abnormally high levels of lipids or fats in the blood), and hypertension (is a chronic condition where the pressure of blood in your arteries is consistently too high). Record review of Resident #80's significant change in status MDS assessment dated [DATE] indicated Resident #80 was usually understood and usually understood others. Resident #80 had a BIMS score of 10 which indicated moderate cognitive impairment. Resident #80 received as needed pain medication. Resident #80 received an opioid during the last 7 days of the assessment period. Record review of Resident #80's care plan dated 10/08/24 indicated: *Antihypertensive as evidenced by hydralazine 25 mg tablet and amlodipine (relaxes your blood vessels so that blood can move through them more easily and your heart does not have to work as hard) 10 mg tablet. Intervention included monitor blood pressure every shift. *Pain related to hemiplegia (is a condition that causes paralysis or weakness on one side of the body) or hemiparesis (is a condition that causes weakness or an inability to move on one side of the body) and stroke as evidence by acetaminophen 325mg tablet and resident was taking pain medication. Intervention included administer pain medication as ordered. *Statin as evidence by atorvastatin 80 mg tablet. Intervention included monitor blood cholesterol and triglycerides levels at intervals during therapy. Record review of Resident #80's medication summary report dated 11/01/24-12/04/24 indicated: *Acetaminophen 325 mg tablet, 2 tablets by mouth every 4 hours as needed pain/temp. Diagnosis: acute kidney failure (occurs when kidneys suddenly lose their ability to filter waste from the blood, developing within hours or days). Start date 10/08/24. Entered by RN A. *Tramadol 50 mg 1 tablet by mouth every 8 hours as needed for pain. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. *Hydralazine 25 mg tablet, 1 tablet by mouth 3 times per day. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Hold if pulse less than 60. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Amlodipine 10 mg tablet, 1 tablet by mouth 1 time per day. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Hold if pulse less than 60. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. *Aspirin 81 mg chewable tablet, 1 tablet by mouth 1 time per day. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. *Atorvastatin 80 mg tablet, 1 tablet by mouth at bedtime. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. Record review of Resident #80's medication administration record dated 11/01/24-11/30/24 indicated: *Acetaminophen 325 mg tablet, 2 tablets by mouth every 4 hours as needed pain/temp. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. Received 25 times as needed. *Tramadol 50 mg 1 tablet by mouth every 8 hours as needed for pain. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. Received 33 times as needed. *Hydralazine 25 mg tablet, 1 tablet by mouth 3 times per day. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Hold if pulse less than 60. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. Received 78 of 90 doses. *Amlodipine 10 mg tablet, 1 tablet by mouth 1 time per day. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Hold if pulse less than 60. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. Received 29 of 30 doses. *Aspirin 81 mg chewable tablet, 1 tablet by mouth 1 time per day. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. Received 30 doses. *Atorvastatin 80 mg tablet, 1 tablet by mouth at bedtime. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. Received 30 doses. During an interview on 12/05/24 at 11:40 a.m., RN A said he worked the 100 hall. He said he had taken care of Resident #80 and Resident #65. He said diagnoses were added from the resident's diagnosis list in the facility's electronic charting system. He said he added the diagnoses, the physician told him to when the order was received. He said he did not remember inputting Resident #80's orders. He said acute kidney failure was probably not the best diagnosis for Tramadol, Atorvastatin, or some of the blood pressure medications. He said Resident #80's pain diagnosis would be more appropriate with the Tramadol and Acetaminophen. He said hyperlipidemia would be more appropriate for Atorvastatin. He said the appropriate diagnoses needed to correlate with the ordered medication for coding and billing. He said he did not know who was supposed to ensure the nurses placed an appropriate diagnosis to the physician order. He said maybe the MDS Coordinator or Interdisciplinary Team in the care plan meetings. He said if the medications or orders did not have an appropriate diagnosis, follow ups, labs, and monitoring could not be done. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/05/24 at 11:57 a.m., LVN N said she had been employed at the facility for a year. She said she had worked the night shift initially but currently was working day shift. She said she was working the 200 and 100 halls. She said she had taken care of Resident #80 and Resident #65. She said she added diagnoses from the admission paperwork. She said when she received a physician order, she added the diagnosis the physician gave or what the medication was treating. She said an anticoagulant (apixaban) did not normally treat type II diabetes, so Resident #65's order was inappropriate. She said it was important for medications to have appropriate diagnosis to communicate the resident's information to outside the facility. She said a resident could get admitted to the hospital and the hospital staff could not know why the resident was taking a medication. She said it could be detrimental to the resident. She said the ADON, and the DON did audits to ensure nurses were adding appropriate diagnosis to physician orders. During an interview on 12/05/24 at 12:55 P.M., the DON said usually the ADON was the one to check the diagnoses and medications. She said the ADON was new at the role. The DON said she had provided verbal education on making sure the appropriate diagnosis was with the correct medication. She said the negative effects of not having the correct diagnosis for a medication was sometimes the medications cost were not covered and not paid for if the diagnosis does not match the medications. During an interview on 12/05/24 at 2:41 P.M., the ADM said he would expect the nurses to put the medication in the system to correlate to the diagnosis. He said the risks of a resident not having medication with the correct diagnosis could affect not checking for the right outcome of the medication. Record review of a facility's Medication Management policy dated 01/2024 indicated .each resident's drug regimen is reviewed to ensure it is free from unnecessary drugs .this includes any drug . without adequate indications for its use . 44933

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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 and diagnosis) for 2 (Resident # 65 and Resident #80) of 5 residents whose medications were reviewed. The facility failed to ensure Resident #65 had an appropriate diagnosis on entered order for her prescribed Escitalopram (is commonly used to treat depression and anxiety). The facility failed to ensure Resident #80 had behavior monitoring for her prescribed Venlafaxine (is used to treat major depressive disorder, anxiety, and panic disorder), Divalproex (is used to treat seizure disorders, certain psychiatric conditions (manic phase of bipolar disorder and to prevent migraine headaches), and Mirtazapine (is an atypical antidepressant and is used primarily for the treatment of a major depressive disorder). Finding included: Record review of Resident #65's face sheet dated 12/02/24 indicated a 76-years-old female admitted to the facility on [DATE]. Resident #65 had diagnoses including metabolic encephalopathy (is a brain dysfunction caused by a chemical imbalance in the blood that affects the brain) and acute myocardial infarction (is a life-threatening medical emergency that occurs when blood flow to the heart is blocked). Record review of Resident #65's significant change in status MDS assessment dated [DATE] indicated Resident #65 was usually understood and usually understood others. Resident #65's BIMS score was not completed. Resident #65 received an antidepressant during the last 7 days of the assessment period. Record review of Resident #65's care plan dated 09/24/24 indicated antidepressant as evidenced by escitalopram. Intervention included monitor closely for worsening of depression and/or suicidal behavior or thinking. Record review of Resident #65's Medication Summary Report dated 11/01/24-12/04/24 indicated Escitalopram 20 mg tablet, 1 tablet by mouth 1 time per day. Diagnosis: Type 2 diabetes. Start date 09/24/24. Entered by LVN C. Record review of Resident #65's medication administration record dated 11/01/24-11/30/24 indicated Escitalopram 20 mg tablet, 1 tablet by mouth 1 time per day. Diagnosis: Type 2 diabetes. Start date 09/24/24. Entered by LVN C. Resident #65 received 30 doses. Record review of Resident #80's face sheet dated 12/02/24, indicated a 59-years-old female who admitted on [DATE] and readmitted on [DATE]. (continued on next page)

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	675444	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #80's diagnosis report dated 12/04/24 indicated cerebral infarction (is a serious condition that occurs when blood flow to the brain is blocked, resulting in brain tissue death), acute kidney failure, and major depressive disorder, recurrent, severe with psychotic symptoms. Record review of Resident #80's significant change in status MDS assessment dated [DATE] indicated Resident #80 was usually understood and usually understood others. Resident #80 had a BIMS score of 10 which indicated moderate cognitive impairment. Resident #80 received as needed pain medication. Resident #80 received an antidepressant during the last 7 days of the assessment period. Record review of Resident #80's care plan dated 10/08/24 indicated antidepressant as evidenced by Mirtazapine and Effexor (Venlafaxine). Intervention included monitor closely for worsening depression and/or suicidal behavior or thinking. Record review of Resident #80's care plan dated 10/17/24 indicated anticonvulsant as evidenced by Depakote (Divalproex Sodium). Intervention included observe for possible side effects. Record review of Resident #80's Medication Summary Report dated 11/01/24-12/04/24 indicated: *Mirtazapine 15 mg tablet, 1 tablet by mouth at bedtime. Diagnosis: major depressive disorder. Start date 10/08/24. Entered by RN A. *Venlafaxine extended release 150 mg capsule 24 hour, 1 capsule by mouth 1 time per day. Diagnosis: major depressive disorder. Start date 10/17/24. Entered by RN A. *Divalproex 250 mg tablet delayed release, 1 tablet by mouth at bedtime. Diagnosis: major depressive disorder. Start date 10/17/24. Entered by LVN HH. Record review of Resident #80's medication administration record dated 11/01/24-11/30/24 indicated: *Mirtazapine 15 mg tablet, 1 tablet by mouth at bedtime. Diagnosis: major depressive disorder. Start date 10/08/24. Entered by RN A. Resident #80 received 30 doses. *Venlafaxine extended release 150 mg capsule 24 hour, 1 capsule by mouth 1 time per day. Diagnosis: major depressive disorder. Start date 10/17/24. Entered by RN A. Resident #80 received 30 doses. *Divalproex 250 mg tablet delayed release, 1 tablet by mouth at bedtime. Diagnosis: major depressive disorder. Start date 10/17/24. Entered by LVN HH. Resident #80 received 30 doses. Record review of Resident #80's behavior monitoring log dated 12/04/04 did not reflect any data. During an interview on 12/04/24 at 11:00 a.m., LVN D said she was assigned the 100 hall and had Resident #80. She said Resident #80 used to yell out a lot. She said since Resident #80 returned from a behavioral hospital, she has calmed down. She said Resident #80 required redirection when she yelled out or calling her family helped. She said behaviors were documented in the nurse's note and on the behavior monitoring report. She said the nurses were required to document every shift, any resident behaviors and if any events happened. She said it was important to document the resident's behaviors to know if the treatment was working. (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 12/05/24 at 11:57 a.m., at 11:57 a.m., LVN N said she had taken care of Resident #80 and Resident #65. She said she added diagnoses from the admission paperwork. She said when she received a physician order, she added the diagnosis the physician gave or what the medication was treating. She said Escitalopram did not treat Type 2 diabetes. She said it was important for medications to have appropriate diagnosis to communicate the resident's information to outside the facility. She said a resident could get admitted to the hospital and the hospital staff could not know why the resident was taking a medication. She said it could be detrimental to the resident. She said the ADON and the DON did audits to ensure nurses were adding appropriate diagnoses to the physician orders. She said the behavior monitoring was supposed to be done by the nurse every shift. She said the resident behavior monitoring was done in the facility's electronic charting system. She said the behavior monitoring was personalized to each patient. She said some behaviors were crying, yelling, or refusing ADL care. She said on the resident behavior monitoring, the nurse was supposed to chart the number of episodes, interventions, and response to the interventions. She said she had recently returned from a leave of absence. She said she did not know why Resident #80 did not have behavior monitoring. On 12/05/24 at 1:39 p.m., Resident #80's November and December 2024 behavior monitoring logs were requested by email. The email was sent to RNC T and the Administrator. Resident #80's logs were not received prior or after exit. During an interview on 12/05/24 at 2:42 p.m., the Director of Nursing, said the ADON normally did the resident's diagnoses. She said the diagnosis needed to be correct for billing and insurance. She said she had several conversations with the staff on the importance of appropriate diagnoses with physician orders. She said behavior monitoring should have been documented on the nurse notes and behavior monitoring by the nurses. She said Resident #80 had recently been to a behavior hospital. She said when Resident #80 was readmitted , it could have not been reordered. She said it was important to know if a resident was having episodes and if the current prescribed medications and interventions were working. During an interview on 12/05/24 at 3:32 p.m., the Administrator said the admission nurse was the first person who should make sure the residents had an appropriate diagnosis for their physician orders. He said the ADON, the DON, and the MDS Coordinator should be ensuring the charge nurses were adding appropriate diagnosis to the right medication. He said he expected the nursing staff and management to monitor the resident's behaviors and side effects for medications. Record review of a facility's Psychotropic Drugs-Use revised 07/27/2022, indicated .for non-drug therapy . implement and document non-drug interventions on the monitoring/behavior form .assess the patient/resident for the use of antidepressants: needs supporting diagnosis .careful evaluation of the residents' records should be reviewed for appropriate diagnosis for medication use .other medications: is subject to psychotropic medication requirement if documented use appears to be a substitution for another psychotropic medication rather than for the original and approved indication .staff will complete and sign the monitoring/behavior form each shift .Menu>EMR>Nurse>Monitoring .to identify and document number of episodes, interventions, and outcomes of targeted behaviors .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview, and record review, the facility failed to ensure that residents were free of significant medication errors for 1 of 18 residents (Residents #80) reviewed for pharmacy The facility failed to ensure Resident #80 Amlodipine, Carvedilol, Hydralazine, and Losartan were not administered when her blood pressure and/or pulse were outside of the ordered parameters on 11/03/24, 11/06/24, and 11/10/24. This failure could place residents at risk of medical complications and not receiving the therapeutic effects of their medications. Findings included: Record review of Resident #80's face sheet dated 12/02/24, indicated a 59-years-old female who admitted on [DATE] and readmitted on [DATE]. Resident #80 had diagnoses including cerebral infarction (is a serious condition that occurs when blood flow to the brain is blocked, resulting in brain tissue death), pain, hyperlipidemia (is a condition where there are abnormally high levels of lipids or fats in the blood), and hypertension (is a chronic condition where the pressure of blood in your arteries is consistently too high). Record review of Resident #80's significant change in status MDS assessment dated [DATE] indicated Resident #80 was usually understood and usually understood others. Resident #80 had a BIMS score of 10 which indicated moderate cognitive impairment. Record review of Resident #80's care plan dated 10/08/24 indicated Antihypertensive as evidenced by Hydralazine 25 mg tablet and Amlodipine (relaxes your blood vessels so that blood can move through them more easily and your heart does not have to work as hard) 10 mg tablet. Intervention included monitor blood pressure every shift. Record review of Resident #80's medication summary report dated 11/01/24-12/04/24 indicated: *Hydralazine 25 mg tablet, 1 tablet by mouth 3 times per day. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Hold if pulse less than 60. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. *Amlodipine 10 mg tablet, 1 tablet by mouth 1 time per day. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Hold if pulse less than 60. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. *Losartan 100 mg tablet, 1 tablet by mouth 1 time per day. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Hold if pulse less than 60. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Carvedilol 25 mg tablet, 1 tablet by mouth 2 times per day. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Hold if pulse less than 60. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. Record review of Resident #80's medication administration record dated 11/01/24-11/30/24 indicated: *Hydralazine 25 mg tablet, 1 tablet by mouth 3 times per day. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Hold if pulse less than 60. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. Received 78 of 90 doses. Administration documented on 11/03/24 at 8:00 a.m.: Blood Pressure 90/52. Administration documented on 11/03/24 at 12:00 p.m.: Blood Pressure 90/50. Administration documented on 11/06/24 at 8:00 a.m. and 12:00 p.m.: Blood Pressure 103/68. *Amlodipine 10 mg tablet, 1 tablet by mouth 1 time per day. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Hold if pulse less than 60. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. Received 29 of 30 doses. Administration documented on 11/06/24 at 8:00 a.m.: Blood Pressure 103/68. *Losartan 100 mg tablet, 1 tablet by mouth 1 time per day. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Hold if pulse less than 60. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. Received 29 of 30 doses. Administration documented on 11/06/24 at 8:00 a.m.: Blood Pressure 103/68. *Carvedilol 25 mg tablet, 1 tablet by mouth 2 times per day. Hold if systolic blood pressure less than 110. Hold if diastolic blood pressure less than 60. Hold if pulse less than 60. Diagnosis: acute kidney failure. Start date 10/08/24. Entered by RN A. Received 56 of 60 doses. Administration documented on 11/06/24 at 8:00 a.m.: Blood Pressure 103/68. Record review of Resident #80's nurse note dated 10/02/24-10/02/24 did not reflect phone calls to the physician on 11/03/24 or 11/06/24 related to Resident #80's blood pressure being out of the ordered parameters. During an interview on 12/05/24 at 11:57 a.m., LVN N said depending on the hall, a medication aide or nurse administered the resident's medications. She said a nurse administered the medication on the 100 hall. She said the resident's blood pressure should be checked each time the blood pressure medication was due. She said the blood pressure protocol ordered by the physician should be followed. She said if Resident #80's blood pressure was low and was still given a blood pressure medication, it could get too low. She said Resident #80 was at risk for passing out or dizziness resulting in a fall or injury. During an interview on 12/05/24 at 2:42 p.m., the Director of Nursing said she expected the nursing staff to follow the blood pressure parameters. She said if a resident's blood pressure was lower than the set parameters, then the physician needed to be notified. She said the physician then should decide to hold or give the blood pressure medication. She said staff should receive a physician order to give the blood pressure medication even though the resident's blood pressure was out of range. She said if a resident's blood pressure was low and the blood pressure medication was administered, it could bottom out. She said the resident could experience syncope (fainting or passing out), confusion, and even death. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/05/24 at 3:32 p.m., the Administrator said he expected the nursing staff to follow the blood pressure parameters ordered by the physician. Record review of a facility's Medication Administration- General Guidelines policy dated 01/2024, indicated . medications are administered in accordance with written orders of the prescriber .obtain and record any vitals as necessary prior to medication administration .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44933 Based on observations, interviews, and record review, the facility failed to ensure the menus met the nutritional needs of residents and were followed for 2 of 2 meals (the lunch meals on 12/2/24 and 12/3/24) reviewed for nutritional adequacy. The facility did not serve the posted lunch menu of breadstick and iced cinnamon raisin bars on 12/02/24. Cook Q did not follow the recipe for cheesy rice by using sliced cheese instead of shredded cheese per the recipe on 12/03/24. The facility did not follow the soup recipe on 12/03/24 by serving canned mushroom soup instead of homemade soup. The facility failed to use the appropriate size serving scooper for the pureed chicken, tomatoes and okra and potatoes and ground chicken for the lunch meal service on 12/03/24. The facility failed to ensure [NAME] Q scooped full serving sizes during the lunch meal on 12/03/24. These failures could affect all residents in the facility, who eat from the kitchen, by placing them at risk of not receiving adequate nutritive food value needed to promote/maintain health. Findings included: Record review of a grievance filed by a family member of Resident #63, dated 10/23/24, indicated the menu was not being followed during mealtimes. Record review of the Week at a Glance Current Menu provided on 12/02/24, indicated: *Monday (12/02/24) Lunch: Spaghetti with Meat Sauce, Italian Tossed Salad, Iced Cinnamon Raisin Bars, Breadstick, Coffee or Tea, and Water. *Tuesday (12/03/24) Lunch: Baked Chicken Thigh, Cheesy Rice, Okra and Tomatoes, Spiced Peaches, Dinner roll, Coffee or Tea, and Water. Record review of the facility's Baked Chicken Thigh recipe provided on 12/03/24, indicated portion size 3oz. Record review of the facility's Okra and Tomatoes recipe provided on 12/03/24, indicated portion size 4oz spoodle (a unique cross between a serving spoon and a ladle). (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Cheesy Rice recipe provided on 12/03/24, indicated portion size #8 dip (4oz). The recipe indicated once rice is cooked, remove from heat, add shredded cheese and margarine. Record review of the facility's Homemade Soup of the Day recipe provide on 12/03/24 indicated scratch, fresh vegetables. The recipe indicated any homemade soup of choice may be prepared. During an interview on 12/02/24 at 9:35 a.m., Resident #52 said the portion sizes were small. She said sometimes they had enough for seconds and sometimes not. During an observation on 12/02/24 at 12:00 p.m., a posted menu in the main lobby area indicated . Monday, December 2, 2024, Monday- Lunch, Spaghetti with Meat Sauce, Italian Tossed Salad, Iced Cinnamon Raisin Bars, Breadstick, Coffee or Tea, Water . During an observation on 12/02/24 at 12:05 p.m., residents in the dining room were being served sliced white bread instead of breadsticks and chocolate chip cookies instead of iced cinnamon raisin bars. During an observation and interview on 12/03/24 starting at 11:25 a.m., [NAME] Q had a pan of white rice on the stove. [NAME] Q added sliced yellow cheese to the white rice and stirred the mixture. The DM said the soup on the tray line was canned cream of mushroom soup. [NAME] Q placed a black handled ladle (4 oz) in the tomatoes and okra, a blue scooper (2 oz) in the pureed mashed potatoes, a green scooper (2.67 oz) in the pureed chicken, a blue scooper (2 oz) in the ground chicken, a gray ladle (4oz) then a gray scooper (4 oz) in the cheesy rice, and a green scooper (2.67 oz) in the pureed tomatoes and okra. Towards the end of the plating, [NAME] Q started scooping less than the amount of the serving size. At 12:32 p.m., there was no more cheesy rice, tomatoes and okra, or canned soup. Seven residents and the test tray received mashed potatoes instead of cheesy rice and tomatoes instead of tomatoes and okra. During an interview on 12/05/24 at 1:26 p.m., CNA O said she received a lot of complaints from the residents about the menu not being followed, small portion sizes, and the kitchen running out of food. She said the residents got upset and sometimes asked for something else. On 12/05/24 at 1:40 p.m., attempted phone interview with [NAME] Q. Unable to leave a message. During an interview on 12/05/24 at 1:46 p.m., [NAME] P said the kitchen had a chart on the wall that showed the scoop and ladle sizes. She said the scoops and ladles themselves had the sizes on them. She said the recipes specified the portion size. She said it was important to follow the recipe instructions. She said not following the recipe instruction or portion size could cause weight loss. She said not following the recipe also had the potential to serve an unapproved ingredient a resident could be allergic to. She said if the recipe was followed correctly, you should not run out of food. She said she was the cook on 12/02/24. She said the residents did get served slices of white bread instead of breadsticks. She said she overlooked them in the freezer. She said the residents were served a different dessert because she did not have all the ingredients on hand to make the posted dessert. She said some items did not come on the delivery truck. She said only certain ingredients could be bought at the local grocery store. She said the kitchen notified the resident if they did not have something. She said the cooks were responsible for portion sizes, following the menu and recipes. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/05/24 at 2:21 p.m., the Dietary Manager said cooks were responsible for portion sizes and following the menu and recipes. She said those things affected the resident weights, the consistency of the food and the caloric value of the food. She said the residents could experience weight loss. She said she was responsible for ensuring the cooks were serving the correct portion sizes and following the menu and recipes. She said substitution were allowed as long as it was documented. During an interview on 12/05/24 at 2:42 p.m., the Director of Nursing said the cooks were responsible for serving the resident the correct portion sizes. She said the cooks should be following the recipes and the menus. She said the Dietary Manager should be overseeing the cooks to ensure it was happening. She said the resident had the potential to not get their nutritional needs met. She said the residents could experience weight loss or weight gain. During an interview on 12/05/24 at 3:32 p.m., the Administrator said the cook and the Dietary Manager were responsible for portion control, following the menu and recipes. He said he expected the cook to serve the portion size on the recipe. He said he expected the cook to use the right scoops to serve the residents food. He said he expected the cook and Dietary Manager to ensure supplies were available for meals. He said all those things were important for the resident's caloric needs. Record review of a facility's Portion Control policy revised 02/06/24, indicated .portion control will be maintained to ensure adequate nutritional value for all foods offered and to maintain inventory control . serving sizes and yield are listed on standardized recipes .spreadsheets indicating portion sizes per diet are posted at tray line and used to guide the serving at each meal . Record review of a facility's Use of Recipes policy revise 02/06/24, indicated .recipes will be used when preparing menu items .recipes (in appropriate portion sizes) for each menu cycle are available .Nutrition Service employees are expected to use and follow the recipes provided . Record review of a facility's Menus policy revised 02/06/24, indicated .nutrition service will provide a nourishing, palatable, well-balanced meal that observes the nutritional requirements .of each resident . Record review of a facility's Tray Line policy revised 02/06/24, indicated .tray line positions and set up procedures should promote an efficient and accurate meal service .spreadsheets, indicating portion sizes per diet, are posted at the tray line and used to guide the serving at each meal .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44933 Based on observations, interviews, and record review, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 7 of 86 residents (Resident #77, Resident #52, Resident #83, Resident #50, Resident #74, Resident #62, and Resident #40), 1 of 1 family member (Resident #63), and 1 of 1 meal (Lunch meal) reviewed for food and nutrition services. The facility failed to provide palatable food served at an appetizing temperature or taste to Resident #77, Resident #52, Resident #83, Resident #50, Resident #74, Resident #62, and Resident #40, and a family member of Resident #63, who complained the food was served cold, was bland, over, or undercooked and did not taste good. This failure could place residents who ate food from the kitchen at risk of weight loss, altered nutritional status, and diminished quality of life. Findings included: During an interview on 12/02/24 at 9:35 a.m., Resident #52 said the food was not that good. She said the breakfast was cold and sometimes dinner was cold too. She said sometimes the alternative choice on the menu was not good either. During an interview on 12/02/24 at 9:36 a.m., Resident #74 said she did not like the food that much. During an interview on 12/02/24 at 10:01 a.m., Resident #62 said the food was not good. He said breakfast was good but lunch and dinner were not. During an interview on 12/02/24 at 10:10 a.m., Resident #83 said she hated the food. She said the food was cold and it did not taste good. During an interview on 12/02/24 at 10:32 a.m., Resident #50 said she sometimes did not like the food. She said when that happened, she ordered food from outside the facility. During an interview on 12/02/24 at 11:13 a.m., Resident #77 said he did not like the food. He said sometimes he did not even know what he was being served. He said the food selection was not good either. During an interview on 12/02/24 at 11:16 a.m., Resident #40 said the food was not good. He said the facility served ham 3 days in a row last week. During an interview on 12/02/24 at 3:26 p.m., a family member of Resident #63 said the food selection was not good. The family member said the food did not look appetizing. The family member said when she fed Resident #63, the food was either overcooked or undercooked. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 12/03/24 at 12:45 p.m., a test tray of a chicken breast, mashed potatoes, stewed tomatoes, roll, and spiced peaches was sampled by four surveyors and the Dietary Manager. The Dietary Manager said the mashed potatoes were bland but everything else was okay. All surveyors agreed the mashed potatoes were bland and the food was lukewarm. During an interview on 12/05/24 at 1:26 p.m., CNA O said resident complained about the lack of flavor and temperature of the food. She said the residents complained about all the meals being cold. She said the CNAs had to take the resident's food back to the kitchen and eventually the kitchen would give the resident something else. She said the residents got upset about the food being not good. During an interview on 12/05/24 at 1:46 p.m., [NAME] P said the cook was responsible for serving the resident warm and seasoned food. She said the kitchen had options to add flavor to dishes like chicken and beef broth and seasoning. She said no one wanted to eat cold, bland food. She said the residents would not eat their food and could lose weight. During an interview on 12/05/24 at 2:21 p.m., the Dietary Manager said the cook was responsible for preparing warm, flavorful food. She said if the recipes were followed the food should be flavorful. She said she was supposed to ensure the cook was preparing good food. She said if the food was not good, the residents could experience weight loss. During an interview on 12/05/24 at 2:42 p.m., the Director of Nursing said the cook was responsible for the resident's food. She said the facility could not please everyone but the food should be appetizing and warm. She said the Dietary Manager should ensure the cook provided the resident appetizing meals. She said the residents could experience weight loss and depression when they were served unappetizing meals. She said the kitchen had recently made some changes to the menu the resident were not happy. She said the facility was trying to getting used to the new system. During an interview on 12/05/24 at 3:32 p.m., the Administrator said the cook and dietary manager were responsible for serving the residents palatable food. He said the cook and Dietary Manager should be tasting the food before it was served. He said the residents should be served meals they cared about and would want to eat. Record review of a facility's Menus policy revised 02/06/24, indicated .Nutrition Services will provide a nourishing, palatable, well-balanced meal .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observations, interviews, and record review the facility failed to ensure each resident receives and the facility provides food that accommodates residents' food preferences for 1 of 18 residents (Resident #77) reviewed for food preferences and the accommodation of resident's meal choices. The facility failed to honor Resident #77's preference for boiled eggs at breakfast on 12/03/24, 12/04/24, and 12/05/24. The facility failed to obtain Resident #77's meals choice for each meal. These failures could result in a decrease in resident choices, diminished interest in meals, and weight loss. Findings included: Record review of Resident #77's face sheet dated 12/02/24 indicated a 61-years-old male admitted to the facility on [DATE]. Resident #77 had diagnoses including cerebral infarction (stroke), major depressive disorder (is a serious mental health condition that affects how a person feels, thinks, and acts), and hemiplegia (is a condition that causes paralysis or weakness in one side of the body) and hemiparesis (is a condition that causes weakness or an inability to move on one side of the body) following cerebrovascular disease (is a general term for conditions that affect the blood vessels in the brain and spinal cord) affecting right dominant side. Record review of Resident #77's quarterly MDS assessment dated [DATE] indicated Resident #77 was understood and understood others. Resident #77 had a BIMS score of 11 which indicated moderate cognitive impairment. Record review of Resident #77's care plan dated 10/30/24 indicated altered nutritional status as evidence by regular diet with thin liquids. Intervention included dietician referral as indicated. Record review of Resident #77's Nutrition Therapy Assessment completed by the Dietary Manager, dated 10/30/24, indicated preference would be accommodated through personal choice and the selective menu process. During an interview on 12/02/24 at 11:13 a.m., Resident #77 said the staff were supposed to come the day before, to ask the residents what they wanted for the next day's meals. He said all he wanted for breakfast was cereal, boiled eggs, toast, and milk. He said the kitchen sent him all kinds of stuff he did not want. During an interview on 12/03/24 at 3:17 p.m., Resident #77 said all he had for breakfast today was cereal. He said he was a big guy, so that did not fill him up. He said yesterday (12/02/24), the 2nd shift did not come and ask him what he wanted to eat for today (12/03/24). (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/04/24 at 10:00 a.m., RNC T was at Resident #77's bedside. Resident #77 was reporting his complaints regarding the food. RNC T said she would send the Dietary Manager down to talk to him to get his preferences. Resident #77 said he got 2 bowls of cereal this morning but not toast or boiled eggs. Resident #77's breakfast tray was partially eaten. Resident #77's tray did not have toast, breadcrumbs, or boiled eggs. During an observation and interview on 12/05/24 at 9:00 a.m., Resident #77 said he did not get boiled eggs again this morning. He said he did not get any protein this morning. Resident #77's plate had toast and a bowl of cereal. Resident #77's meal ticket indicated scrambled eggs but scrambled eggs were not on the tray. He said the Dietary Manager spoke to him yesterday (12/04/24) about what he wanted to eat. He said that did not do him any good. During an interview on 12/05/24 at 1:26 p.m., CNA O said any aide could fill out the resident's meal tickets. She said but the 2nd shift CNAs were supposed to do it. She said the residents complain the 2nd shift CNAs did not go around and fill the meal tickets out. She said the residents then complain when they got stuff they did not want to eat. During an interview on 12/05/24 at 1:46 p.m., [NAME] P said if the resident's meal ticket was not marked with their preferences, they received the posted meal. She said it was the resident's right to have what they asked for. During an interview on 12/05/24 at 2:21 p.m., the Dietary Manager said the 2-10pm shift CNAs were supposed ask the residents, what they wanted to eat for the next day. She said that was not happening. She said it had been addressed with nursing administration and corrected before but it did not last long. She said only the residents who could walk to the nurse's station filled out their meal ticket. She said it was a dignity issue and the resident had the right to choose what they wanted to eat. She said not being able to choose their meals could cause weight loss and malnutrition. She said she spoke to Resident #77 on admission and yesterday (12/04/24) about his preferences. She said she did not know why he did not get what he wanted this morning. She said she was shocked Resident #77's meal ticket said scrambled eggs and he did not even get that. During an interview on 12/05/24 at 2:42 p.m., the Director of Nursing said the ambulatory residents normally filled out their meal tickets at the nursing station. She said the facility was working on getting the 2-10 pm CNAs responsible for the residents who could not complete the meal ticket themselves. She said the cook and Dietary Manager should be ensuring a resident's food preferences were honored. She said it could affect the resident's quality of life. During an interview on 12/05/24 at 3:32 p.m., the Administrator said the Dietary Manager was responsible for obtaining the resident's food preferences on admission. He said the Dietary Manager was supposed to interview the resident and document the information in the system. He said the CNAs should be filling out the resident meal tickets with their meal choices. He said it was the cook's and Dietary Manager's responsibility to ensure the resident's choices and preferences were served at each meal. He said the facility should not be serving food the residents did not want. He said it was important for the resident's caloric intake. Record review of a facility's Tray Line policy revised 02/06/24 indicated .each tray will be checked for .special requests (food preferences) . (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility's Menu revised 02/06/24 indicated .Nutrition Services will provide a nourishing, palatable, well-balanced meal that observes the nutritional requirements, special dietary needs, preferences and allergies of each resident .individual resident menus are written in consideration of known allergies, intolerance and preference .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44933 Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure food stored in the kitchen refrigerator was labeled and dated on 12/02/24. 2. The facility failed to ensure cookware stored in the pantry and main kitchen area did not have carbon build up on 12/02/24. 3. The facility failed to ensure containers of cornmeal and sugar were properly sealed on 12/02/24. 4. The facility failed to ensure cornmeal was not spilled on the dry pantry floor on 12/02/24. 5. The facility failed to ensure 3 white bins, storing metal lids, did not have food particles in them on 12/02/24. 6. The facility failed to ensure the food steamer did not have a brown film and food particles at the bottom on 12/03/24. 7. The facility failed to ensure the pureed chicken, ground chicken, canned soup, pureed tomatoes and okra, 2nd batch of mashed potatoes and 2nd pan of chicken breast were temped before serving on 12/03/24. 8. The facility failed to ensure the scoopers did not fall into the food during plating on 12/03/24. 9. The facility failed to ensure the Dietary Manager practiced proper hand hygiene on 12/03/24. 10. The facility failed to ensure the juice dispenser and vent were clean on 12/03/24. These deficient practices could place residents at risk for foodborne illness. Findings include: During an observation on 12/02/24 starting at 8:34 a.m., in the refrigerator/freezer combo the following was observed (refrigerator): *One bag of meat not labeled or dated. *One opened container of blueberry frozen muffin batter was not dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/02/24 at 8:37 a.m., in the dry pantry the following was observed: *Five metal pans had carbon build up around the edges. *The lid of a large container of cornmeal was open. *The lid of a large container of sugar was broken. *A moderate amount of yellow, grainy material was on the floor, underneath a rack. During an observation on 12/02/24 at 8:40 a.m., in the main kitchen area the following was observed: *Three white bins had small amounts of food particle in the bottom. Several plastic and metals lids were stored in the white bins. During an observation on 12/03/24 starting at 11:25 a.m., in the main kitchen area the following was observed: *All compartments on the steamer, at the bottom, had a brown film and food particles floating in the water. *Two deep metal pans, on the bottom and sides, had carbon build up. *Cook JJ temped the pureed chicken (108.5 degrees) and ground chicken (114 degrees). [NAME] JJ placed the food items in the steamer. [NAME] Q placed pureed chicken and ground chicken back on the steam table. A metal pan of soup, pureed tomatoes and okra were on the steam table. [NAME] Q served all the residents without re-temping the pureed chicken and ground chicken. [NAME] Q served all the residents without temping the soup and pureed tomatoes and okra. *The scooper fell in the pureed tomatoes and okra, chopped chicken, and cheesy rice. *The Dietary Manager placed a new pan of chicken breast on the steam table. [NAME] Q served residents from the pan without temping. *At 12:37 p.m., the Dietary Manager coughed on her arm then without washing her hands put on gloves and plated one resident meal. *A new pot of mashed potatoes was made and placed on the steam table. [NAME] Q served resident from the pot without temping. *Inside the juice dispenser handle, was a small amount of orange substance. The juice dispenser vent was brown and fuzzy material was noted. Two unused tubing ports had several brown spots on the tubing and the bag covering the attachment port. On 12/05/24 at 1:40 p.m., attempted phone interview with [NAME] Q. Unable to leave a message. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/05/24 at 1:46 p.m., [NAME] P said the cooks were responsible for doing internal temps on all the food served. She said it was important to know if the food was hot enough. She said the residents could get sick if the food was served at the wrong internal temp. She said the cook and dietary aides were responsible for labeling and dating food items when received or opened. She said it was important to label and date food items to know if something was safe to use or serve. She said the cook or whoever opened the lid, should make sure the container lids were closed. She said the lids needed to be closed to prevent bugs or dust from getting into the product. She said the kitchen cleanliness was everybody's responsibility. During an interview on 12/05/24 at 2:21 p.m., the Dietary Manager said she expected the cooks to do internal temps after cooking the food and on the tray line. She said she expected the cooks to also document the temps on the temperature log for each food item served. She said it was important to do internal temperature to make sure the food had reached a safe serving level. She said everybody was responsible for labeling and dating food items. She said whoever opened it, should do it. She said she or the cooks did daily kitchen walk throughs to make sure things were labeled and dated. She said it was important to label and date to ensure proper rotation of certain food items. She said it also prevented food borne illnesses. She said whoever opened the container, should make sure it was closed. She said the containers needed to be closed to prevent debris or bugs from falling in. She said it was important to keep the product safe. She said the pans should not have carbon build up on them. She said the pans were a fire hazard. She said she should have made sure they were out of circulation. She said everybody should make sure food particles and debris were not at the bottom of bins. She said it attracted bugs and contaminated whatever it touched. She said she should be ensuring the sanitation of the kitchen. She said everyone was responsible for the cleanliness of the juice dispenser. She said the company also serviced the machine quarterly. She said it was important to keep the juice dispenser clean to be sanitary and not contaminate the resident's drinks. She said she did not realize she had coughed on her arm then plated a tray. She said she should not have done that. During an interview on 12/05/24 at 2:42 p.m., the Director of Nursing said the cook was responsible for temping the food before serving it. She said the food needed to be safe to eat. She said the residents could get sick from unsafe food. She said the Dietary Manager should ensure the cook was temping all the food before it was served. She said the sanitation, storage, labeling, and dating of food items were the responsibility of the kitchen staff. She said the Dietary Manager should be making sure it was happening. She said the residents were at risk for food borne illnesses. During an interview on 12/05/24 at 3:32 p.m., the Administrator said he expected the food to be temped and served at a safe level or within the parameters on the menu. He said he expected the kitchen and the equipment to be clean. He said he expected food items to be labeled and dated and stored correctly. He said it was the responsibility of the cook with the Dietary Manager overseeing. He said it was important to prevent food borne illnesses and cross contamination. He said he expected staff to perform proper hand hygiene for infection control. Record review of a facility's Hot and Cold Food Temperatures policy revised 02/06/24 indicated .the temperature of the food items will be managed to conserve maximum nutritive value and flavor and to be free of harmful organisms and substances .hot temperature will be taken and recorded prior to service to ensure foods are at or above 135 .prior to serving, deficient temperature must be corrected . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility's Tray Line policy revised 02/06/24 indicated .tray line positions and set up procedure should promote an efficient and accurate meal service .food temperatures are taken on the tray line .hot food held at a minimum temperature of 135 degrees .temperature problems are corrected prior to service . Record review of a facility's Food Storage policy revised 02/06/24 indicated .food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination .scoops and storage bins are routinely washed and sanitized .air-tight containers .are used for all opened packages of food .all foods are covered, labeled and dated . Record review of a facility's Handwashing policy revised 02/06/24 indicated .nutrition services employee wash hands before starting work .

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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** 44933 Based on observations, interviews, 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 2 of 3 residents (Resident #63 and Resident #65) reviewed for infection control. The facility failed to ensure, on 12/04/24, CNA E and CNA L, changed their gloves and performed hand hygiene appropriately while providing catheter care to Resident #65. The facility failed to ensure, on 12/04/24, CNA F, changed her gloves and performed hand hygiene appropriately while providing incontinent care to Resident #63. These failures could place residents at risk of exposure to cross-contamination and infections. Findings included: Record review of Resident #65's face sheet dated 12/02/24 indicated a 76-years-old female admitted to the facility on [DATE]. Resident #65 had diagnoses including metabolic encephalopathy (is a brain dysfunction caused by a chemical imbalance in the blood that affects the brain), urinary tract infection (is a common bacterial infection that occurs in the urinary tract, which includes the bladder, kidneys, and urethra), Type II diabetes (is a condition that occurs when the body doesn't use insulin properly, leading to high blood sugar levels), pressure ulcer of right buttock, unstageable (is a type of bed sore that occurs when too much pressure is applied to a specific area of the skin over a long period of time), and pressure ulcer of left buttock, stage 4 (is the most severe stage, characterized by full thickness tissue loss where the underlying muscle, tendon, or bone is exposed, often with significant damage to surrounding tissue, and a high risk of infection). Record review of Resident #65's significant change in status MDS assessment dated [DATE] indicated Resident #65 was usually understood and usually understood others. Resident #65's BIMS score was not completed. Resident #65 was dependent for toileting hygiene. Resident #65 had an indwelling catheter (is a thin, hollow tube that is inserted into the bladder to drain urine and is left in place for a period of time) and was always incontinent of bowel. Resident #65 had a multi-drug resistant organism (is a bacterial infection caused by a microorganism that is resistant to multiple classes of antibiotics and antifungals), pneumonia (is a lung infection that causes the air sacs in the lungs to fill with fluid or pus, making it difficult to breathe), and septicemia (is a life-threatening infection that occurs when bacteria, viruses, or fungi enter the bloodstream). Record review of Resident #65's care plan dated 10/15/24 indicated infection control as evidence by enhanced barrier precautions every 2 shift and indwelling medical device. Intervention included enhanced barrier precautions: gown and glove use during high-contact resident care activities. (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 observation on 12/04/24 at 2:30 p.m. CNA E and CNA L provided Resident #65 peri/catheter care. WCLVN G was also at the bedside. CNA E wiped Resident #65's catheter tubing with the disposable wipes four times. CNA E then wiped down Resident #65's perineum three times with disposable wipes. CNA E wiped Resident #65's peri area two times with disposable wipes. CNA L slightly retracted Resident #65's labia majora (outer folds) and CNA E wiped down the middle three times with the disposable wipes. CNA L and CNA E without changing their gloves, straightened Resident #65's brief and reattached the straps. CNA E reattached Resident #65's catheter tubing to her leg anchor. CNA E and CNA L then removed their gloves and washed their hands. Record review of Resident #63's face sheet dated 12/02/24, indicated an 84-years-old female who admitted to the facility on [DATE]. Resident #63 had diagnoses including Alzheimer's disease (is a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to perform everyday tasks), muscle weakness, and pain. Record review of Resident #63's quarterly MDS assessment dated [DATE] indicated Resident #63 was rarely/never understood and rarely/never understood others. Resident #63 had unclear speech. Resident #63 could not complete the BIMS assessment due to being rarely/never understood. Resident #63 had short-and-long term memory recall problem. Resident #63 had severely impaired cognitive skills for daily decision making. Resident #63 was dependent for toileting hygiene. Resident #63 was always incontinent for urine and bowel. Record review of Resident #63's care plan dated 10/20/24 indicated self-care deficit related to end stage Alzheimer's, hospice services, and history of seizures as evidence by dependent with toileting hygiene. Intervention included hospice and facility staff to perform ADLs. During an observation and interview on 12/04/24 at 2:40 p.m., WCLVN G performed a skin assessment of Resident #63 with the assistance of CNA F. WCLVN G detached Resident #63's brief to inspect her skin. The leg creases on Resident #63's brief was light brown but only urine was noted in the brief. The WCLVN G instructed CNA F to clean a dark brown substance on Resident #63's thigh/buttock area. The WCLVN G said it looked like something was left from the prior changing. CNA F cleaned Resident #63's rectum area then wiped towards her vagina. CNA F grabbed Resident #63's skin protectant cream and applied it with the same gloves. CNA F placed a new cloth pad in the middle of the bed and a new brief underneath Resident #63. CNA F then removed her gloves and placed on new gloves without performing hand hygiene. CNA F then attached Resident #63's brief and straightened her clothes. On 12/05/24 at 11:31 a.m., called CNA E and left voice mail. No return call before or after exit. On 12/05/24 at 11:32 a.m., called CNA L and unable to leave message. On 12/05/24 at 11:34 a.m., called CNA F and left voice mail. No return call before or after exit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675444	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reunion Plaza Senior Care and Rehabilitation Cente	1401 Hampton Rd Texarkana, TX 75503

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/05/24 at 12:35 p.m. WCLVN G said CNA F did not change gloves after cleaning Resident #63 and she touched her bed pad and new brief. She said she also did not see CNA F use hand sanitizer or wash her hands after she removed her gloves and put on new ones. She said she kept trying to prompt CNA F to change her gloves more frequently. She said CNA E and CNA L should have also changed their gloves before they touched anything after Resident #65's catheter care. She said it was hard to try to teach people who thought they knew everything. She said CNA F, CNA E, and CNA L not changing their gloves properly and touching other things was cross contamination. She said it placed Resident #65 and Resident #63 at risk for an infection. During an interview on 12/05/24 at 2:42 p.m., the Director of Nursing said she expected staff to perform hand hygiene before putting on gloves and after removal. She said performing hand hygiene was important for infection control and preventing cross contamination. During an interview on 12/05/24 at 3:32 p.m., the Administrator said he expected nursing staff to wash their hands or use hand sanitizer after removal of their gloves. He said proper hand hygiene was important for infection control. He said when hand hygiene was not performed cross contamination could happen. Record review of a facility's Hand Hygiene for Staff and Residents policy reviewed 01/2022, indicated . purpose .to reduce the spread of infection with proper hand hygiene .hand hygiene is the most important component for preventing the spread of infection .hand hygiene is done .after .resident contact .toileting or assisting others with toileting, or after personal grooming .removal of medical/surgical or utility gloves . Record review of a facility's Perineal Care policy reviewed 04/22/2024, indicated . 8. Turn resident to clean all areas of buttocks with new wipe or section of washcloth wiping front to back to remove feces present. Observe for redness, bruising, open skin, rash, or other abnormalities. 9. Dispose of gloves and used supplies and perform hand hygiene. 10. Apply new gloves and place new brief and change linens as needed .