STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675462	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Nursing and Rehabilitation Center	3200 Parkway Big Spring, TX 79720

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plans were developed in consultation with the resident and the resident's representative for 4 of 6 residents (Resident #66, Resident #11, Resident #51, and Resident #38) reviewed for comprehensive care plan in that: The facility failed to ensure Resident #66, Resident #11, Resident #51 and Resident #38 or the resident's representative were invited to participate in the resident's care plan meetings. This failure could place residents at risk of not receiving the interventions, treatments and care necessary for the residents to reach their highest practicable physical, mental, and psychosocial well-being by not involving the residents and/or resident's representatives in care plan meetings. Findings included: Resident #66 Record review of Resident #66's face-sheet dated 06/11/2025, revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Record review of Resident #66's quarterly MDS dated [DATE], revealed Resident #66 had a BIMS score of 15, indicative of cognitively intact. Resident #66's primary medical condition category that best describe the primary reason for admission was coded as Paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease). Other active diagnosis included Urethral discharge, Pain, Constipation (problem with passing stool), Hematuria (the presence of blood in the urine), and Type 2 Diabetes Mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood). Under section Q - participation in assessment and goal setting only the resident was coded as active participant in the assessment process. Record review revealed Resident #66's last Care Plan meeting note was undated. The Care Plan document did not include information regarding the date or time the Care Plan meeting was held, who was invited, nor who attended. In an interview on 06/11/2025 at 2:39 PM, Resident #66 stated he did not know what a care plan meeting was. Resident #66 stated he had not been invited to a care plan meeting that he could recall because, I know if there is something like that, my family member would be involved. Resident #66 stated no one had mentioned care planning meeting to him in the last year he had been in the facility. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/12/2025 at 10:08 AM, a family member of Resident #66 stated that the family member had not been involved in any care plan meetings for Resident #66 and no one had communicated to him for care planning meeting. The family member stated, I had to get my Resident #66 to the ER (Emergency room) for 3days due to extended stomach and vomiting some few weeks back. The family member stated he would like to be informed and involved in Resident #66's care planning meetings. The family member stated, the negative outcome of not having such meeting would be not knowing when certain things are going on around my Resident #66. Resident # 11 Record review of Resident # 11's face-sheet dated 06/11/2025, revealed a [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #11's quarterly MDS dated [DATE], revealed Resident #11 had a BIMS score of 12, indicative of moderate impairment. Resident #11's primary medical condition category that best described the primary reason for admission was medically complex condition related to Fibromyalgia (a long-term condition that involves widespread body pain). Other active diagnoses included Shortness of breath, GERD - Gastro-esophageal reflux disease (a condition where stomach acid flows back up into the esophagus (the tube connecting the stomach and mouth), causing heartburn and other symptoms), Calculus of kidney (hard deposits that form in the kidneys from minerals and salts in urine), Constipation (problem with passing stool), Muscle weakness (a decrease in the strength and ability of muscles to perform their normal functions, often resulting in a reduced ability to move the body) and Essential (Primary) Hypertension (a type of high blood pressure where no specific underlying cause, such as a medical condition, can be identified). In an interview on 06/12/2025 at 10:20 AM, a family member of Resident #11 stated they had not been informed of any care plan meetings for Resident #11 and had not attended such meetings before. The family member stated, My understanding would be, if am happy with Resident #11, other than that, I really don't know if the facility has asked me to come in for care planning meetings and I have talked to one of the nurses sometime about Resident #11 when she was feeling bad. The family member stated she would like to be informed and involved in Resident 11's care planning meetings. The family member stated, the negative outcome of not having such meeting maybe the facility will not do all they said they will do that could have prevented some of Resident #11's physical decline. Record review revealed Resident #11's last Care Plan meeting note was undated. The Care Plan document did not include information regarding the date or time the Care Plan meeting was held, who was invited, nor who attended. Resident # 51 Record review of Resident # 51's face-sheet dated 06/18/2025, revealed a [AGE] year-old female admitted to the facility on [DATE]. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the quarterly MDS assessment dated [DATE], revealed Resident #51 had a BIMS score of 12, indicative of moderate impairment. Resident #51's primary medical condition category that best described the primary reason for admission was coded as fractures and other multiple traumas. Other active diagnoses included anemia (low levels of healthy red blood cells to carry oxygen throughout the body), Hypertension (high blood pressure), asthma, chronic obstructive pulmonary disease, or chronic lung disease. Under section O, Special Treatments, Resident #51 received Oxygen therapy while a resident of the facility and within the last 14 days. Record review revealed Resident #51's last Care Plan meeting note was undated. However, the focus column included revisions dated 12/31/2024. The Care Plan document did not include information regarding the date or time the Care Plan meeting was held, who was invited, nor who attended. In an interview on 06/11/2025 at 03:02 PM, Resident #51 stated she had not participated or heard about any care plan meetings. Resident #51 stated, I hate to say because, I don't remember, like my family member does that and takes care of it. In an attempted interview on 06/12/2025 at 10:37 AM, Resident's family member was not accessible over the phone. Resident #38 Record review of Resident #38's face-sheet dated 06/18/2025, revealed an [AGE] year-old female originally admitted to the facility on [DATE]. Record review of the quarterly MDS assessment dated [DATE] revealed Resident #38 had a BIMS score of 11, indicative of moderate cognitive impairment. Resident #38's primary medical condition category that best described the primary reason for admission was coded as Medically complex conditions related to Parkinson's disease without dyskinesia (progressive neurological disorder that primarily affects movement, causing symptoms like tremors, stiffness, and difficulty with balance and coordination). Other active diagnoses included Type 2 Diabetes Mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), Hyperkalemia (a condition where there is too much potassium in the blood). Resident #38 was coded as the only active participant in the assessment process in Section Q, Participation in Assessment and Goal Setting. In an interview on 06/11/2025 at 03:08 PM, Resident #38 stated 'I do not know what is care plan and I have not heard that before. She stated if the facility had such, that would be her family member and not me. In an interview on 06/12/2025 at 10:48 AM, the DON stated she has worked in the facility for 27years. The DON stated that care plan meetings were the responsibility of the MDS Coordinator. The DON stated Residents, their family members and employees would attend and rare times the ombudsman participate in the care plan meetings. The DON stated that the goals would be to ensure everyone was aware of all the information in the care plan, and an opportunity for Residents, family members to request changes. She stated that the whole point is to ensure highest quality of care. The DON stated possible negative outcome could be lower quality of care and wishes of Resident and family member would not be met. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/12/2025 at 11:08 AM, the MDS Coordinator stated she had worked at the facility for almost 10years and was responsible for care planning meetings. The MDS Coordinator stated care planning meetings were supposed to take place quarterly and as needed. She stated Residents and concerned parties were communicated through mails and emails with no evidence/records and the goal was to make sure Resident's concerns were addressed and their needs met. The MDS Coordinator stated mandatory attendees include family member, Resident and staff designate. Record review of the facility's policy labeled Care Plans, undated, revealed the following documentation, Procedures: Each resident, family, and/or responsible party member will be invited to meetings to review the care plan at least quarterly.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review, the facility failed to provide information to resident's and their representatives on their rights related to filing grievances or concerns for 12 of 22 confidential residents. The facility failed to ensure confidential residents were provided access to the Grievance form and provided the procedure for how to file an anonymous grievance. This failure could place the residents at risk of unresolved grievances and decreased quality of life. Findings include: During Resident Council on, 06/11/2025 at 2:00pm, 12 of 22 confidential residents, stated they did not have access to the Grievance form, they did not know they could file a Grievance anonymously, they did not know where to submit an anonymous Grievance form, and the procedure for filing a grievance had not been discussed in Resident Council. The Residents attending Resident Council stated they can ask the AD for the grievance form; residents stated the grievance form was not available for them without asking the AD for the form. The residents stated the AD completed the grievance forms during Resident Council when complaints are voiced. The twelve Residents unaware of the grievance procedure had all been Residents of the facility for 6 plus months. Record Review of the facility Grievance policy on 6/12/2025 at 11:07am; according to the facilities' Grievance policy anonymous grievances can be submitted in a locked boxed on hall 3. Surveyor observed the locked box on hall 3, the label on the box indicated the locked box was for payments, the box did not have a label indicating its' use for anonymous grievances. Observation completed each of the hallways of the facility on 6/12/2025 at 11:45am, grievance forms were not available for the residents. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DON on 6/12/2025 at 12:05pm; the DON stated she was the Grievance Officer for the facility. The DON stated she was responsible for the review of Grievances and assigned them to department heads. The DON stated she had Grievance forms in her office and the AD had Grievance forms. The DON stated staff completed Grievance forms for Residents, Residents do not ask for forms and complete them on their own. The DON stated residents trusted her to complete the form on their behalf. The DON stated there was no procedure for Residents to submit Grievances anonymously. The DON stated the facility addressed Grievances immediately, the DON stated her desire was to have all Grievances resolved within 48 hours. The DON stated she assigned the Grievance to the appropriate department, that department addressed the grievance with the complainant, resolved the grievance, and explained the resolution to the complainant. The resolution was documented on the Grievance form and the completed form was submitted to the ADM for review. The DON stated completed Grievance forms were kept in a notebook. The DON stated she monitored the Grievance process for success by following up with the staff member assigned to resolve the Grievance, the DON stated the ADM will meet with the complainant to ensure they were satisfied with the resolution. The DON stated she was responsible for ensuring staff were trained on the Grievance process. The DON stated she was not aware the Grievance procedure was not being discussed in Resident Council. The DON stated the potential negative outcome for the Grievance policy not being followed was Resident issues will not be resolved. Grievance Policy Record Review of the Grievance Policy last updated in 2025. Policy Statement: Residents has the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances without discrimination or reprisal and without fear of discrimination or reprisal. Grievances can be completed orally or in writing, grievances can also be submitted anonymously. If the grievance is anonymous, it can be submitted in the locked box outside of the business on hall 3.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure PRN orders for psychotropic drugs were limited to 14 days unless the attending physician or prescribing practitioner believed, and documented, that it was appropriate for the PRN order to be extended beyond 14 days for 1 of 1 resident (Resident #61) reviewed for PRN psychotropic medications, in that: Resident #61 continued to have a PRN order for Lorazepam 2 MG/ML after 14 days without a duration. This failure could result in residents receiving antipsychotic medications when contraindicated and could result in residents experiencing adverse drug reactions. The findings include: Record review of Resident #61's face sheet, dated 06/12/25, reflected a [AGE] year-old-female who was admitted to the facility on [DATE] with diagnoses to include Alzheimer's (cognitive loss), diabetes (high blood sugar), anxiety (felling of fear and worry) and major depressive disorder (mental illness). Record review of Resident #61's significant change in status, dated 04/12/25, reflected Resident #61's BIMS was a 00 which indicated Resident #61 had severely impaired cognitive impairment. The MDS further reflected Resident #61 had a diagnosis of anxiety disorder. Record review of Resident #61's physician order summary dated 03/19/24 reflected the following orders: *Order start date 04/03/25 with an indefinite end date for Lorazepam Oral Concentrate 2 mg/ml, give 0.25 ml by mouth every 2 hours as needed for anxiety. *Order start date 04/03/25 with an indefinite end date for Lorazepam Oral Concentrate 2 mg/ml, give 0.50 ml by mouth every 2 hours as needed for anxiety. *Order start date 04/03/25 with an indefinite end date for Lorazepam Oral Concentrate 2 mg/ml, give 0.75 ml by mouth every 2 hours as needed for anxiety. *Order start date 04/03/25 with an indefinite end date for Lorazepam Oral Concentrate 2 mg/ml, give 1 ml by mouth every 2 hours as needed for anxiety. Record review of Resident #61's PRN MAR reflected the following: *Lorazepam Intensol Oral Concentrate 2 mg/ml give 0.25 ml by mouth every 2 hours as needed for anxiety. Start Date 04/03/25 - DC Date 6/12/25. No medication was administered for the month of June. *Lorazepam Intensol Oral Concentrate 2 mg/ml give 0.50 ml by mouth every 2 hours as needed for anxiety. Start Date 04/03/25 - DC Date 6/12/25. No medication was administered for the month of June. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Lorazepam Intensol Oral Concentrate 2 mg/ml give 0.75 ml by mouth every 2 hours as needed for anxiety. Start Date 04/03/25 - DC Date 6/12/25. No medication was administered for the month of June. *Lorazepam Intensol Oral Concentrate 2 mg/ml give 1 ml by mouth every 2 hours as needed for anxiety. Start Date 04/03/25 - DC Date 6/12/25. No medication was administered for the month of June. During an interview on 06/12/25 at 09:20 AM with the DON, she stated she was not aware that Resident #61 had an order for Lorazepam PRN with no duration. She stated PRN psychotropic medications must have a stop dated and can only be given for 14 days. She stated lorazepam was a psychotropic medication. She stated the QA Nurse was responsible for checking all new doctor orders and all new medications. She stated all staff had been trained on PRN psychotropic medications. She stated the potential negative outcome could be resident declining and interfering with cognition. During an interview on 06/12/25 at 10:20 AM with the QA Nurse, she stated Resident #61 has an order for Lorazepam PRN because she was admitted to hospice services. She stated PRN psychotropic medications must have a stop dated and can only be given for 14 days even if on hospice. She stated she was responsible for competing medication audits. She stated she would be discontinuing the medication because resident has not used it. She stated the medication was not discontinued because she was waiting for pharmacy physician letter to come back from the physician. She stated all staff have been trained on PRN psychotropic medications. She stated the potential negative outcome could be giving the PRN psychotropic to the resident that really does not need it. Record review of the facility policy titled Psychoactive Medications revised date 11/05 reflected the following: Policy: Resident's will only receive psychoactive medications when medically necessary. Every effort will be made to ensure that residents who use these medication receive the intended benefit of the medications and to minimize the unwanted effects of the medications. Procedure: . The continued need for and the effectiveness of this type of medication will be reassessed monthly by the attending physician .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure all Pre-admission Screening and Resident Review (PASRR) Level I residents with mental illness were provided with a PASRR Evaluation assessment for 2 of 22 residents (Residents #59 and #62) reviewed for PASRR screening, in that: Residents #59 and #62 did not have an accurate PASRR Level 1 assessments when they had a diagnosis of mental illness. These failures could place residents with an inaccurate PASRR Level 1 and no PASRR Level 2 Evaluation at risk for not receiving care and services to meet their needs. The findings were: Resident #59 Record review of Resident #59's electronic face sheet undated revealed a [AGE] year-old female initially admitted to the facility on [DATE]. Resident #59 had a medical diagnosis of major depressive disorder (a mental disorder characterized by persistent sadness), post-traumatic stress disorder (mental health condition that can develop after a person experiences or witnesses a traumatic event), cerebral infarction (occurs when the blood supply to the brain is interrupted, leading to brain tissue death) and dementia (a general term for the loss of cognitive function, including memory, language, problem-solving, and reasoning, that can interfere with daily life). The document did not indicate Resident #59 had a primary diagnosis of dementia. Record review of Resident #59's annual MDS dated [DATE], revealed under section I, Resident #59 had an active diagnosis of depression and post-traumatic stress disorder (PTSD). Additionally, under Section C Cognitive Patterns, Resident #59's MDS revealed a BIMS of 10, indicating the resident was moderately, cognitively impaired. Record review of Resident #59's care plan, last revised on 4/12/2025, revealed The resident has a mood problem r/t DEPRESSION, DEMENTIA, PTSD. Initiated on 12/10/2024. Additionally, the document revealed interventions to Monitor/record/report to MD prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills. The resident needs time to talk. Encourage the resident to express feelings. Monitor/record/report to MD prn mood patterns s/sx of depression, anxiety, sad mood as per facility behavior monitoring protocols. Educate the resident/family/caregivers regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance. Record review of Resident #59's physician's Order Summary as of 06/12/2025 revealed Resident #59 had been prescribed Sertraline 100mg tablet for Depression with a start date of 2/23/2025. Record review of Resident #7's Preadmission Screening and Resident Review (PASRR) Level One (PL1) form dated 11/11/2022 revealed under section C0100 Mental Illness an answer of NO, indicating the resident does not have a mental illness. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #62 Record review of Resident #62's electronic face sheet undated revealed a [AGE] year-old female initially admitted to the facility on [DATE]. Resident #62 had a medical diagnosis of major depressive disorder (a mental disorder characterized by persistent sadness) and post-traumatic stress disorder (mental health condition that can develop after a person experiences or witnesses a traumatic event). Resident #62 does not have a diagnosis of dementia. Record review of Resident #62's annual MDS dated [DATE], revealed under section I, Resident #62 had an active diagnosis of depression and post-traumatic stress disorder (PTSD). Additionally, under Section C Cognitive Patterns, Resident #62's MDS revealed a BIMS of 15, indicating the resident was cognitively intact. Record review of Resident #62's most recent care plan, dated 06/14/2025, revealed a diagnosis of Major Depressive Disorder and PSTD. Interventions included referring to mental authorities as needed, referring to psychiatrist, and referring to therapy. Record review of Physician orders for Resident #62's dated 06/18/2024 revealed under Diagnoses, Resident #62 has a diagnosis of Major Depressive Disorder and PTSD. Resident #62 is prescribed Buspirone 15mg, to be administered by mouth .5 tablet three times a day for anxiety. Record review of Resident #62's Preadmission Screening and Resident Review Level One (PL1) form dated 05/27/2025 revealed under section C0100 Mental Illness an answer of No, indicating the resident did not have a mental illness. During an interview conducted on 06/12/25 at 11:15AM with the MDS Nurse, she verified Residents #59 and #62 had a diagnosis of mental illness. The MDS Nurse verified Residents #59 and #62 did not have PASRR 2 Evaluations as their PASRR 1s were negative. The MDS Nurse stated the purpose of the PASRR 1 was to identify if Residents require additional services. She said if the PASRR 1 was positive then it gets put into an online system and they reach out to the necessary people to ensure a PASRR 2 Evaluation was done. She said she was responsible for entering the PASRR 1 into the system, the MDS nurse was also responsible for ensuring PASRR 1s were accurate by comparing them to medical records. The MDS Nurse stated the potential harm if a resident with a diagnosis of a mental illness had a negative PASRR 1, and no subsequent level PASRR 2 evaluation was the residents could potentially go without services. During an interview with the DON on 06/12/25 at 12:15PM, she verified Residents #59, and #62 had diagnosis of mental illnesses. The DON confirmed Residents #59, and #62 did not have PASRR 2 Evaluation as their PASRR 1s were negative. The DON stated it was the MDS nurses' responsibility to ensure every resident admitted to the facility had an accurate PASRR 1. The DON also stated it was the MDS nurses' responsibility to ensure PASRR 1s are completed accurately by comparing them to the residents' medical records. The DON stated residents with a positive PASRR 1 should be referred to the local mental health authority for completion of a PASRR 2 Evaluation. The DON stated the potential harm to a resident without an accurate PASRR 1 and a subsequent PASRR 2 Evaluation was the resident will not receive the services they need. ADM stated via email, on 6/18/2025 at 4:05pm, the facility does not have a PASRR policy.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents were free of any significant medication errors for 1 (Resident #185) of 4 residents reviewed for medication administration. The facility failed to ensure metoclopramide (used to increase muscle contraction in the upper digestive tract) administered to Resident #185 as ordered. This failure could place residents at risk for not receiving medications as ordered by their physician. The findings include: Record review of Resident #185's face sheet dated 06/11/25 revealed an [AGE] year-old female admitted to the facility on [DATE]. Resident #185 had a medical history of gastroparesis (stomach muscles don't move food well), acute kidney failure, depression (feelings of sadness, loss or anger), anxiety (feeling of fear and worry) and hypertension (high blood pressure). Record review of Resident #185's physician orders revealed the following: Metoclopramide HCL Oral Tablet 10 MG give 1 tablet by mouth before meals for gastroparesis with a start date 06/07/25. Record review of Resident #185's medication administration record revealed Resident #185 received the following: Metoclopramide HCL 10MG on 06/11/25 at 07:30 AM. During an observation on 06/11/25 at 08:30 AM MA exited Resident #185 room and stated to CNA Resident #185 was done with her breakfast but would like more coffee. During an observation on 06/11/25 at 08:40 AM MA prepared the medication for Resident #185: Metoclopramide 10 MG along with five additional medications (Amlodipine 2.5mg, KCL 10meq, Coreg 6. 25mg, Cefdinir 300mg, Amiodarone 200mg) and 30cc liquid (lactulose). Record review blister pack on 06/11/25 at 08:40 AM revealed a pharmacy label Metoclopramide 10 MG 1 tablet give before meals. During an observation on 06/11/25 at 08:45 AM Resident #185 at bedroom door in wheelchair. MA gave Resident #185 her medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675462	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Nursing and Rehabilitation Center	3200 Parkway Big Spring, TX 79720

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with DON on 06/12/25 at 09:20 AM, she stated Metoclopramide needs to be given before breakfast. She stated the charge nurses would be responsible for making sure MA give medications timely. She stated all nursing staff had been trained on medication times. She stated the pharmacy consultant does medication pass audits monthly. She stated her expectation was for the medications to be passed timely. She stated medications can be given an hour before or hour after the scheduled time. She stated Metoclopramide was scheduled before meals at 0730 AM. She stated the medication would be late if given at 08:40 AM. She stated the purpose of the medication was to help the stomach digest food. She stated if medication was not given timely the MD would need to be contacted. She stated the potential negative outcome could be the resident experiencing nausea, vomiting or stomach cramps. During an interview with MA on 06/12/25 at 10:32 AM, she stated the medication Metoclopramide for Resident #185 was scheduled for 07:30 AM. She stated the medication should be given before meals. She stated she was aware this medication needs to be given before meals, but she never can get to her before meals. She stated her hall medications start at 09:00 AM. She stated medications can be given one hour before or one hour after the scheduled time. She stated the medication was late because she gave it after 08:30 AM. She stated she has had training on giving medication timely. She stated she was not sure what the potential negative outcome could be. Record review of facility policy titled Medication Administration undated revealed: Purpose: To assure that residents receive their medication as ordered by the physician. Procedure: . 9. Medications are to be given within one hour prior to or after time ordered.

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	675462	A. Building B. Wing	06/12/2025

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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 6 residents (Residents #17) reviewed for infection control. CNA A failed to change gloves and utilize hand hygiene during incontinence care with Resident #17. This failure could place residents at risk for cross contamination and infection. The findings include: Record review of Resident #17's undated face sheet revealed a [AGE] year-old-female originally admitted to the facility on [DATE]. Resident #17 had a medical history of chronic respiratory failure with hypoxia (a condition where the lungs struggle to adequately oxygenate the blood, leading to low blood oxygen levels), end stage renal disease, and type 2 diabetes. Record review of Resident #17's annual MDS dated [DATE], Section C- Cognitive Patterns revealed a BIMS of 15, which indicated Resident #17 was cognitively intact. Section H- Bladder and bowel revealed resident was frequently incontinent of bowel and bladder. Record review of Resident #17's care plan last revised on 1/17/2025 revealed an intervention to Provide peri-care after each incontinent episode as needed. During an incontinence care observation on 6/11/2025 at 2:24pm, CNA A turned Resident #17 onto her right side and cleaned her bottom. CNA A grabbed clean linen and placed it underneath Resident #17 without changing her contaminated gloves or performing hand hygiene. During an interview with CNA A on 6/11/2025 at 2:47pm, she stated she was trained on infection control and her infection preventionist was the DON. She stated she was trained to change her gloves when going from dirty to clean during incontinence care. She stated the potential negative outcome of not changing gloves during incontinence care could be spreading infection. She stated she knew to change her gloves after turning the resident onto their right side but did not think to change them again before placing the clean linen. During an interview with the DON on 06/12/25 10:08 AM, she stated she was the infection preventionist and staff was trained monthly on infection control. She stated training on changing gloves during incontinence care was included in the infection control training. She stated they have annual competencies as well. She stated the potential negative outcome of staff not changing gloves when going from clean to dirty during incontinence care could be spreading infection. She stated they monitor compliance with infection control by monitoring monthly infection trends. She stated they also have hall monitors that make rounds and observations for noncompliance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675462	A. Building B. Wing	06/12/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility undated policy titled Hand-washing Guideline revealed; Purpose: The purpose of this guideline is to provide guidance to employees for proper and appropriate hand-washing techniques that will aid in the prevention of the transmission of infections. To prevent the spread of infectious disease .When to wash hands guidelines: 10) After contact with blood, body fluids, secretions, excretions, mucous membranes, or broken skin .11) After handling items potentially contaminated with a resident's blood, body fluids, excretions, secretions.