STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675471	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Star Ranch Rehabilitation and Health Care Ce	709 W Fifth St Bonham, TX 75418

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interviews and record review, the facility failed to ensure consent to the prescription of psychoactive medications given by a resident or by a person authorized by law to give consent on behalf of the resident is valid only if consent is given in writing on a form prescribed by HHSC for 1 of 18 (Residents #1) residents reviewed for psychoactive medications. The facility did not ensure written consent was obtained from the legal authorized representative on HHSC Form 3713 to administer Seroquel 25mg to Resident #1. This failure could place residents at risk for receiving antipsychotic medications without informed consent. Findings included: Record review of Resident #1's face sheet, dated 04/23/25, reflected Resident #1 was a [AGE] year-old male, readmitted to the facility on [DATE] with diagnoses which included schizoaffective disorder (a condition that can make you feel detached from reality and can affect your mood) and bipolar (a disorder associated with episodes of mood swings ranging from depression lows to manic highs). Record review of Resident #1's order summary report, dated 04/23/25 reflected an active physician order for Seroquel 25 mg: 1 tablet by mouth at bedtime related to schizoaffective disorder and bipolar. Record review of Resident #1's quarterly MDS, dated [DATE], reflected Resident #1 made himself understood, and understood others. Resident #1's BIMS score was 10, which indicated his cognition was moderately impaired. Resident #1 had an active diagnosis of anxiety, depression, psychotic, and schizophrenia. Resident #1 took an antipsychotic 7 out of 7 days during the look-back period. Record review of Resident #1's comprehensive care plan revised 04/30/24, reflected Resident #1 used a psychotropic medication Seroquel related to Schizophrenia and psychotic disorder with delusion diagnosis. The care plan interventions included administer psychotropic medications as ordered by physician and consult with pharmacy. Record review of Resident #1's Antipsychotic or Neuroleptic Medication Treatment Form 1013 dated 12/20/22 reflected a consent was signed for Seroquel 50 mg. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/24/25 at 3:32 p.m., the ADON stated she, and the DON were responsible for ensuring the correct psych consents were obtained with the correct medications. The ADON stated not having a DON in the building was a lot to keep up with for one person. The ADON stated she, and the regional nurse recently audited the consents, and this one was missed because it was the correct medication and form but not the correct dosage. The ADON stated it was important to obtain consents on the new HHSC Form 3713 to ensure the correct medications were given per the diagnoses. During an interview on 04/24/25 at 3:54 p.m., the Administrator stated he expected the ADON to ensure HHSC Form 3713 was filled out for psychotropic medications. The Administrator stated it was important to obtain consent on the required HHSC form to address the resident concern better. A request for the facility policy regarding psychotropic medications was submitted to the DON on 04/23/25 at 4:50 p.m. A policy regarding psychotropic medications was not received prior to exit.

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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** 43047 Based on observation, interview, and record review, the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 18 residents (Resident #45) reviewed for reasonable accommodations. The facility did not ensure portable oxygen was available to allow Resident #45 to leave his room. This failure could place residents at risk for decreased quality of life, self-worth, and dignity. Findings included: Record review of Resident #45's face sheet, dated 04/23/25, reflected Resident #45 was a [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included COPD (chronic obstructive pulmonary disease with (acute) exacerbation (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #45's physician order summary report, dated 04/23/24, reflected an active physician's order for oxygen at 2-3 liters per minute via N/C continuously with a start date 11/20/24. Record review of Resident #45's quarterly MDS assessment, dated 02/12/25, reflected Resident #45 made himself understood, and understood others. Resident #45's BIMS score was 15, which indicated his cognition was intact. Resident #45 received oxygen therapy. Record review of the comprehensive care plan, revised 10/23/24, reflected had SOB related to DX of COPD. The care plan interventions included assist resident/family/ caregiver in learning signs of respiratory compromise, and monitor /document changes in orientation, increased restlessness, anxiety, and air hunger. During an interview on 04/21/25 at 2:55 p.m., Resident #45 stated he had been stuck in his room since 4/17/25 because the facility was out of portable oxygen. Resident #45 stated he was told by several staff members (unable to call names) that the facility did not have portable oxygen. Resident #45 stated no other option was given. Resident #45 stated he had asked the Administrator about it, and it was still not delivered. Resident #45 stated I missed bingo today (04/21/25). During an interview on 04/21/25 at 3:30 p.m., the Administrator stated he was told on 04/17/25 by staff that they were running low on portable oxygen tanks, so he immediately called the DME company to order more oxygen. The Administrator stated a staff member came back shortly after to inform him they were completely out. The Administrator stated he should have contacted another facility to get back up supply of portable oxygen tanks to fill the gap before the DME company brought the facility more. The Administrator stated he was responsible for monitoring and overseeing to ensure the facility kept an adequate stock by relying on staff to notify him or the ADON if they were running low. The Administrator stated the Maintenance Supervisor should also report if there was a low count when he checked to see if the tanks were secured. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Resident Rights revised 04/2017 indicated . b. Be treated as individuals in a manner that supports their dignity . e. Receive care and services that are adequate, appropriate, and in compliance with contractual terms of residency, relevant federal and state laws, rules and regulations and shall include the right to refuse such care and services . r. Live in a physical environment which ensures their physical and emotional security and well-being .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interview and record review, the facility failed to ensure the right to formulate an advanced directive was provided for 1 of 18 residents (Resident #37) reviewed for advanced directives. 1. The facility did not ensure Resident #37's OOH-DNR included the MPOA printed name and date the document was signed. 2. The facility did not ensure Resident #37's OOH-DNR included the notary's signature. These failures could place residents at risk of not receiving care and services to meet their needs. Findings included: Record review of Resident #37's face sheet, dated 04/23/25, reflected Resident #37 was a [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included Parkinson's (brain disorder that causes unintended or uncontrollable movements). Record review of Resident #37's physician order summary report, dated 04/23/25, reflected an active physician's order for code status: DNR with an order date 12/15/23. Record review of Resident #37's quarterly MDS assessment, dated 04/21/25, reflected Resident #37 made himself understood, and understood others. Resident #37's BIMS score was 15, which indicated his cognition was intact. Record review of the comprehensive care plan, revised on 12/15/23, reflected Resident #37 was a DNR. The care plan interventions included Resident #37 was aware of his DNR status, obtain a copy of his DNR status physician order, and review his advanced directive options and resident rights, quarterly and PRN, with him and his family. Record review of Resident #37's OOH-DNR form dated 12/12/23 reflected a missing MPOA printed name, date the document was signed by the MPOA and a missing signature by the notary. During a telephone interview on 04/24/25 at 11:16 a.m., the Regional Social Worker stated the Business Development Social Services was responsible for completing DNRs. After reviewing Resident #37's electronic medical record, the Regional Social Worker stated Resident #37 OOH-DNR was missing the date, printed name by the MPOA, and a missing signature by the notary. The Regional Social Worker stated the Administrator and DON were responsible for overseeing and monitoring DNR accuracy. The Regional Social Worker stated for a DNR to be accurate all required information must be filled out completely to ensure the residents wishes were carried out. During a telephone interview on 04/24/25 at 11:32 a.m., the Director of Marketing/Business Development Social Services stated she was not responsible for DNRs. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/24/25 at 3:54 p.m., the Administrator stated he expected DNRs to be filled out, including signatures and dates. The Administrator stated the Social Worker was responsible for monitoring and overseeing DNRs which was the Regional Social Worker. The Administrator stated it was important to ensure the DNRs were completed to ensure the resident wishes were respected. Record review of the facility's policy titled Advanced Directive revised 08/2023 indicated . Advance directives will be respected in accordance with state law and facility policy . 6. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives .

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interview and record review, the facility failed to ensure each resident was informed before, or at the time of admission, and periodically during the residents stay, of services available in the facility and of changes for those services, which included changes for services not covered under Medicare/Medicaid or by the facility's per diem rate for 1 of 3 residents (Resident #104) reviewed for Medicare/Medicaid coverage. The facility failed to ensure Resident #104 was given a SNF ABN when discharged from skilled services at the facility prior to covered days being exhausted. This failure could place residents at risk for not being aware of changes to provided services. Findings include: Record review of Resident #104's face sheet, dated 04/23/25, reflected Resident #104 was a [AGE] year-old male, readmitted to the facility on [DATE] with a diagnosis which included acute kidney failure (condition in which the kidneys suddenly cannot filter waste from the blood). Record review of Resident 104's annual MDS assessment, dated 01/24/25, reflected Resident #104 made himself understood and understood others. Resident #104's BIMS score was 9, which indicated his cognition was moderately impaired. Resident #104 received occupational and physical therapy. Record review of Resident #104's SNF Beneficiary Protection Notification Review indicated Resident #104 was receiving Medicare Part A services starting on 10/27/24, and the last covered day of Part A services was 12/31/24. It was reflected that a SNF ABN was not completed which would have informed Resident #104 of the option to continue services at the risk of out-of-pocket. During an interview on 04/24/25 at 12:19 p.m., the Regional Financial Specialist stated the BOM was responsible for ensuring Resident #104 was issued a SNF ABN. The Regional Financial Specialist stated Resident #104 had 65 days remaining. The Regional Financial Specialist stated the form should have been issued if the resident had skilled benefit days remaining and was being discharged from Part A services and continued in the facility. The Regional Financial Specialist stated the BOM was out sick today (04/24/25). The Regional Financial Specialist stated she was unaware of why the form was not completed, but it was important for the resident to receive the form so he would know what he was responsible for. During an interview on 04/24/25 at 3:54 p.m., the Administrator stated the BOM was responsible for ensuring the SNF ABN was completed. The Administrator stated he expected the SNF ABN to be handed out if the resident had days remaining in the facility. The Administrator stated it was important for the resident to receive the form so they would know what they were responsible for. During an interview on 04/24/25 at 7:25 a.m., the ADON stated the facility did not have a policy regarding SNF ABN.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source were reported immediately, but no later than 2 hours after the allegation was made, for 1 of 18 (Resident #11) residents reviewed for abuse and neglect. The Abuse Coordinator failed to identify and report an allegation of abuse to HHSC within 2 hours when LVN E informed him on 04/22/25 that CNA D witnessed Resident #16 hit Resident #11 right arm. This failure to report could place the residents at risk for abuse. Findings included: Resident #11 Record review of Resident #11's face sheet, dated 04/24/25, reflected Resident #11 was a [AGE] year-old female, readmitted to the facility on [DATE] with a diagnosis which included atherosclerotic heart disease of native coronary artery without angina pectoris (buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow). Record review of Resident #11's quarterly MDS assessment, dated 02/21/25, reflected Resident #11 made herself understood, and understood others. The assessment did not address Resident #11 BIMS score. The MDS reflected Resident #11 had no behaviors or refusal of care during the look-back period. Record review of the comprehensive care plan, revised on 04/11/24, reflected Resident #11 had impaired cognitive function/dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life) or thought processes related to Dementia/Alzheimer's (progressive disease that destroys memory and other important mental functions). The care plan interventions included administer medications as ordered, communicate with the resident/family/caregivers regarding residents' capabilities needs, and monitor/document/report PRN any changes in cognitive function. Resident #16 Record review of Resident #16's face sheet, dated 04/23/25, reflected Resident #16 was a [AGE] year-old male, readmitted to the facility on [DATE] with a diagnosis which included paranoid schizophrenia (a person feels distrustful and suspicious of other people and acts accordingly). Record review of Resident #16's quarterly MDS assessment, dated 04/15/25, reflected Resident #16 made himself understood, and understood others. Resident #16's BIMS score was 3, which indicated his cognition was severely impaired. Resident #16 had physical and verbal symptoms directed towards others and other behavioral symptoms not directed toward others during the look-back period. Resident #16 refused care during the look back period. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the comprehensive care plan revised on 09/26/24, reflected Resident #16 had behavior problems related to yelling out at others, repetitive actions, repetitive verbalizations, and cursing at others. The care plan interventions included administer medication as ordered, communicate behaviors with psychiatric care providers, and intervene as necessary to protect the rights and safety of others. Record review of the progress note dated 04/22/24 written by LVN E reflected Resident #16 was standing in doorway of room yelling and cursing. CNA D reported that Resident #16 hit Resident #11 on her right arm. The progress note reflected Resident #11 had no injuries and denied Resident #16 hitting her. The progress reflected the Abuse Coordinator notified. Record review of Residents' #16 and #11 electronic medical records reflected no incident or skin assessment was completed. During a telephone interview on 04/24/25 at 12:59 p.m., CNA D stated she was sitting at the nursing station and Resident #11 was sitting in front of Resident #16 door facing the nursing station. CNA D stated Resident #16 came out of his room yelling and cursing at Resident #11. CNA D stated Resident #11 stated you better not and the next thing CNA D saw was Resident #16 reach down to Resident #11's right arm and contacted it. CNA D stated she could not tell if it was a pinch or slap because Resident #11 had on long sleeves, but she did see the upper part of Resident #11 move. CNA D stated she immediately removed Resident #11 and Resident #16 went back in his room yelling and cursing. CNA D stated she immediately reported the incident to LVN E. An attempted interview on 04/24/25 at 1:06 p.m. with Resident #11, indicated she was non-interview able. An attempted interview on 04/24/25 at 1:08 p.m., with Resident #16, indicated he refused to be interviewed. During a telephone interview on 04/24/25 at 1:09 p.m., LVN E stated she was told by CNA D that Resident #16 hit Resident #11 on her right arm. LVN E stated after she assessed Resident #11 for injuries, she went down to report the incident to the ADON and Administrator. LVN E stated there were no injuries noted. LVN E stated she was told by the ADON that an incident report was not needed because when she asked Resident #11 if Resident #16 hit her, she stated no. During an interview on 04/24/25 at 12:49 p.m., the Administrator stated he could not remember who reported the incident between Resident #11 and Resident #16 to him. The Administrator stated he did not report the incident to HHSC because there was no injury. The Administrator stated he did not talk to Resident #11 nor Resident #16 about the incident because it was reported to him that Resident #11 denied Resident #16 hitting her. The Administrator stated he should have asked CNA D what she witnessed in the affirmative by statute it would be reportable. During an interview on 04/24/25 at 1:22 p.m., the Executive Director stated the Administrator did not have to report the incident because Resident #16 had a BIMS score of 3 and it was not willful. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/24/25 at 1:25 p.m., the ADON stated she was aware the incident between Resident #11 and Resident #16 was witnessed until the state surveyor asked for LVN E phone number. The ADON stated her understanding was it was another resident that witnessed the incident. The ADON stated LVN E reported no injuries, and Resident #11 denied Resident #16 struck her. The ADON stated she did not talk to either resident when the allegation was made to her and the Administrator. The ADON stated she would not tell a nurse to not complete an incident report. The ADON stated she expected her to complete an incident report and skin assessment. The ADON stated if she would have known sooner, she would have questioned the staff that witnessed the incident and investigated a little more. Record review of the facility's Abuse Prohibition Policy, reviewed 05/17/2024 indicated, . Each resident has the right to be free from abuse . Reporting/Response: 2. The facility will report all allegations and substantiated occurrences of abuse to the state agency and to all other agencies as required by law . The Abuse Coordinator will report all allegations of abuse immediately or within two hours of the allegation .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source, and misappropriation of resident property were thoroughly investigated for 1 of 18 residents (Resident #11) reviewed for abuse. The Abuse Coordinator failed to investigate/protect/correct when an allegation of abuse allegedly occurred when LVN E informed him on 04/22/25 that CNA D witnessed Resident #16 hit Resident #11 right arm. This failure could place residents at risk for abuse, neglect, exploitation, mistreatment, and further injuries of unknown source. Findings included: Resident #11 Record review of Resident #11's face sheet, dated 04/24/25, reflected Resident #11 was a [AGE] year-old female, readmitted to the facility on [DATE] with a diagnosis which included atherosclerotic heart disease of native coronary artery without angina pectoris (buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow). Record review of Resident #11's quarterly MDS assessment, dated 02/21/25, reflected Resident #11 made herself understood, and understood others. The assessment did not address Resident #11 BIMS score. The MDS reflected Resident #11 had no behaviors or refusal of care during the look-back period. Record review of the comprehensive care plan, revised on 04/11/24, reflected Resident #11 had impaired cognitive function/dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life) or thought processes related to Dementia/Alzheimer's (progressive disease that destroys memory and other important mental functions). The care plan interventions included administer medications as ordered, communicate with the resident/family/caregivers regarding residents' capabilities needs, and monitor/document/report PRN any changes in cognitive function. Resident #16 Record review of Resident #16's face sheet, dated 04/23/25, reflected Resident #16 was a [AGE] year-old male, readmitted to the facility on [DATE] with a diagnosis which included paranoid schizophrenia (a person feels distrustful and suspicious of other people and acts accordingly). Record review of Resident #16's quarterly MDS assessment, dated 04/15/25, reflected Resident #16 made himself understood, and understood others. Resident #16's BIMS score was 3, which indicated his cognition was severely impaired. Resident #16 had physical and verbal symptoms directed towards others and other behavioral symptoms not directed toward others during the look-back period. Resident #16 refused care during the look back period. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the comprehensive care plan revised on 09/26/24, reflected Resident #16 had behavior problems related to yelling out at others, repetitive actions, repetitive verbalizations, and cursing at others. The care plan interventions included administer medication as ordered, communicate behaviors with psychiatric care providers, and intervene as necessary to protect the rights and safety of others. Record review of the progress note dated 04/22/24 written by LVN E reflected Resident #16 was standing in doorway of room yelling and cursing. CNA D reported that Resident #16 hit Resident #11 on her right arm. The progress note reflected Resident #11 had no injuries and denied Resident #16 hitting her. The progress reflected the Abuse Coordinator notified. Record review of Residents' #16 and #11 electronic medical records reflected no incident or skin assessment was completed. During a telephone interview on 04/24/25 at 12:59 p.m., CNA D stated she was sitting at the nursing station and Resident #11 was sitting in front of Resident #16 door facing the nursing station. CNA D stated Resident #16 came out of his room yelling and cursing at Resident #11. CNA D stated Resident #11 stated you better not and the next thing CNA D saw was Resident #16 reach down to Resident #11's right arm and contacted it. CNA D stated she could not tell if it was a pinch or slap because Resident #11 had on long sleeves, but she did see the upper part of Resident #11 move. CNA D stated she immediately removed Resident #11 and Resident #16 went back in his room yelling and cursing. CNA D stated she immediately reported the incident to LVN E. An attempted interview on 04/24/25 at 1:06 p.m. with Resident #11, indicated she was non-interview able. An attempted interview on 04/24/25 at 1:08 p.m., with Resident #16, indicated he refused to be interviewed. During a telephone interview on 04/24/25 at 1:09 p.m., LVN E stated she was told by CNA D that Resident #16 hit Resident #11 on her right arm. LVN E stated after she assessed Resident #11 for injuries, she went down to report the incident to the ADON and Administrator. LVN E stated there were no injuries noted. LVN E stated she was told by the ADON that an incident report was not needed because when she asked Resident #11 if Resident #16 hit her, she stated no. During an interview on 04/24/25 at 12:49 p.m., the Administrator stated he could not remember who reported the incident between Resident #11 and Resident #16 to him. The Administrator stated he did not report the incident to HHSC because there was no injury. The Administrator stated he did not talk to Resident #11 nor Resident #16 about the incident because it was reported to him that Resident #11 denied Resident #16 hitting her. The Administrator stated he should have asked CNA D what she witnessed in the affirmative by statute it would be reportable. During an interview on 04/24/25 at 1:22 p.m., the Executive Director stated the Administrator did not have to report the incident because Resident #16 had a BIMS score of 3 and it was not willful. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/24/25 at 1:25 p.m., the ADON stated she was aware the incident between Resident #11 and Resident #16 was witnessed until the state surveyor asked for LVN E phone number. The ADON stated her understanding was it was another resident that witnessed the incident. The ADON stated LVN E reported no injuries, and Resident #11 denied Resident #16 struck her. The ADON stated she did not talk to either resident when the allegation was made to her and the Administrator. The ADON stated she would not tell a nurse to not complete an incident report. The ADON stated she expected her to complete an incident report and skin assessment. The ADON stated if she would have known sooner, she would have questioned the staff that witnessed the incident and investigated a little more. Record review of the facility's Abuse Prohibition Policy, reviewed 05/17/2024 indicated, . Each resident has the right to be free from abuse . Investigation: 1. The facility will thoroughly investigate alleged violations and take appropriate actions . 2. The Abuse Coordinator will report such allegations to the state agency in accordance with state law. The Abuse Coordinator will report all allegations of abuse within two hours of the allegation .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident status for 2 of 18 residents (Residents #16 and #30) reviewed for MDS assessment accuracy. 1. Resident #16's quarterly MDS, dated [DATE], identified the resident had a feeding tube. However, Resident #16 did not have a feeding tube. 2. Resident #30's quarterly MDS, dated [DATE], identified the use of restraint for Resident #30. However, Resident #30 had a transfer assist bar (bar used on the side of the bed to help with movement). These failures could place residents at risk of not receiving adequate care and services to meet their needs. Findings included: 1. Record review of Resident #16's face sheet, dated 04/23/25, reflected Resident #16 was a [AGE] year-old male, readmitted to the facility on [DATE] with a diagnosis which included paranoid schizophrenia (a person feels distrustful and suspicious of other people and acts accordingly). Record review of Resident #16's quarterly MDS assessment, dated 01/15/25, reflected Resident #16 made himself understood, and understood others. Resident #16's BIMS score was 3, which indicated his cognition was severely impaired. Resident #16 assessment indicated Resident #16 had a feeding tube. Record review of Resident #16's comprehensive care plan revised on 09/26/24, did not address a feeding tube. An attempted interview on 04/21/25 at 2:54 p.m., with Resident #16, indicated he refused to be interviewed. During an interview on 04/24/25 at 10:00 a.m., the MDS Coordinator stated she was told by the ADON, that week, that Resident #16 had not had a feeding tube for the last few years. The MDS Coordinator stated she had just started her position three weeks ago. The MDS Coordinator stated it was important for the MDS assessments to be accurate because it reflected the resident care. During an interview on 04/24/25 at 3:32 p.m., the ADON stated Resident #16 had a feeding tube before the facility changed over to a different company. The ADON stated she did not know why the assessment was coded he had a feeding tube because he had not had one in the past 5 years, she believed. The ADON stated it was marked by mistake. The ADON stated it was important to ensure the assessment was coded accurate because it reflected the resident care. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #30's face sheet, dated 04/23/25, reflected Resident #30 was a [AGE] year-old female, readmitted to the facility on [DATE] with a diagnosis which included multiple sclerosis (chronic, progressive disease involving damage to the sheaths of nerves cells in the brain and spinal cord causing numbness, impairment of speech, and of muscular coordination, blurred vison and sever fatigue). Record review of Resident #30's physician order summary report, dated 04/23/25, reflected an active physician's order for routine monitoring for transfer assist bar with a start date 02/24/25. Record review of Resident #30's quarterly MDS assessment, dated 03/25/25, reflected Resident #30 made herself understood, and understood others. Resident #30's BIMS score was 15, which indicated her cognition was intact. Resident #30 assessment indicated the use of a restraint. Record review of the comprehensive care plan revised on 05/22/23, reflected Resident #30 had an ADL self-care performance deficit related to DX of multiple sclerosis and tremors and used hand hoops on bilateral side of upper bed to assist with positioning, and steady self when sitting up related to poor core strength. The care plan interventions included, encourage the resident to discuss feelings about self-care deficit as needed, encourage the resident to participate to the fullest extent possible with each other interaction and encourage the resident to use bell to call for assistance. During an interview and observation on 04/21/25 at 11:45 a.m., a transfer assist bar was attached to Resident #30's upper bed. Resident #30 stated I use it to help me get up when asked what the bar was used for. During an interview on 04/24/25 at 10:12 a.m., Regional Case Mix F stated the transfer bar was not considered a restraint. Regional Case Mix F stated the transfer bar was a positioning bar, and it should not have been coded. After reviewing Resident #30's electronic medical record, Regional Case Mix F stated Regional Case Mix G was responsible for coding the inaccuracy. Regional Case Mix F stated it was important for the assessments to be accurate to be able to care plan correctly on the resident and provide the most sufficient care. During a telephone interview on 04/24/25 at 10:18 a.m., Regional Case Mix G stated the transfer assist bar should have not been coded as a restraint Regional Case Mix G stated it was marked an error. Regional Case Mix G stated she was responsible for monitoring and overseeing for accuracy or coding errors by random audits and if a problem was identified a more thoroughly review will be conducted, and an education provided. Regional Case Mix G stated it was important for the assessment to be accurate so a POC can be developed to provide the best care. During an interview on 04/24/25 at 3:54 p.m., the Administrator stated he expected for the MDS assessments to be coded accurately by the MDS nurses. The Administrator stated the ADON was responsible for providing oversight to the MDS nurse. The Administrator said it was important for the MDS assessments to be coded accurately to ensure the residents were receiving the proper care. Record review of the facility's policy titled MDS Coding Policy revised 02/24/25 indicated . the facility affiliated facilities utilize the most up to date Resident Assessment Instrument (RAI) manual for determination of coding each section of the resident assessment, timely and accurately .

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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** 45879 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs, for 2 of 5 (Resident #203 and Resident #36) residents reviewed. The facility failed to care plan Resident #203 and Resident #36's oxygen. These failures could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. The findings included: 1. Record review of Resident #203's face sheet, dated 04/24/25, indicated an [AGE] year-old female who was admitted to the facility on ,d+[DATE] /25 with diagnoses which included urinary tract infection, also known as a UTI (is an infection in any part of the urinary system), stroke, diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and high blood pressure. Record review of Resident #203's admission MDS assessment, dated 04/03/25, indicated Resident #203 understood others and was understood by others. The MDS assessment indicated she had a BIMS score of 0, indicating she was severely cognitively impaired. Resident #203 required assistance with bathing, toileting, dressing, bed mobility, personal hygiene, and eating. The MDS did not indicate she required oxygen. Record review of Resident#203's care plan dated 04/10/25 did not indicate she required oxygen. Record review of Resident #203 's physician orders dated 04/21/24 did not indicate any oxygen orders. During an observation and interview on 04/21/25 at 10:32 a.m., Resident #203 was in her room wearing a nasal cannula supplying oxygen at 3 liters per minute. She said she had been wearing oxygen for 2 years and needed it to help her breathe. 2. Record review of Resident #36's face sheet, dated 04/24/25, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Apraxia (a neurological disorder that makes it difficult to plan and execute purposeful movements), shortness of breath, also known as dyspnea, (is the feeling of not getting enough air into your lungs), high blood pressure, Dementia (impaired ability to remember, think, or make a decision) and Depression(feeling of sadness). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #36's quarterly MDS assessment, dated 01/25/25, indicated Resident #36 understood others and was understood by others. Resident #36's BIMS score was 12, which indicated she was moderately cognitively impaired. The MDS indicated Resident #36 was independent with dressing, personal hygiene, toileting, bathing, bed mobility, transfers, and eating. The MDS during the 7-day look-back period did not indicate Resident #36 was receiving oxygen. Record review of Resident #36's care plan revised on 02/21/25, did not indicate she required oxygen. Record review of Resident #36 's physician orders dated 10/17/24 indicated to change O2 tubing as needed for infection control. Record review of Resident #36 's physician orders dated 04/21/25 did not indicate any oxygen orders. Record review of Resident #36 's physician orders dated 04/24/25, after the surveyors' intervention indicated O2 at 2 liters per minute via nasal cannula continuously. During an observation and interview on 04/21/25 at 12:29 p.m., Resident # 35 was sitting on the side of her bed. Resident 336's oxygen concentrator was sitting on her left side with oxygen tubing dated 04/20/25. Resident #36's oxygen was not on, but she said she had just taken off her oxygen. During an interview on 04/24/25 at 3:30 p.m., LVN U said she had only been at the facility for a brief time, but was aware that all residents should have care plans. She said the care plan gave guidelines for the care of the residents. She said she had not been trained on care plans but was told by the ADON that the nurses were responsible for the acute care plans. She said Resident #203 and Resident #36 used oxygen, and therefore, it should have been care planned. During an interview on 04/24/25 at 3:33 p.m., the MDS nurse said she had only been in the MDS role for 3 weeks. She said the ADON/charge nurses were responsible for the acute care plans. She said she was responsible for the care plans done on admission, quarterly, significant change in condition, and annually. She said she was aware of all new orders, falls, or changes in condition from the morning meetings. She said she would take notes and look at the care plans to see if other clinical staff had updated them, and if not, she would update them. She said she was unaware why Resident #203 and Resident #36 were not care planned for oxygen. She said care plans were done/updated so staff would be aware of the care the residents needed. During an interview on 04/24/25 at 4:06 p.m., the ADON said the MDS nurse was responsible for completing the care plans. She said she was responsible for the acute care plans. The ADON said she was unaware that Resident #203's and Resident #36's use of oxygen was not care planned. She said they were missed because they did not have orders in their electronic records. She said care plans reflected residents' care and needs and should be complete and accurate. During an interview on 04/24/25 4:27 p.m., the Administrator said all disciplines should work together to complete a resident's care plan, but the MDS nurse was the overseer. He said if residents were receiving oxygen, then it should have been care planned. He said care plans were generated to provide each resident with the best care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled Care plans, Comprehensive Person-Centered, revised January 2023, indicated Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: #1 The interdisciplinary team (IDT) in conjunction with residents and his or her family develops and implements A comprehensive, person-centered care plan for each resident. #12 The comprehensive, person-centered care plan is developed within seven days of the completion of the required MDS assessment. #13 assessments of residents are ongoing, and care plans are revised as information about the resident and the residence condition changes.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents for 5 (Resident #25, Resident #22, Resident #48, Resident #32, and Resident #15) of 53 residents reviewed for accidents and hazards. 1.The facility failed to ensure Resident #25 did not receive a cigarette burn on 08/24/24. 2.The facility did not ensure Resident #22, who was assessed as an unsafe smoker, signed out to smoke in an unsafe area on 04/21/25 and kept his cigarettes, vapor and lighter in his possession. 3.The facility did not ensure that Resident #48, who was assessed as a safe smoker, did not sign out of the facility to smoke on the side of a residential street on 04/22/25. 4.The facility did not ensure Resident #32, who was assessed as an unsafe smoker, signed herself out to smoke in an unsafe area on 03/31/25. 5. The facility failed to ensure Resident #15 did not have 7 razors stored insecurely in a light blue stainless-steel cup in his room on the mini refrigerator. An Immediate Jeopardy (IJ) situation was identified on 04/22/25. The IJ template was provided to the facility on [DATE] at 4:34 pm, and an amendment IJ template was provided on 04/23/25 at 11:54 a.m. While the IJ was lowered on 04/24/25 at 2:45 p.m., the facility remained out of compliance at a severity level of no actual harm with a potential for more than minimal harm, with a scope of pattern due to the facility's need to evaluate the effectiveness of its corrective actions. These failures could put residents at risk of accidents and could result in burn injuries related to smoking paraphernalia that was not monitored/secured by the facility, harm, impairment, and death. Findings included: 1.Record review of Resident #25's face sheet, dated 04/24/25, indicated an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included seizures, anemia (a condition where the blood doesn't have enough healthy red blood cells or hemoglobin to carry oxygen to the body's organs and tissues), glaucoma (a group of eye conditions that damage the optic nerve, potentially leading to vision loss or blindness), and high blood pressure. Record review of Resident #25's quarterly MDS assessment dated [DATE] indicated Resident #25 understood others and was understood by others. The MDS assessment indicated he required assistance with bathing, toileting, dressing, bed mobility, personal hygiene, and eating independently. Record review of Resident #25's comprehensive care plan, dated on 8/26/24, indicated he had a cigarette burn on 08/24/24. The intervention dated 11/22/24 was for staff to provide a smoking apron. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #25's comprehensive care plan, dated on 04/23/25, indicated he was an unsafe smoker. The interventions were to evaluate his smoking safety ability and provide appropriate interventions as indicated by the smoking apron. Record review of Resident #25's smoking assessment dated [DATE] indicated that he required supervision while smoking. Record review of Resident #25 's progress note dated 08/24/24 by LVN CC indicated she was alerted by a laundry staff member that Resident #25 dropped his cigarette and burned himself. LVN CC assessed Resident #25 and noted a small burn to his right bilateral thigh. The area was cleaned, and Triple Antibiotic Ointment was applied. The physician was notified. LVN CC attempted to notify a family member, but there was no answer, so she left a message. Record review of Resident #25 's incident report dated 08/24/24 by LVN CC indicated Resident #25 said he burned his thigh when his cigarette dropped. Record review of Resident #25's skin assessment done on 08/24/24 indicated he had a burn to his bilateral right thigh measuring 1.5 x 1.3. Record review of Resident #25's smoking assessment dated [DATE] indicated that he required supervision and the use of an apron. Record review of Resident #25 's progress note dated 08/26/24 by LVN DD indicated she looked at the burned area on Resident #25's distal back of his right thigh. The area had a small intact blister with no redness or swelling. Record review of Resident #25's skin assessment done on 08/27/24 indicated he had no skin issues. Record review of Resident #25's physician orders dated 8/01/24 through 08/30/24 did not indicate any treatment orders for the right thigh. Record review of the Texas Unified Licensure Information Portal, also known as TULIP (It is an online system used by the Texas Health and Human Services Commission (HHSC) for managing long-term care licensure applications and other related activities) did not reveal an intake on Resident #25's related to a burn. During an observation on 04/22/25 at 11:00 a.m., Resident #25 was supervised while smoking outside. Resident #25 did not have on an apron. During an interview on 04/23/25 at 10:00 a.m., Resident #25 said he could not remember anything about a cigarette burn. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/23/25 at 3:27 p.m., the ADON said she vaguely remembered that incident. She said she was the MDS nurse back in August 2024, so she was unaware of what happened during the investigation process. The ADON said she was unaware if Resident #25's cigarette burn was reported to the state of Texas. She said if someone reported a cigarette burn to her, she would do an assessment and check for any injuries. She would apply treatment and notify the doctor and the responsible party if injuries were noted. She said she would do another smoking assessment and then call her corporate nurse to see what else she needed to do. During an interview on 04/23/25 at 3:32 p.m., the Administrator said he was not aware of Resident #25's burn. He said he was not employed at the facility at the time of that incident. He said he was not aware of any investigation into Resident #25's burn. The Administrator and the surveyor went over the notes in the chart, and he said he was not sure what steps he would have taken but said he would have investigated and gone from there. During an interview on 04/23/25 at 3:37 p.m., LVN DD said she remembered Resident #25 had a small burn to his pants. She said she received in report that he had obtained a burn, therefore she went to assess the area. She said she did not remember what the area looked like, but said she charted what she saw. She said she did not know if the injury was reported to the state of Texas, or if an in-service was conducted about the cigarette burns. During an attempted phone interview on 04/23/25 at 4:12 p.m., LVN FF (nurse that worked on 08-24 and 08-25-24) did not answer; a message was left. During an attempted phone interview on 04/23/25 at 4:14 p.m., LVN BB (nurse that worked on 08-24 and 08-25-24) did not answer; a message was left. During an attempted phone interview on 04/23/25 04:16 p.m., LVN GG (nurse that worked on 08-24 and 08-25-24) did not answer; a message was left. During an attempted phone interview on 04/23/25 at 10:05 a.m., LVN CC had no number listed. LVN CC was the nurse who completed Resident #25's skin assessment and incident report. The ADON said LVN CC had moved out of state, and they did not have her number. During an interview on 04/24/25 at 11:59 a.m., Housekeeper HH said she was on duty on 08/24/24 but did not recall a cigarette burn for Resident #25. She said Laundry Aide EE, usually smoked the residents at the 1:30 pm smoke break. During a phone interview on 04/23/25 at 12:15 p.m., the previous Administrator said she was the Administrator in August 2024. She said she did not recall Resident #25's cigarette burns. She said if it was reported to her, then she would have investigated to see why Resident #25 dropped his cigarette. She said she would have talked to the resident and staff to see what happened to cause Resident #25 to burn himself. She said since she did not recall Resident #25's burn, she could not say what she would have done or what she had done related to his investigation for the cigarette burn. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a phone interview on 04/24/25 at 1:30 p.m., Laundry aide EE said she did not remember a cigarette burn for Resident #25. She said she was usually the person who took them out to smoke but did not recall reporting his burn. She said she did not recall if he was required to wear a smoking apron during that time. She said if a resident received a burn while she was smoking them, she would have reported it to the nurse. 43047 2.Record review of Resident #22's face sheet, dated 04/23/25, reflected Resident #22 was a [AGE] year-old male, readmitted to the facility on [DATE] with a diagnosis which included multiple sclerosis (chronic, progressive disease involving damage to the sheaths of nerves cells in the brain and spinal cord causing numbness, impairment of speech, and of muscular coordination, blurred vison and sever fatigue). Record review of Resident #22's significant change in status MDS, dated [DATE], reflected Resident #22 made himself understood, and understood others. Resident #22's BIMS score was 15, which indicated his cognition was intact. Resident #22 required substantial/maximum assistance with eating, oral hygiene, upper body dressing, personal hygiene and dependent with toileting, shower/bath, and lower body dressing. Record review of the comprehensive care plan, revised 04/23/25, reflected Resident #22 was at risk for injury due to his smoking preference. The care plan interventions included to educate Resident #22 and encourage him to follow facility smoking times, designated smoking areas as needed. The care plan initiated on 03/31/25, reflected Resident #22 had a history of being signed out of facility in parking lot in electric wheelchair using his chair to block staff from parking their cars. The care plan interventions included staff to call into facility for assistance if they could not park their vehicle due to Resident #22 blocking parking spaces or entrances to parking lot. Record review of a quarterly smoking/vaping safety evaluation dated 03/31/25 reflected Resident #22 had a DX of multiple sclerosis and had burned himself during previous admission when he dropped a cigarette on himself while signed out to smoke. The evaluation reflected Resident #22 was confirmed not to be a safe smoker/vaper. Record review of a resident sign out/in log reflected on 04/21/25 Resident #22 signed out at 10:00 a.m. and did not sign back in until 12:02 p.m. During an observation on 04/21/25 at 10:15 a.m., Resident #22 and Resident #32 was observed in the wheelchairs sitting directly on a public roadway, near a residential home while they smoked without supervision. There were no sidewalks provided off the roadway. (continued on next page)

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	675471	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Star Ranch Rehabilitation and Health Care Ce	709 W Fifth St Bonham, TX 75418

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview and observation on 04/22/25 at 10:21 a.m., Resident #22 was sitting outside in front of the facility vaping without supervision. Resident #22 stated he was told by the facility if he wanted to smoke a cigarette, outside the smoking times, he must sign out and go across the road. Resident #22 was unsure why he was made to do that. Resident #22 stated if he vaped, he could just come outside the facility to do that. Resident #22 stated he did not require supervision unless he went to smoke during the smoke breaks. Resident #22 stated he kept 1 vape on him and the facility kept the other one. Resident #22 stated his lighter was battery operated and was able to light his own cigarette unless the battery was dead. Resident #22 stated if the battery was dead, he would stop and ask someone that was driving by or walking to light his cigarette. During an observation on 04/22/25 at 2:00 p.m., Resident #22 was sitting in his electric wheelchair visiting with another resident. A vape was noted on top of his dresser. During an interview and observation on 04/22/25 at 2:15 p.m., Resident #22 was observed sitting outside in front of the facility vaping with cigarettes noted in the black pouch. Resident #22 stated he was not signed out at the moment, but he knew if he went across the street to smoke, he must go in and sign out. During an interview on 04/22/25 at 2:36 p.m., the ADON stated Resident #22 had to sign out if he wanted to smoke outside the smoke breaks. The ADON stated there was an incident, prior to him been readmitted to the facility, where he was signed out and when he came back, burn holes were noted to the hoyer sling and his shorts. The ADON stated if Resident #22 vapes, he did not have to sign out, but he must go outside in the front of the facility to vape. The ADON stated he was not considered a safe smoker, but he was alert and oriented x3, so he was able to make decisions on his own. The ADON stated Resident #22 did keep a few cigarettes in his pouch that he keeps on him, but he was aware that he must sign out to smoke the cigarettes he had in the pouch. The ADON stated Resident #22 did not require supervision unless during smoke breaks. After reviewing Resident #22's smoking evaluation with the state surveyor, the ADON stated he should not have the cigarettes or vapes on him because he was deemed not a safe smoker/vaper. The ADON stated she was not aware the policy stated, when deemed not a safe smoker/vaper, the resident required supervision. During an interview on 04/22/25 at 2:31 p.m., LVN A said Resident #22 had the right to smoke if he wanted to. She said Resident #22 was not a safe smoker. She said Resident #22 had to sign himself out if he wanted to go across the street to smoke. She said Resident #22 always kept a small bag with cigarettes in it with him. She said she was not aware of any vapes he had. She said Resident #22 did not always comply with the rules, and it was his right to keep his cigarettes if he wanted them. During an interview on 04/22/25 at 2:40 p.m., LVN E said residents could sign out independently. She said Resident #22 had a little pouch that he always kept his cigarettes in. She said he would sign himself out and go smoke. She said she had never gave him a vape but only his cigarettes when he asked for them. She said she was aware he had a special lighter that he used to light his cigarettes but felt he was an unsafe smoker because of his hand dexterity. She said he kept his cigarette in his mouth, which put him at risk of burning his lips or dropping his ashes. She said when he signed out to go smoke, he was supposed to return his cigarettes when he came in, but sometimes he did not. She said that because he would go in and out so much, he would keep his cigarettes until the next time he wanted to smoke. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/22/25 at 3:19 p.m., the Administrator stated he was told by the Regional Director of Operations that Resident #22 was allowed to vape outside the facility without supervision. The Administrator stated Resident #22 should be signing himself out to smoke when he was off the property. The Administrator stated he did not know why Resident #22 had to sign himself to go across the street to smoke. The Administrator stated he was unaware Resident #22 was deemed as not a safe smoker/vaper. The Administrator stated if that was the case, he should always be supervised per the policy. The Administrator stated for as he knew, Resident #22 could not light his cigarette himself and he did not know who did it for him. The Administrator stated he was not aware Resident #22 had a battery-operated lighter he could use for himself. The Administrator stated he was unaware that he kept a vape and cigarettes on him. 3.Record review of Resident #48's face sheet, dated 04/24/25, indicated an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included urinary tract infection, also known as a UTI (is an infection in any part of the urinary system), stroke, diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), chronic obstructive pulmonary disease also known as COPD (a common lung disease causing restricted airflow and breathing problems), and high blood pressure. Record review of Resident #48's admission MDS assessment, dated 03/10/25, indicated Resident #48 understood others and was understood by others. The MDS assessment indicated she had a BIMS score of 15, indicating she was cognitively intact. Resident #48 required assistance with bathing and dressing, and was independent with toileting, bed mobility, personal hygiene, and eating. Record review of Resident #48's smoking assessment dated [DATE] indicated she was safe to smoke independently. Record review of Resident #48's care plan dated 3/31/25 indicated she was a safe smoker. The interventions were for staff to educate her and encourage her to follow the facility's smoking times, designated smoking areas, and policy as needed. During an observation on 04/22/25 at 7:58 a.m., Resident #48 was across the street, sitting on her rolling walker, smoking on the side of the road. During an observation on 04/22/25 at 2:02 p.m., Resident #48 was sitting on the front porch smoking. Resident #48 said she had signed out, so she could smoke. Review of the sign-out book, revealed on (date) Resident #48 had signed out at 1:50 pm. During an interview on 04/23/25 at 8:52 a.m., Resident #48 said she was told that if she wanted to smoke outside of the designated smoking times, she had to go across the street to smoke. She said she was told to sign out and go across the street. She said today (04/23/25), she was told she no longer had to sign out and smoke across the street. She said she could smoke on the premises if someone was smoking with her. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4.Record review of Resident #32's face sheet, dated 04/24/25, indicated an [AGE] year-old female who was admitted to the facility on ,d+[DATE] /25 with diagnoses which included urinary tract infection, also known as a UTI (is an infection in any part of the urinary system), stroke, diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), chronic obstructive pulmonary disease also known as COPD (a common lung disease causing restricted airflow and breathing problems), and high blood pressure. Record review of Resident #32's admission MDS assessment, dated 04/03/25, indicated Resident #32 understood others and was understood by others. The MDS assessment indicated she had a BIMS score of 0, indicating she was severely cognitively impaired. Resident #32 required assistance with bathing, toileting, dressing, bed mobility, personal hygiene, and eating. The MDS did not indicate she required oxygen. Record review of Resident #32's smoking assessment dated [DATE] indicated she was not a safe smoker/vaper related to contractures. Record review of Resident #32's smoking assessment dated [DATE] indicated she was safe to smoke/vape independently. Record review of Resident #32's care plan revised on 1/07/25, indicated Resident #32 was a safe smoker. The interventions were for staff to educate her and encourage her to follow the facility's smoking times, designated smoking areas, and policy as needed. During an interview on 04/23/25 at 8:30 a.m., Resident #32 said she was told that if she wanted to smoke outside of the designated smoking times, she had to go across the street to smoke. She said today (04/23/25) she was informed she no longer had to sign out to go across the street to smoke. She said she was able to smoke on the premises. During an interview on 04/22/25 at 2:40 p.m., LVN E said residents could sign out independently. She said Resident #32 often signed out and went across the street with Resident #22 to smoke. She was not sure of Resident #22's smoking assessment. During an interview on 04/24/25 at 3:27 p.m., LVN U said before the in-service today (04/24/25), she was under the impression that the resident who wished to smoke outside of designated smoking times had to sign out to go across the street. During an interview on 04/22/25 at 2:36 p.m., the ADON said the residents signed themselves out to smoke. She said Resident #48 and Resident #32 were safe smokers. She said she thought they wanted to go smoke across the street. During an interview on 04/22/25 at 3:20 p.m., the Administrator said residents were supposed to smoke in the back courtyard, and if it were raining, they could smoke on the front porch. He said they had the proper disposal out back and on the front porch. He said if a resident had been deemed a safe smoker, then they could smoke on the premises on the back or the front porch. He said he was not aware why Resident #48 and 32 signed out to go smoke. He said he thought Resident #48 and Resident #32 were safe smokers. 45810 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5.Record review of Resident #15's face sheet dated 04/30/25 indicated he was an [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses atherosclerotic heart disease (disease in which the build up of fat and cholesterol cause decreased blood flow), diabetes mellitus (disease that causes too much sugar in the blood stream), parkinsonism (neurogenerative disease that causes motor symptoms like tremors and slow movements), and anxiety (characterized by emotions involving increased fear or worry). Record review of Resident #15's quarterly MDS dated [DATE] indicated he understood others and could make himself understood. The MDS also indicated he had a BIMS score of 8 which meant he had moderate cognitive impairment. The MDS also indicated Resident #15 was dependent on staff for personal hygiene. Record review of Resident #15's care plan dated 2/14/23 indicated he had impaired cognitive function and an ADL self-care performance deficit and was dependent on staff for personal hygiene and required extensive assistance from the staff for personal hygiene. During an observation on 04/22/25 at 05:08 PM, Resident #15 had a light blue stainless-steel cup on his mini refrigerator with 7 disposable razors in it. During an observation on 04/23/25 at 07:53 AM, CNA X was in the room feeding Resident #15 and the light blue cup with 7 disposable razors were still sitting on the mini refrigerator in Resident #15's room. During an observation and interview on 04/23/25 at 09:30 AM, Resident #15 was in bed and continued to have the 7 disposable razors on the fridge in the blue cup. CNA X came in to Resident #15's room and said the facility CNAs shaved him but the disposable razors should not have been left there on Resident #15's refrigerator. CNA X said the disposable razors were not to be kept in the residents' rooms She said the disposable razors were kept in the locked bin for the CNAs to use and placed in the sharp's container after use. CNA X said Resident #15's family member would bring things into the facility at times. CNA X said the failure of the disposable razors being left out placed a risk for danger of the resident or other residents cutting themselves, but the facility did not have residents who wander. During an observation and interview on 04/23/25 at 09:41 AM, LPN A said the CNAs should keep the disposable razors stored in the sharp's containers in the bathroom after use. She said no disposable razors should have been left in any resident's room and in reach. LPN A said the failure placed a risk for residents to be injured or cut someone else. LPN A said all the staff were responsible for ensuring the razors were not left in resident's as she went and removed the disposable razors from the room and discarded them in the sharp's container. During an interview on 04/23/25 at 01:52 PM, the ADON said her expectation was for the disposable razors to be used and then disposed of properly in a sharp's container immediately after use. The ADON said the failure placed a risk for other residents getting the disposable razors and cutting themselves. She said all staff were responsible for ensuring no disposable razors or sharp objects were left out in reach of residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/23/25 at 02:04 PM, the Administrator said his expectation was for the CNAs to dispose of the disposable razors in the sharp's containers when they complete the residents' ADL care. He said the CNA assigned to the Resident #15 was responsible for ensuring the disposable razors were not left out in the room. The Administrator said the failure placed a risk for the resident or other resident to cut themselves. This was determined to be an Immediate Jeopardy (IJ) on 04/22/25 at 4:34 PM. The Administration was informed of the IJ. The Administrator was provided with the IJ template amendment on 04/23/25 at 11:54, and a plan of removal was requested. Record review of the facility's policy titled, Smoking Policy-Supervised and Unsupervised, revised 07/21/18 , indicated Safe Smoking Environment: it is the responsibility of the facility to provide a safe and hazard-free environment for those residents who have been assessed as being safe for facility smoking privileges. The facility is responsible for informing residents, staff, visitors, and other affected parties of the smoking policies through verbal means, distribution, and posting. This facility is intended to minimize the risk to residents: residents who smoke, including possible adverse effects on treatment; Passive smoke to others; and fire. Smoking accommodation: E cigarettes will be treated like cigarettes per policy at no time will E cigarettes be permitted for inside use of the facility. The facility is responsible for the enforcement of the smoking policy. Smoking is prohibited in any room or area within the facility. All residents who wish to smoke must provide funds to purchase their own smoking paraphernalia. Smoking Evaluation: Residents wishing to smoke while at the facility will have a smoking safety evaluation completed by the interdisciplinary team to determine the resident's ability to follow the smoking policy safely. If a resident is determined to be a safe smoker, the resident can smoke unsupervised, resident can keep their smoking supplies and smoke in a designated area at their leisure. Or a resident can smoke unsupervised, the facility will keep all smoking supplies, and the resident can smoke in designated areas at their leisure. If a resident is determined to be unsafe smoker then they must be supervised at all times when smoking facility staff will keep all smoking supplies and smoking times will be established by the facility and adhered to by the resident a supervised smoking schedule will be posted and residents will be required to smoke with supervision only according to the schedule. Record review of Plan of Removal accepted on 04/23/25 at 8:19 p.m. reflected the following: Plan of Removal Starting on 4/23/2025, resident #22, #48, and #32 will be supervised when in an unsafe area. The physician was notified of both the smoking and residents leaving safe supervised area. Immediately on 4/22/2025, all smoking assessments were audited for accuracy and care plan updated as indicated. Residents #22, #48, and #32 were reassessed and evaluation determined they are safe smokers and able to vape safely. Resident #25 was reassessed and evaluation determined he is an unsafe smoker. All smokers were reassessed, and changes made to safe or unsafe smoking, including vaping as indicated. Assessments completed by Corporate Clinical Specialist and Corporate Case Mix. Residents assessed to be unsafe will be supervised and smoking supplies will be held at the nurse's station. Residents assessed to be a safe smoker will be able to smoke unsupervised at their leisure in the designated smoking area. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/23/2025, an emergency care plan meeting was conducted with residents (#22, #48, #32, and #25) regarding safe supervision and smoking policy, to include vaping. Residents #22, #48 and #32 were informed they can smoke only in the smoking area of the facility. Resident #25 was informed that he remains and unsafe smoker and must be supervised. All smoking residents were educated in regards to the smoking area of the facility and informed that location is the only place they can smoke. Care plans updated as indicated to include education regarding safety plan and pedestrian safety. On 4/23/2025, Ombudsman notified of the incident with Resident #22, #48, and #32 smoking unsupervised in an unsafe area. Informed of Resident #25 incident of cigarette burn from 8/24/2024. On 4/23/2025, Medical Director notified of the incident with Resident #22, #48, and #32 smoking unsupervised in an unsafe area. Informed of Resident #25 incident of cigarette burn from 8/24/2024. On 4/22/2025, Corporate Clinical Specialist in-serviced Administrator and ADON regarding Accident/Hazard Supervision, specifically in regard to safe smoking policy, smoking assessment accuracy, designated smoking areas, and remaining in safe supervised area. Competency verified by quiz. Completed 4/22/2025. On 4/22/2025, facility Administrator and ADON in-serviced all staff regarding Accident/Hazard Supervision, specifically in regard to safe smoking policy, designated smoking areas, and remaining in safe supervised area. Competency verified by quiz. Staff will not be allowed to work until completion. Completed on 4/22/2025. On 4/23/2025, Corporate Clinical Specialist in-serviced staff on residents that are safe smokers and those that are not, and how to find that information. Completed 4/23/2025 On 4/23/2025, Corporate Clinical Specialist, or designee, in-serviced licensed nurses on completing smoking risk assessment accurately as related to current health concerns/conditions, resident capabilities, and resident smoking material preference (cigarettes and/or electronic cigarettes). In-service included that Licensed Nurses are responsible for completing the smoking assessments upon admission, change of condition, and quarterly. The above training regarding Accident/Hazard Supervision, specifically in regard to safe smoking and safe supervision will be implemented into new hire orientation effective 4/22/2025. To monitor compliance, residents will be monitored by the DON/designee through observations and communication with staff daily x4 weeks and monthly x3 months. DON/designee will review smoking assessments weekly x4weeks monthly x3 months. The QA committee will meet weekly for the next eight weeks to review compliance with the plan of action. If no further concerns are noted, the facility will continue to be monitored as per the routine facility QA committee. On 04/24/2025 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on 04/24/2025 at 01:35 PM, Resident #22 was in the designated smoking area with supervision while smoking. Record review of an in-service dated 4/22/2025 provided by Corporate Clinical Specialist to the Administrator and ADON regarding Accident/Hazard Supervision, specifically in regard to safe smoking policy, smoking assessment accuracy, designated smoking areas, and remaining in safe supervised area. Record review of competency verified by quiz, including all unsafe smokers to be supervised, encourage and educate on safe supervision areas, storage of paraphernalia, smoking assessments, and smoking violations were dated 4/22/2025 completed by the Administrator and ADON. Record review of an in-service dated 4/22/2025 provided by the facility Administrator and ADON was initiated to all staff regarding Accident/Hazard Supervision, specifically in regard to safe smoking policy, designated smoking areas, and remaining in a safe supervised area. Record review of 51 employees with a total of 51 competencies included questions regarding Accident/Hazard Supervision, specifically in regard to safe smoking policy, designated smoking areas, and remaining in safe supervised areas were verified by a quiz completed on 4/22/2025. Record review of in-service dated 04/23/2025, Corporate Clinical Specialist in-serviced staff on residents who were safe smokers and those who were not, and how to find that information. Re [TRUNCATED]

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on observation, interview, and record review the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice for 4 of 8 residents (Residents #103, #35, #203, and #36) reviewed for oxygen therapy. 1. The facility failed to ensure Resident #103 had physician's order in his chart for oxygen. 2. The facility failed to ensure Resident #35 's oxygen was placed on 2 liters per nasal cannula as ordered by the physician. 3.The facility failed to ensure Resident #203 had an oxygen order and an oxygen sign on her door. 4.The facility failed to ensure Resident #36 had orders for oxygen. These failures could place residents who receive respiratory care at risk for developing respiratory complications and a decreased quality of care. Findings Included: 1. Record review of Resident #103's face sheet, dated 04/23/25, reflected Resident #103 was an [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included metabolic encephalopathy (brain dysfunction caused by chemical imbalance in the blood). Record review of Resident #103's physician order summary report, dated 04/22/25, did not address Resident #103 had an order for oxygen. Record review of the MDS assessment list, accessed 04/21/25, reflected Resident #103's admission MDS had not been completed yet. Record review of the baseline care plan dated 04/17/25 reflected Resident #103 received oxygen therapy. Record review of Resident #103's hospital discharge medication list did not address oxygen. During an interview and observation on 04/21/25 at 11:30 a.m., Resident #103 was sitting in his wheelchair wearing oxygen via nasal cannula. Resident #103's five-liter oxygen concentrator was set on 2 LPM. Resident #103 stated he wore oxygen all the time due to SOB. During an interview on 04/24/25 at 9:00 a.m., LPN A stated she was Resident #103's 6am-2pm charge nurse. LPN A stated Resident #103 had the oxygen in use since admission. LPN A stated she was unaware Resident #103 did not have an order for oxygen until the state surveyor intervention. LPN A stated that it was the admitting nurse and all the nurses' responsibility to make sure orders were put in correctly. LPN A stated she had not had time to review Resident #103's orders for accuracy. LPN A stated a possible negative outcome for not having accurate orders for oxygen would be too much Co2 in the lungs. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/24/25 at 3:32 p.m., the ADON stated the nurse that admitted Resident #103 was very overwhelmed and asked the ADON if she could help with admission orders. The ADON stated she took the orders from the discharge paperwork and entered the medications from the discharge medication list. The ADON stated she was unsure if the order for oxygen was on the medication list. The ADON stated if the oxygen order was not on the discharge medication list, she would not have put the order in for oxygen. The ADON stated she was not aware that there were no orders for oxygen until surveyor intervention. The ADON stated she, and the DON were responsible for overseeing and monitoring new admissions. The ADON stated it was important to ensure orders were placed in PCC (electronic medical records) to make sure the staff know the resident required oxygen and ensure their levels were staying adequate. During an interview on 04/24/25 at 3:54 p.m., the Administrator stated he expected proper documentation by obtaining an order for oxygen. The Administrator stated the nursing management was responsible for overseeing nursing floor staff to ensure orders were put in and documented. The Administrator stated it was important to ensure orders were placed in PCC to adhere to the resident care plan. 45879 2. Record review of Resident #35's face sheet, dated 04/24/25, indicated a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included dementia (impaired ability to remember, think, or make a decision), shortness of breath, also known as dyspnea, (is the feeling of not getting enough air into your lungs), diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and high blood pressure. Record review of Resident #35's quarterly MDS assessment, dated 04/10/25, indicated Resident #35 understood and was understood by others. Resident #35's BIMS score was 06, which indicated she was severely cognitively impaired. The MDS indicated Resident #35 required extensive assistance with dressing, personal hygiene, toileting, bathing, bed mobility, transfers, and set-up/supervision for eating. The MDS during the 7-day look-back period did not indicate Resident #35 was receiving oxygen. Record review of Resident #35 's physician orders dated 04/17/25 indicated oxygen at 2 liters per minute via nasal cannula continuously. Record review of Resident #35 's physician orders dated 04/17/25 indicated to change oxygen tubing as needed. Record review of Resident #35 's care plan dated 04/21/25 indicated she required oxygen. The intervention was for staff to apply oxygen at 2 liters per minute via nasal cannula, continuously, and change oxygen tubing as needed. During an attempted interview and observation on 04/21/25 at 12:19 p.m., Resident #35 was in her bed with no oxygen on. Resident #35 did not have an oxygen concentrator in her room. Resident 335 was not able to say if she wore oxygen or not. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #203's face sheet, dated 04/24/25, indicated a [AGE] year-old female who was admitted to the facility on ,d+[DATE] /25 with diagnoses which included urinary tract infection, also known as a UTI (is an infection in any part of the urinary system), stroke, diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and high blood pressure. Record review of Resident #203's admission MDS assessment, dated 04/03/25, indicated Resident #203 understood and was understood by others. The MDS assessment indicated she had a BIMS score of 0, indicating she was severely cognitively impaired. Resident #203 required assistance with bathing, toileting, dressing, bed mobility, personal hygiene, and eating. The MDS did not indicate she required oxygen. Record review of Resident #203 's physician orders dated 04/21/25 did not indicate any oxygen orders. Record review of Resident #203 's physician orders dated 04/23/25, after the surveyor's intervention indicated oxygen at 2 liters per minute via nasal cannula continuously. Record review of Resident#203's care plan dated 04/10/25 did not indicate she required oxygen. During an observation on 04/21/25 at 11:39 a.m., Resident #203 was in her room wearing oxygen at 3 liters per nasal cannula. Resident #203 did not have a smoking sign outside of her door. Resident #203 said she had been wearing oxygen for 2 years and needed it to help her breathe. During an observation and interview on 04/23/25 at 9:09 a.m., LVN verified that Resident #203 was receiving oxygen at 3 liters per nasal cannula and did not have a smoking sign on her door. She said sometimes they fall, and she was unaware of where they went. She said she would ask the maintenance supervisor for the oxygen signs. 4. Record review of Resident #36's face sheet, dated 04/24/25, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Apraxia (a neurological disorder that makes it difficult to plan and execute purposeful movements), shortness of breath, also known as dyspnea, (is the feeling of not getting enough air into your lungs), high blood pressure, Dementia (impaired ability to remember, think, or make a decision) and Depression (feeling of sadness). Record review of Resident #36's quarterly MDS assessment, dated 01/25/25, indicated Resident #36 understood and was understood by others. Resident #36's BIMS score was 12, which indicated she was moderately cognitively impaired. The MDS indicated Resident #36 was independent with dressing, personal hygiene, toileting, bathing, bed mobility, transfers, and eating. The MDS during the 7-day look-back period did not indicate Resident #36 was receiving oxygen. Record review of Resident #36 's physician orders dated 10/17/24 indicated to change O2 tubing as needed for infection control. Record review of Resident #36 's physician orders dated 04/21/25 did not indicate any oxygen orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #36 's physician orders dated 04/24/25, after the surveyors' intervention indicated O2 at 2 liters per minute via nasal cannula continuously. Record review of Resident#36's care plan revised on 02/21/25, did not indicate she required oxygen. During an observation on 04/21/25 at 11:31 a.m., Resident # 36 was sitting on the side of her bed. Resident #36's oxygen was not on, but she said she had just taken off her oxygen. She said she had her oxygen saturation checked frequently, and if needed, she would apply her oxygen. During an interview on 04/22/25 at 3:45 p.m., LVN C said Resident #203 and Resident #36 wore oxygen. She said Resident #36 was on 2 liters per nasal cannula as needed, as she was a smoker, and her oxygen saturation rates would decrease without oxygen. She said Resident #203 was on 3 liters per nasal cannula and was admitted on oxygen. She said she was unaware why Resident #35 had orders for oxygen. She said she had never placed Resident #35 on oxygen. LVN C looked into the computer system and said the ADON placed Resident #35 on oxygen but said she did not know why. She said when a nurse received a new order, it should be written and placed on the 24-hour report so that other nurses would know. She said it was important to write orders to ensure residents were receiving the correct amount of oxygen, and if not, it could lead to further respiratory issues. She said she would notify the doctor and get the orders updated to the correct ones. During an interview on 04/24/25 at 3:27 p.m., LVN U said Resident #203 and Resident #36 wore oxygen, and she did not realize they did not have oxygen orders. She said it was important to have an oxygen order in the electronic records so that staff were aware they needed oxygen. During an interview on 04/24/25 at 4:06 p.m., the ADON said the charge nurses were responsible for placing orders in the computer when they received a new order. She said she did not know why Resident #36 and Resident #203 did not have oxygen orders. She said she could not remember why she obtained the oxygen order for Resident # 35. She said she had been doing too many tasks and had not been following through with checking orders. She said if a nurse looked in the computer system and did not see an order, they could potentially remove Resident #36 and Resident #203's oxygen and cause respiratory issues. She said it was important to have orders in the system and follow them to prevent respiratory issues. During an interview on 04/24/25 at 4:27 p.m., the Administrator said nurse managers were the overseers of orders. He said oxygen should not be applied without an order. He said that without a written order, staff would not know the correct oxygen rate. He said if a resident had an order for oxygen, it should be applied. He said failure to have an oxygen order or follow the oxygen order could cause respiratory issues. Record review of facility policy titled, Oxygen Administration, revised May 2024, indicated, Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: Verify there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration. Equipment and Supplies: #4 No smoking/oxygen in use signs .

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 45810 Based on observation, interview, and record review the facility failed to post the nurse staffing data on a daily at the beginning of each shift for 2 days of 23 days of reviewed for April 2025 nursing staffing. The facility failed to post the total number of hours worked for licensed nurses and certified nurse aides or the daily census on April 22, 2025, and April 23, 2025. This failure could place residents at risk of being unaware of the facility daily staffing requirements. Findings included: During an observation on 04/22/25 at 5:21 PM the staffing sheet was hung on the employee bulletin board by the time clock on the hallway leading outside to the smoking area with a date of 04/21/25. During an observation on 04/23/25 at 09:00 AM the staffing sheet was hung on the employee bulletin board by the time clock on the hallway leading outside to the smoking area with a date of 04/21/25. During an interview on 04/23/25 at 01:50 PM the ADON said she was responsible for the daily staffing because they did not have a DON. She said she had just been busy and missed completing the staffing form for 04/22/25 and 04/23/25. The ADON said she did not know what risk not posting the staffing caused for the residents. She said she knew it was just a regulation for long term nursing facilities related to staffing. The ADON said she just completed the staffing forms daily to ensure adequate staffing was in the facility. During an interview on 04/23/25 at 02:17 PM the Administrator said he expected the staffing to be completed by the ADON and posted daily. He said the failure placed a risk for staffing to be missed or for residents and families not able to be aware of the staffing numbers. Record review of the facility policy Posting Direct Care Daily Staffing Numbers dated last reviewed 3-2023 indicated: Policy Statement Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review, the facility failed to ensure each resident's drug regimen was free of unnecessary medication for 1 of 9 residents reviewed for unnecessary medication (Resident #40) The facility did not monitor Resident #40 for side effects of the anticoagulation medication, Eliquis (a blood-thinning medication). This failure could place the residents at risk for adverse consequences of the anticoagulant medication. Findings included: Record review of a face sheet dated 04/25/25 indicated Resident #40 was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with a diagnosis of atrial fibrillation (irregular, often rapid heart rate that causes poor blood flow), and atherosclerotic heart disease (a condition where plaque buildup narrows the arteries that supply blood to the heart, leading to a reduced blood flow and oxygen delivery to the heart muscle). Record review of Resident #40's care plan, initiated on 10/17/24, indicated an anticoagulant medication of Eliquis for the diagnosis of Atrial fibrillation. The interventions were for staff to administer medication as ordered and monitor/document/report adverse reactions of anticoagulant therapy, such as: black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, loss of appetite, or sudden changes in mental status. Record review of Resident #40's annual MDS dated [DATE] indicated Resident #40 understood and was understood by others. The MDS assessment indicated she had a BIMS score of 15, which meant she was cognitively intact. Resident #40 required assistance with bathing, toileting, dressing, bed mobility, personal hygiene, and eating. The MDS during the 7-day look-back period indicated she received an anticoagulant medication. Record review of Resident #40's physician orders dated 03/06/25 indicated Eliquis 5 mg, give 1 tablet two times a day for infection and inflammatory reaction due to the internal left knee prosthesis. The order did not address monitoring the anticoagulant medication. Record review of a medication administration record dated 04/01/25 through 04/21/25 for Resident #40 did not indicate any monitoring for anticoagulant medication. During an observation and interview on 04/21/25 at 12:31 p.m., Resident # 40 was in her bed with no observed bruised areas. She said she received an unknown blood thinner. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 04/24/25 at 3:27 p.m., LVN C said she was Resident #40's nurse. She said Resident #40 received Eliquis. She said anticoagulant monitoring should be done if a resident was on an anticoagulant medication. She said they should monitor for any bruising or bleeding. She looked at Resident #40's electronic record and did not see the anticoagulant monitoring listed. She said the nurse who received the medication of Eliquis for Resident #40 should have entered the anticoagulant monitoring. During an interview on 04/24/25 at 4:06 p.m., the ADON said she expected all anticoagulant medication to be monitored for side effects on entry of the medication order. She said the admitting nurse was responsible for adding the anticoagulant monitoring into the computer system for all anticoagulants. She said the nurses providing care for the resident and herself were the backup to ensure side effect monitoring was added into the computer system for all anticoagulants. The ADON said Resident #40's Eliquis should have been monitored for side effects but was not. She said the monitoring was overlooked. She said the risk of anticoagulant medication monitoring not being added into the computer system was staff being unaware to monitor for bleeding or bruising. During an interview on 04/24/25 at 4:27 p.m., the Administrator said the nurses providing care for the resident were responsible for ensuring all anticoagulant medication was monitored for side effects. He said the ADON was responsible for ensuring the side effect monitoring was added to the computer system. The Administrator said the resident's risk was potential bruising or bleeding. During an interview on 04/24/25 at 4:30 p.m., the ADON said she did not have a policy on anticoagulant monitoring or medication administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on observations, interviews, and record review the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel for 1 of 18 resident (Resident #103) reviewed for medications at their bedside. The facility did not ensure Resident #103's fluticasone propionate (nasal spray), biotene dry mouth Moisturizing Spray, and barbasol shaving cream were secured in locked compartments and not left on his bedside table and windowsill. This failure could place residents at risk for misuse of medication, overdose, drug diversions, adverse reactions of medications, and not receiving the therapeutic benefit of medications. Findings included: Record review of Resident #103's face sheet, dated 04/23/25, reflected Resident #103 was an [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included metabolic encephalopathy (brain dysfunction caused by chemical imbalance in the blood). Record review of Resident #103's physician order summary report, dated 04/22/25, did not address the use of fluticasone propionate (nasal spray) or biotene dry mouth moisturizing spray. Record review of the MDS assessment list, accessed 04/21/25, reflected Resident #103's admission MDS had not been completed yet. Record review of the baseline care plan dated 04/17/25 reflected Resident #103 required partial/moderate assistance with personal hygiene/eating, set-up or clean-up assistance with oral hygiene and substantial/maximum assistance with toileting and shower/bath. During an interview and observation on 04/21/25 at 11:30 a.m., Resident #103 was sitting in his wheelchair and the state surveyor observed a bottle of Fluticasone Propionate (nasal spray) and biotene dry mouth moisturizing Spray on his bedside table. There was a can of barbasol shaving cream observed in the window sill. Resident #103 stated he used the nasal spray for allergies BID, dry mouth moisturizing spray as needed and the barbasol every morning with staff. During an interview on 04/24/25 at 9:00 a.m., LPN A stated Resident #103 had not been evaluated for self-administration of medications. LPN A stated if a resident was able to self-administer, he/she must be assessed for competence. LPN A stated once the resident was safe to self-medicate an order must be obtained. LPN A stated the family member brings medications and other items in she thinks Resident #103 needs. LPN A stated medications should be stored on the medication cart and the shaving cream should be stored in the storage closet. LPN A stated it was important to ensure medications were not left at bedside for resident safety. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/24/25 at 3:32 p.m., the ADON stated she expected medications to be stored securely by nursing and shaving cream stored in the shower room. The ADON stated she was not aware Resident #103 had those things in his room, but she will be educating the resident and family member. The ADON stated if a resident would like to self-administer, he/she must be assessed, and an order must be obtained from the MD to self-administer. The ADON stated she, and the DON were responsible for overseeing and monitoring that residents did not have items that were not supposed to be in their rooms. The ADON stated without a DON in the building it was a lot to keep up with as one person. The ADON stated it was important to ensure medications/shaving cream were not left at bedside for resident safety and to prevent harm. During an interview on 04/24/25 at 3:54 p.m., the Administrator stated his expectations were that all medications were left with the nurse unless the resident was assessed to self-administer. The Administrator stated shaving cream should be stored in the shower room out of the reach of residents. The Administrator stated the DON/ADON was responsible for monitoring and overseeing. The Administrator stated it was important to ensure medications were not left at bedside for resident safety. Record review of the facility policy Storage of Medications reviewed, July 2024, indicated . Policy Statement The facility stores all drugs and biologicals in a safe, secure, and orderly manner . Policy Interpretation and Implementation . 1. Drugs and biologicals used in the facility and are stored in locked compartments under proper temperature, light, and humidity controls .

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview and record review, the facility failed to ensure laboratory services were obtained to meet the needs of 1 of 18 residents (Resident #25) reviewed for laboratory services. The facility failed to ensure Resident #25's Comprehensive Metabolic Panel, also known as CMP (a blood test that checks for a wide range of substances in your blood, including proteins, enzymes, electrolytes, and minerals) was drawn every 6 months as ordered. Also, his Phenobarbital (used to control seizures) and Dilantin (an anti-seizure medication) levels were not drawn every 3 months as ordered. This failure could place residents at risk of not receiving lab services as ordered and not managing medications at a therapeutic level. Finding included: Record review of Resident #25's face sheet, dated 04/24/25, indicated an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included seizures, anemia (a condition where the blood doesn't have enough healthy red blood cells or hemoglobin to carry oxygen to the body's organs and tissues), glaucoma (a group of eye conditions that damage the optic nerve, potentially leading to vision loss or blindness), and high blood pressure. Record review of Resident #25's quarterly MDS assessment dated [DATE], indicated Resident #25 understood and was understood others. The MDS assessment indicated he required assistance with bathing, toileting, dressing, bed mobility, personal hygiene, and eating independently. Record review of Resident #25's comprehensive care plan, last reviewed on 07/24/22, indicated Resident #25 had epilepsy. The interventions were to obtain and monitor lab/diagnostic studies as ordered. Report results when available to the physician and follow up as needed. Record review of Resident #25's physician orders dated 01/09/25 indicated CMP every 6 months. Record review of Resident #25's physician orders dated 01/09/25 indicated Phenobarbital and Dilantin level upon admission, and every 3 months, (December, March, June, September). Record review of Resident #25's physician orders dated 01/09/25 indicated Phenobarbital 32.4 milligrams, give 32.4 mg by mouth two times a day, related to seizures. Record review of Resident #25's physician orders dated 01/09/25 indicated Phenytoin Sodium Extended Capsule 100 milligram, give 1 capsule by mouth in the morning, related to seizures. Record review of Resident #25's physician orders dated 01/09/25 indicated Phenytoin Sodium Extended Capsule 100 milligram, give 2 capsules by mouth at bedtime, related to epilepsy. Record review of Resident #25's electronic health record revealed his last CMP was drawn on 07/06/24. It did not indicate any CMP afterwards. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #25's electronic health record revealed his last Phenobarbital and Dilantin level was drawn on 11/27/24. It did not indicate any Phenobarbital or Dilantin levels were drawn after 11/27/24. During an interview on 04/24/25 at 3:27 p.m., LVN U said when the nurses received an order for a lab, they would enter it in their electronic system. She said they used an outside lab company that was able to see what labs were ordered and due. She said she did not know about routine labs, but nurses could check daily to see what labs had been drawn and the results, if ready. She said if a resident had an abnormal lab, they were supposed to call the doctor, the responsible party, and document in the nurse's notes. She said it was important to notify the doctor of any abnormal labs so he would know and in case he needed to change medication. During an interview on 04/23/25 at 4:06 p.m., the ADON said she expected labs to be drawn per the physician's order. The ADON said she was unaware Resident #25 was missing his labs until questioned by the state surveyor. The ADON said they did not have an effective lab monitoring system in place. The ADON said she had started a QAPI related to several labs noted not done as ordered. The ADON said it was important to ensure labs were drawn per the physician's order to ensure their health had been monitored per those lab values. During an interview on 04/23/25 at 4:27 p.m., the Administrator said he expected labs to be drawn as ordered. He said the ADON was the overseer of labs. He said the ADON had already let him know they had a lab problem, and they were going to come up with a solution. The Administrator said it was important that labs were drawn per the physician's orders to ensure the residents were getting the highest quality of care for their health. Record review of the facility's policy titled Laboratory Services revised January 2023 indicated Policy: It is the policy of this facility to ensure that laboratory services meet the needs of residents and that the results are reported promptly to the ordering provider to address potential concern and for disease prevention, provide for resident assessment, diagnosis, treatment, and that the facility has established policies and procedures. Procedure: #3 The facility will provide or obtain laboratory services only when ordered by a physician in accordance with state law, including scope of practice law. #4 The facility will promptly notify the ordering physician of laboratory results that fall outside of clinical reference ranges. Critical labs will be called in to the provider, and other lab results will be made available per the provider's preference. #5 The facility will file the results of lab reports and document communication with the physician and responsible party in the medical records.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interview and record review the facility failed to promptly notify and follow-up with the ordering physician regarding laboratory results outside of clinical reference range for 1of 18 residents (Resident #1) reviewed for laboratory services. 1. The facility did not ensure the physician was notified when Resident #1's Dilantin (used to control seizures) and Phenobarbital (used to control seizures) level was low. This failure could place residents at risk of not receiving lab services as ordered and not managing medications at a therapeutic level. Findings included: Record review of Resident #1's face sheet, dated 04/23/25, reflected Resident #1 was a [AGE] year-old male, readmitted to the facility on [DATE] with diagnosis which included seizures (sudden, uncontrolled electrical disturbance in the brain). Record review of the order summary report, dated 04/23/25, reflected an active physician order for Phenytoin (Dilantin) 100 mg: 1 tablet by mouth BID related seizures with a start date 04/22/25. Record review of the order summary report, dated 04/23/25, reflected an active physician order for Phenobarbital 97.2 mg: 1 tablet by mouth QD related to seizures. Record review of Resident #1's quarterly MDS, dated [DATE], reflected Resident #1 made himself understood, and understood others. Resident #1's BIMS score of 10, which indicated his cognition was moderately impaired. Resident #1 had an active diagnosis of a seizure disorder or epilepsy. Resident #1 took an anticonvulsant 7 out of 7 days during the look-back period. Record review of Resident #1's comprehensive care plan revised 04/30/24, reflected Resident #1 had a seizure disorder related to head injury as a young man. The care plan interventions included give medication as ordered, monitor labs, and report any sub therapeutic or toxic results. Record review of a lab report dated 04/02/25 reflected labs were collected and approved on 04/02/25 with a Dilantin level of 4.3 and Phenobarbital level 8.7 which reflected both levels were low. The report reflected the physician was not notified until 04/22/25 when the state surveyor [NAME] it to the ADON attention. The physician gave orders to increase both medications and recheck Dilantin in 1 week. Record review of Resident #1's electronic medical records reflected Resident #1 had not had any seizure activity in the past year. (continued on next page)

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	675471	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Star Ranch Rehabilitation and Health Care Ce	709 W Fifth St Bonham, TX 75418

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/23/25 at 2:28 p.m., the ADON stated she expected the charge nurses who received the results to notify the physician in a timely manner of all abnormal labs. The ADON stated honestly, she thought the physician was reviewing the labs through PCC (electronic medical records) but was told by the physician 04/22/25 he was not aware of where to find the lab results. The ADON stated it would take her past the recertification to determine what nurse would be responsible for contacting the physician regarding Resident #1 labs. The ADON stated her, and the DON was responsible for monitoring and overseeing labs. The ADON stated without a DON in the building it was a lot to keep up as one person. The ADON stated not following up the physician with abnormal labs could affect the resident's health. During a telephone interview on 04/24/25 at 11:52 a.m., the Physician stated he was not able to review labs in PCC due to technical issues. The Physician stated he should be notified via phone of an abnormal lab. The Physician stated his expectation was to be notified within 2-3 days. The Physician stated it was important he was notified of abnormal labs to prevent Resident #1 from having a seizure. During an interview on 04/24/25 at 3:54 p.m., the Administrator stated he expected the physician to be notified in a timely manner of labs. The Administrator stated the DON and ADON were responsible for overseeing and monitoring labs. The Administrator stated it was important the facility was made aware of the abnormal to prevent a seizure. Record review of the facility's policy titled Laboratory Services revised, January 2023 indicated . It is the policy of this facility to ensure that laboratory services meet the needs of residents and that the results are reported promptly to the ordering provider to address potential concern and for disease prevention, provide for resident assessment, diagnosis, treatment, and that the facility has established policies and procedures. Procedure: #3 The facility will provide or obtain laboratory services only when ordered by a physician in accordance with state law, including scope of practice law. #4 The facility will promptly notify the ordering physician of laboratory results that fall outside of clinical reference ranges. Critical labs will be called in to the provider, and other lab results will be made available per the provider's preference. #5 The facility will file the results of lab reports and document communication with the physician and responsible party in the medical records .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on observation, interviews, and record review, the facility failed to follow menus for 1 of 12 residents (Resident #4) meal reviewed for menus. The facility did not ensure Resident #4 received ground chicken fried chicken as ordered instead of ground beef patty. This failure could result in a decrease in resident choices, diminished interest in meals, and weight loss. Findings included: Record review of Resident #4's face sheet, dated 04/24/25, reflected Resident #4 was a [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included myocardial infarction (heart attack). Record review of Resident #4's physician order summary report, dated 04/24/25, reflected an active physician's order for a mechanical diet with a start date 04/21/25. Record review of Resident #4's quarterly MDS assessment, dated 03/26/25, reflected Resident #4 usually made himself understood, and usually understood others. Resident #4's BIMS score was 4, which indicated his cognition was severely impaired. Resident #4 required set-up or clean-up assisting with eating. Resident #4 required a mechanically altered diet. Record review of the comprehensive care plan, revised 02/25/25, reflected Resident #4 received a mechanically altered diet (regular chopped meat texture). The care plan interventions included assist resident with meals as needed, set up meal tray, cut foods, and provide assistance as needed. Record review of Resident #4's lunch meal ticket dated 04/21/25 reflected ground fried chicken for the entree as ordered. During an observation and interview on 04/21/25 at 12:43 p.m., Resident #4 was sitting at the table in the dining room. Resident #4 received ground beef patty. The state surveyor showed CNA B that Resident #4 did not receive chicken fried chicken. CNA B stated he should have received ground chicken fried chicken instead of ground beef patty. An attempted interview with Resident #4, indicated he was non-interview able. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/24/25 at 8:03 a.m., [NAME] C stated Resident #4 should have been served ground chicken fried chicken instead of ground beef patty. [NAME] C stated Resident #4 received the ground beef patty instead of the ground chicken fried chicken because when the residents on a regular diet asked for seconds or more, she would have enough to give them. [NAME] C stated she used hamburger patty instead for the residents on a mechanical diet. [NAME] C stated she gave the residents on mechanical and pureed diet a different meat so when the regular diet asked for seconds or more, she would have enough to give them. [NAME] C stated she was educated by the Dietary Manager on 04/21/25 that she should be preparing the same meat for all diets. [NAME] C stated it was important all residents received the same entree because it was their right. During an interview on 04/24/25 at 8:38 a.m., the Dietary Manager stated she was unaware that [NAME] C was not preparing all three textures the same meat until 4/21/25. The Dietary Manager stated the menu that [NAME] C should follow would tell her that all residents received the same meal. The Dietary Manager stated prior to 04/21/25 she had never had any issues with [NAME] C not preparing the same meat for all textures. The Dietary Manager stated she felt comfortable with not watching [NAME] C on Monday because she had an employee that required 1 on 1 and more attention. The Dietary Manager stated when she realized residents on mechanical and pureed diets were being served ground beef patty instead of the chicken fried chicken it was too late to fix. The Dietary Manager stated [NAME] C was immediately in-serviced. The Dietary Manager stated she was responsible for monitoring and overseeing meals by random spot checks. The Dietary Manager stated it was important menus were followed so that the residents would get the proper diet and texture of food and beware of any allergies/dislikes/likes. During an interview on 04/29/25 at 9:00 a.m., LPN A stated she was the charge nurse responsible for checking Resident #4's tray. LPN A stated she was not aware that he received a ground beef patty instead of chicken fried chicken until the state surveyor intervention. LPN A stated the meat was ground and she did not know it was ground beef patty instead of chicken. LPN A stated it was important menus were followed to prevent residents feeling bad that they did not receive what was on the menu. During an interview on 04/24/25 at 3:54 p.m., the Administrator stated he expected the dietary staff to follow the recipe and meal ticket. The Administrator stated he expected LPN A to return the tray and have the dietary staff to fix the entree. The Administrator stated the dietary manager was responsible for monitoring and overseeing the meals and ensuring the menu was followed. The Administrator stated he conducted random spot checks to ensure the correct meals were being served. The Administrator stated he did not notice any issues in the past. The Administrator stated it was important to follow the menu because it was part of their individualized diet plans. Record review of the facility's policy, titled Menus, reviewed 06/12/24, indicated . menus are developed and prepared to meet resident choices .

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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. 45810 Based on observation, interview, and record review the facility failed to provide residents with food and drink that was palatable, attractive, and at a safe and appetizing temperature for 4 of 18 residents (Resident #31, Resident #47, Resident #8, and Resident #42) and 1 of 3 meals observed. The facility failed to provide palatable food served at an appetizing temperature or taste to Resident #47, Resident #31, Resident #8, and Resident #42. The facility failed to provide food that was palatable for 1 of 3 meals observed on 04/22/25 (lunch) meal. This failure could place residents at risk of decreased food intake, weight loss, altered nutritional status, and a diminished quality of life. Findings include: During an interview on 04/21/25 at 11:55 AM Resident #31 stated when staff bring her food it's cold. Stated it makes her sad and pissed. Staff was aware of her food complaints but unable to recall names of staff who were aware of her food complaints. During an interview on 04/21/25 at 12:07 p.m., Resident #8 said the food was cold, and sometimes it had no taste. During an observation on 04/21/25 at 12:20 PM the staff began passing meal trays in the East wing RN H was in the dining room checking trays as they were delivered to each resident. All trays for residents in the dining room and the hall were on one cart. RN H had to remove trays and place them back on the cart multiple times to find the resident's trays the staff needed to serve who were eating in the dining room. During an interview on 04/21/25 at 12:47 p.m., Resident #42 said the food was cold and bland. During an observation and interview on 04/21/25 at 12:54 PM Resident #47 was sitting in his room eating lunch, that included a roll with a dark colored bottom, on his table. He said his roll was burned and he could not eat it. During an observation and interview on 04/22/2025 at 12:30 PM the Dietary Manager and four surveyors sampled a lunch tray. The sample tray consisted of pinto beans with sausage which was warm and okay to taste but not fully cooked, steamed rice that was bland, spinach that was bland and not warm, corn bread that was okay but not warm, and frosted red velvet cake that was okay. The Dietary Manager said she felt the food was okay because they followed the recipe. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/23/25 at 10:00 AM the Dietary Manager said there was not enough time to cook different food and seasoning differently for every resident in the facility and some residents could not have salt. She said the kitchen staff follows the recipe. The Dietary Manager said she did expect the residents to have hot and good food, but she was still in training and the staff were learning as well. She said she was accustomed to using a steam table out where the residents were served. The Dietary Manager said she wished the facility had more carts to provide a better way to get the food out hot. She said it was the residents' right to eat hot food like the staff eat at their homes. During an interview on 04/23/25 at 01:42 PM the ADON said she expected the residents to be able to receive food that was palatable and warm at meal service. She said the Dietary Manager was responsible for preparing the food and everyone was responsible for ensuring the residents received the meals timely and hot. The ADON said the failure placed residents at risk for weight loss. During an interview on 04/23/25 at 02:07 PM the Administrator would not give an answer related to the food tastes and temperatures. During an interview on 04/23/25 at 2:07 PM the Executive Director said hot and palatable food should always be served. He said the cook does not spice the food because the recipes are followed, and the residents are sent out salt and pepper. The Executive Director said the dietary staff were responsible for preparing the foods and staff responsible for delivering in a timely manner. The Executive Director said the failure caused the residents to get hungry quicker.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 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 in (1 of 1) kitchen reviewed for dietary services, in that: 1) The facility failed to ensure the ice scoop holder did not have sediment in the bottom. 2) Dietary staff failed to dispose of expired boiled eggs in the refrigerator dated [DATE]. These failures could place residents at risk for food contamination and foodborne illness. The findings include: Record review of the facility daily cleaning list date [DATE]-[DATE] indicated [DATE] was the last date the ice scoop holder in the facility was cleaned and no other list was provided. During an observation on [DATE] at 10:25 AM the facility refrigerator had a bag of boiled eggs dated [DATE] with no other date on it. During an observation on [DATE] at 11:15 AM the ice scoop holder at the main dining room ice machine had orangish-brown sediment in the bottom of it. During an observation on [DATE] at 12:10 PM the ice scoop holder continued to have orangish-brown sediment in the bottom of it. During an observation and interview on [DATE] at 09:49 AM the Dietary Manager came out of the kitchen and observed the ice scoop holder that continued to have orangish-brown sediment in the bottom of it. She said the kitchen staff were responsible for cleaning the ice scoop holder and she looked in the container to see the orangish-brown sediment and removed it to be cleaned. The Dietary Manager then brought out a schedule from [DATE], which indicated the last time the ice scoop and holder had been cleaned, and said she had a more recent one but would have to find it. The Dietary manage provided the daily cleaning list dated [DATE]-[DATE] and said that was the last date the ice scoop holder was cleaned. During an interview on [DATE] at 09:57 AM the Dietary Manager said she had 7 days from the date of opening for eggs to be kept in the refrigerator and she said the eggs dated [DATE] had been discarded. She said all the kitchen staff were responsible for ensuring the food is removed in a timely manner. The Dietary Manager said the failure placed the residents at risk of getting exposed to bacteria and food borne illnesses. During an interview on [DATE] at 01:44 PM the ADON said she expected the kitchen staff to check the expiration dates and times of disposal and ensure foods were thrown away properly. She said the failure placed residents at risk of sickness from spoiled food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 01:46 PM the ADON said she expected the ice machine and scoop to be cleaned per the facility policy and the dietary staff were responsible for ensuring the cleanings were completed. The ADON said the failure placed residents at risk of getting sickness from the kitchen staff being unsanitary. During an interview on [DATE] at 02:13 PM the Administrator said his expectation was for the fridge to be gone through daily by the dietary staff and the staff should have ensured outdated foods were removed. The Administrator said the failure placed residents at risk for food borne illnesses. During an interview on [DATE] at 02:15 PM the Administrator said he expected the ice scoop holder and the ice machine to be regularly inspected and cleaned on a schedule and the dietary staff were responsible. He said the failure placed residents at risk for potential foodborne illnesses. Record review of the facility policy Food Receiving and Storage dated [DATE] indicated: Policy Statement Foods shall be received and stored in a manner that complies with the safe food handling practices. Policy Interpretation and Implementation 1. Food Services, or other designated staff, will maintain clean food storage areas at all time .8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date) . Record review of the facility policy Sanitization revised [DATE] indicated: Policy Statement The Food service area shall be maintained in a clean and sanitary manner. Policy Interpretation and Implementation 1.All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies, and other insects . 3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions . 11. Ice machines and ice storage containers will be drained, cleaned and sanitized per manufacturer's instructions and facility policy .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public, for 4 of 4 eyewash stations reviewed (kitchen eyewash, laundry eyewash station, east wing medication room eyewash station, and east wing shower room eyewash station) reviewed for physical environment. The facility failed to ensure the Saline eyewash solutions located in the kitchen, the medication room on east wing, the laundry, and the shower room were within the date of expiration. Findings included: During an observation on [DATE] at 10:25 AM the two bottles of saline eyewash solution in the kitchen at the eyewash station were out of date and labeled with an expiration date of ,d+[DATE] for the left-side bottle and ,d+[DATE] for the right-side bottle. During an observation and interview on [DATE] at 8:10 AM the bottle of saline eyewash solution in the east wing medication room was expired with an expiration date of ,d+[DATE] on the bottle. RN H said the Maintenance man was responsible for changing the eyewash out and she would notify him of the expiration date. During an observation and interview on [DATE] at 03:03 PM the eyewash station in the kitchen continued to have expired solution. The left-side bottle expired on ,d+[DATE] and the right-side bottle expired ,d+[DATE]. The Dietary Supervisor said they should have been checked and changed out, but the Maintenance man did not have any to replace the old ones and he was ordering new saline solution. During an observation on [DATE] at 8:46 AM the saline eyewash solution in the laundry was expired with an expiration date of ,d+[DATE]. During an observation and interview on [DATE] at 2:15 PM, the saline eyewash solution located in the east wing shower room was dated ,d+[DATE]. CNA B looked at the eye wash solution and verified it was dated , d+[DATE]. She said she did not know who was responsible for checking the saline eyewash solution. During an interview on [DATE] at 09:37 AM the Maintenance man said he was responsible for checking the eye wash and he normally checked the solutions every 6 months, and he guessed it just slipped his mind. The Maintenance man said the failure placed staff at risk of not being able to wash their eyes if needed and severe damage. During an interview on [DATE] at 01:48 PM the ADON said the eye wash solution should have been monitored per policy and she was unsure of what the times were. She said she expected the eyewash to be within the date of expiration. The ADON said the failure could result in the eye wash not being as effective in an event of chemicals in the eyes. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 02:19 PM the Administrator said his expectation was for the eyewash to be regularly inspected and ensure the bottles of saline eyewash solutions were within the dates of expiration. The Administrator said the failure could result in the eyewash to be ineffective if needed in an emergency. Record review of the facility policy Storage of Medications reviewed [DATE] indicated: Policy Statement The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation 1. Drugs and biologicals used in the facility and are stored in locked compartments under proper temperature, light and humidity controls .5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. 43047 Based on observation, interview, and record review, the facility failed to establish policies regarding smoking areas, and smoking safety for 1 of 1 smoking area. The facility failed to ensure cigarettes were not discarded in the trash can designed for the disposing of trash. This failure could place residents who smoke at risk of physical harm and lead to an unsafe smoking environment. Findings Included: During an observation of the and interview on 04/22/25 at 11:05 a.m., there was a trash can with a cigarette that had been smoked noted inside the trash can located in the designated smoking area. Laundry Aide EE stated whoever takes the residents out to smoke should check the trash can for cigarettes. Laundry Aide EE stated the trash can should not have cigarettes inside, only trash. Laundry Aide EE stated this failure could put residents at risk for a fire. During an interview on 04/24/25 at 3:54 p.m., the Administrator stated cigarettes should be extinguished in the receptable, not a trash can. The Administrator stated whoever takes the residents out to smoke should be monitoring and ensuring the cigarettes are being put out in the proper place. The Administrator stated he did random spot checks and has not noticed any issues. The Administrator stated it was important cigarettes were extinguished in the receptable for fire safety. Record review of a facility's policy titled Facility Smoking Policy Unsupervised and Supervised Smoking, revised 07/11/22, indicated . It is the responsibility of the facility to provide a safe and hazard free environment for those residents having been assessed as being safe for facility smoking privileges .