STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675498	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Heights Rehabilitation Suites	6650 South Soncy Road Amarillo, TX 79119

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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** 48491 Based on interviews and record reviews the facility failed to ensure the residents had the right to participate in his or her treatment which included the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred, for 1 of 24 residents (Resident #38) reviewed for resident rights. The facility failed to obtain a signed informed consent based on information of the benefits, risks, and options available for Resident #38's prior to administering Seroquel, a psychotropic medication, (a psychoactive drug taken to exert an effect on the chemical make-up of the brain and nervous system). This failure could place residents at risk of receiving medications without their prior knowledge or consent, or that of their responsible party or being aware of the benefits and risks of the medications prescribed. Findings included: Record review of Resident #38's face sheet, dated 01/22/2025, revealed a [AGE] year-old-female who was admitted to the facility on [DATE] with diagnoses to include anxiety disorder (fears that are strong enough to interfere with daily life), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), muscle weakness, unspecified dementia (cognitive loss), cognitive communication deficit (impaired thought processes), and difficulty walking. Record review of admission MDS assessment dated [DATE] revealed Resident #38 was sometimes understood. The MDS revealed Resident #38 had a BIMS score of 7 out of 15 which indicated the resident's cognition was severely impaired. Record Review of Section N0415 indicated Resident #38 was taking antidepressants, antipsychotics, and antianxiety medications. Record review of a care plan for Resident #38 dated 12/28/2024 revealed a focus area of Psychotropic Drug Use: Resident is at risk for adverse consequences related to receiving treatment of anxiety. Goal section of care plan revealed that Resident #38 will not exhibit signs of drug related side effects or adverse drug reaction. Approach section of care plan stated that they will assess if the resident's behavioral/mood symptoms present a danger to the resident and/or others. Intervene as needed. (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #38's order summary report dated 12/23/2024-01/23/2025 revealed the following orders: Seroquel 100 mg give 1 tablet by mouth twice a day related to depression. Record review of Resident #38's electronic medical record of revealed no consent for Seroquel. Record review of Resident #38's MRR recommendation dated 12/1/2024-12/16/2024 revealed, Per new regulations, resident is receiving an antipsychotic that requires the new informed consent form (Form 3713) to be filled out and signed by provider + resident/responsible party. Antipsychotic medication needing new informed consent: Seroquel. During an interview on 01/23/2025 at 1:00 PM, the DON stated that the facility did not have a signed consent form for Resident #38's Seroquel. She stated that Hospice had ordered it and the facility requires a signed consent form for all psychotropic medications. The DON stated that a possible negative outcome for not having a consent for psychotropic medications could be that a wrong medication could be given . During an interview on 01/23/2025 at 1:13 PM, the ADON stated the consent should have been obtained prior to the residents being given psychotropic medications. The ADON stated a potential negative outcome to the residents was the resident would have side effects, there could be behaviors and the family would not know. Record review of facility policy titled Pharmacy Services: Section 6 - Medication Management. Subject: Psychotropic Drugs - Use of dated 04/01/2022 revealed in part . 1. A psychotropic drug is any drug that affects brain activities associate with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: a. Anti-psychotic b. Anti-depressant c. Anti-anxiety and d. Hypnotic 6. A consent form will be completed for each psychotropic medication prescribed .

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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 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** 39813 Based on interview, and record review, the facility failed to ensure all residents had the right to formulate an advanced directive for 1 (Resident #21) of 15 residents reviewed for advanced directives in that: Resident #21 had a DNR in her record that both witnesses signed the document 5 days before the Medical Power of Attorney signed the document. This failure could place residents a risk for not receiving healthcare as per their or their legal representatives wishes. Findings included: Record review of Resident #21's face sheet printed [DATE] revealed she was a [AGE] year-old female resident admitted to the facility originally on [DATE] and readmitted on [DATE] with diagnoses to include multiple sclerosis (a chronic disease that damages the central nervous system, specifically the brain and spinal cord), pain, muscle wasting (the loss of muscle mass and strength due to disease, injury, or lack of use), diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), and paraplegia (paralysis of the legs and lower body). Section Advance Directives listed Resident #21 as a DNR (Do Not Resuscitate). Record review of Resident #21's last MDS was a quarterly assessment completed [DATE] listing her with a BIMS score of 15 indicating she was cognitively intact, and she had a functionality of being dependent on staff for most of her activities of daily living. Record review of Resident #21's care plan with last care conference of [DATE] revealed the following: Problem: Start Date-[DATE] Advanced Care Planning: Code Status DNR Goal: Resident will be informed of her rights to complete advanced directives to direct her medical care and make her values and treatment goals known. Resident's stated desires will be honored. Approach: Advanced directives of resident's choice completed and placed on medical record under advanced directive tab or in documents in Matrix. Resident will be informed of her right to complete advanced directives to direct her medical care and make her values and treatment goals known. Residents stated desires will be honored. Record review of the clinical record for Resident #21 revealed an Order Summary with active orders as of [DATE] with the following order: Code Status: DNR - Start date: [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the clinical record for Resident 21 revealed a DNR dated [DATE] (signed by Declaration by legally guardian, agent, or proxy) with the following: Section B: Declaration by legal guardian, agent, or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication. 1. The document is signed by the agent in a Medical Power of Attorney dated [DATE]. Section Two Witnesses: We have witnessed the above noted competent adult person or authorized declarant making his/her signature above and , if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician. -Witness one signed the document [DATE] (5 days before the Medical Power of Attorney) -Witness two signed the document [DATE] (5 days before the Medical Power of Attorney) Section Physician's Statement-signed by the physician [DATE] During an interview on [DATE] at 02:51 PM, LVN G and ADON B were present. Both staff reported that Resident #21 was a DNR and that if Resident 21 was found without a heart rate or respirations they would not initiate CPR. ADON B reviewed Resident #21's DNR and stated, This is not a valid DNR because the witnesses signed the form before anyone else. LVN G reviewed the form and stated, The people who witnessed, witnessed before anybody else signed the form. LVN G reported that she would immediately take the DNR to the social worker for correction. ADON B reported that if a resident had a DNR that was not valid then the staff would have to code the resident and go against that resident or the resident's family's wishes. LVN G reported that the facility possibly would not code a resident that should have been coded. During an interview on [DATE] at 09:48 AM the DON reported that witnesses should never sign a DNR until all other signatures are completed. The DON reported that if a witness signs a DNR before the resident, family, MPOA, or POA then the form was invalid and the resident would not be a DNR, the resident would be a full code and the resident or the family's wishes would not be honored which could affect that residents care. During an interview on [DATE] at 12:26 PM the SW reported that she did not know why Resident #21's DNR was incorrectly completed, that they checked the DNR's each time they had care plan conferences but that they did not review the dates on the DNRs, just that the DNR's were dated, and all the required signatures were present. The SW reported that they were going to implement a new procedure that included checking the dates when the signatures were provided. The SW reported that the facility did not complete Resident #21's DNR form, that the resident's FM O completed the form, and she did not know why FM O had the witnesses sign the form first. The SW reported that neither of the witnesses for Resident #12's DNR form were affiliated with the facility. The SW reported that if the DNR was not completed correctly then it was not valid, and the resident would not receive the care they wished to have. Record review of the facility provided policy titled Advanced Directives revision [DATE], revealed the following: (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy-The facility recognized the resident right to formulate and advanced directive. Intent-This policy and procedure provide instructions to facility staff or obtaining, honoring, and implementing advanced directives to the fullest extent of the law. The Facility's Policy on Advance Directives. 2. Compliance with State Law. The facility will comply with each States law regarding advance directives and similar declarations. Record review of the OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER-TEXAS DEPARTMENT OF STATE HEALTH SERVICES, undated revealed the following: -The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professional In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making an OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on observation, interview, and record review the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 (Resident #246) of 24 residents reviewed for baseline care plans. The facility failed to include Resident #246's oxygen therapy in her baseline care plan. This failure could result in residents not receiving needed care and treatment. Findings Included: Record review of Resident #246's admission record dated 01/21/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, combined congestive heart failure (a progressive heart disease that affects the pumping action of the heart muscles resulting in shortness of breath and fatigue) and anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life). Record review of Resident #246's EHR revealed no MDS assessment completed. Record review of Resident #246's care plan last reviewed and revised by ADON A on 01/17/25 revealed no mention of oxygen therapy. Record review of Resident #246's vitals report regarding her oxygen saturation dated 01/21/25 revealed, during her stay in the facility, her oxygen saturation was checked 13 times and she was receiving oxygen 8 of those times. During an observation on 01/21/25 at 09:43 AM Resident #246 was lying her bed receiving O2 via NC at 5 lpm. During an observation and interview on 01/21/24 at 02:07 PM Resident #246's family member was seated in Resident #246's room. Resident #246 was in the bathroom being assisted by staff. Her oxygen tubing extended from the oxygen concentrator into the bathroom. The concentrator was set on 5 lpm. Resident #246's family member stated Resident #246 had been receiving O2 therapy for 10-[AGE] years. During an interview on 01/23/25 at 09:57 AM MDS LVN and MDS RN stated they were responsible for completing comprehensive care plans and DON and the ADONs were responsible for completing baseline care plans. MDS LVN and MDS RN stated care plans should include details regarding oxygen therapy. MDS LVN stated a possible negative outcome of a care plan not including O2 therapy was there would be no communication between different nurses as far as consistency in care if (oxygen was) not in (the) care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/23/25 at 10:10 AM ADON B stated she, ADON A, and DON were responsible for completing baseline care plans. She stated she was over Resident #246's hall. She stated she did not know why Resident #246 did not have O2 therapy in her care plan. She stated a possible negative outcome of the baseline care plan not mentioning O2 therapy was staff would not have documentation to refer to regarding resident care. During an interview on 01/23/25 at 10:23 AM DON stated she and the ADONs were in charge of baseline care plans. She stated baseline care plans should include information regarding O2 therapy if the resident was receiving O2 therapy. She stated a possible negative outcome of the care plan not mentioning O2 therapy hypoxia and/or a change in the resident's mental status. Record review of facility policy titled Care Plan Process, Person-Centered Care and dated 5/5/2023 revealed the following: . The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The facility will provide the resident and their legal representative with a summary of the baseline person-centered care plan that includes but is not limited to . a summary of the resident's medications, . any services and treatments to be administered by the facility . The baseline person-centered care plan will include the minimum healthcare information necessary to properly care for the resident .

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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** 31882 46534 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 (Resident #68 and Resident #92) of 24 residents reviewed for care plans. 1. The facility failed to include oxygen treatment in Resident #68's comprehensive care plan. 2. The facility failed to remove conflicting information regarding Resident #92 eating and being NPO from his care plan. These failures could lead to residents receiving in accurate care which could lead to harm. Findings Included: 1. Record review of Resident #68's admission record dated 01/21/25 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, wheezing (shrill whistle or coarse rattle heard when the airway is partially blocked), cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), and chronic combined congestive heart failure (a type of progressive heart disease where both aspects of the heart's pumping mechanism are significantly impaired over a prolonged period resulting in shortness of breath, swelling, fatigue, wheezing, and confusion or forgetfulness). Record review of Resident #68's admission MDS completed on 12/26/24 revealed the following: Section C: Resident #68 had a BIMS of 9 which indicated moderately impaired cognition. Section O: Resident #68 received oxygen therapy While a Resident. Record review of Resident #68's care plan last reviewed and revised by MDS RN on 01/21/25 revealed no mention of Resident #68 receiving oxygen therapy. He was to be monitored for signs of respiratory distress, shortness of breath, difficulty breathing, fast/shallow breaths, crackling breath sounds, and oxygen saturation below 95%. No mention made in the care plan regarding how to address any of these concerns, should they arise. Record review of Resident #68's order report dated 12/21/2024 to 01/21/2025 revealed no order for oxygen administration. (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 #68's EMAR dated 01/21/25 and covering his entire stay in the facility revealed no mention of oxygen therapy. Record review of Resident #68's vitals report regarding his oxygen saturation dated 01/21/25 revealed during his stay in the facility his oxygen saturation was checked 66 times and he was receiving oxygen 47 of those times. During an observation on 01/21/25 at 09:55 AM Resident #68 was seated in his w/c in his room receiving O2 via NC at 3.5 lpm. During an observation and interview on 01/21/25 at 02:04 PM Resident #68 was seated in his w/c in his room receiving O2 via NC at 3.5 lpm. He stated he had used O2 24/7 for three years. During an observation on 01/21/25 at 08:24 AM Resident #68 was lying on his bed with his eyes closed receiving O2 via NC at 3.5 lpm. 2. Record review of Resident #92's admission record dated 01/22/25 revealed an [AGE] year-old male admitted to the facility on [DATE]with diagnoses that included, but were not limited to, pneumonitis due to inhalation of other solids and liquids (lung inflammation caused by breathing in foreign substances like food, liquids, or other solid particles) and dysphagia oropharyngeal phase (swallowing disorder that makes it difficult or unsafe to move food from the mouth to the esophagus). Record review of Resident #92's admission MDS completed 01/13/25 revealed the following: Section C: Resident #92 had a BIMS of 7 which indicated severely impaired cognition. Section G: The activity of Eating was Not applicable. Section K: Resident #92 had a Swallowing Disorder which included Loss of liquids/solids from mouth when eating or drinking; Holding food in mouth/cheeks or residual food in mouth after meals; Coughing or choking during meals or when swallowing medications; Complaints of difficulty or pain with swallowing. Resident #92 had a feeding tube On Admission, While Not a Resident, and While a Resident and he received 51% or more of his calories through tube feeding. Section O: Resident was to receive suctioning as needed. Record review of Resident #92's care plan last reviewed and revised on 01/17/25 by DON revealed a statement created on 01/13/25 Resident #92 was dependent on staff for feeding via peg tube. The dietary goals were started on 01/10/25 and included staff were to encourage (Resident #92) to dine in the dining room as is appropriate, honor food preferences as feasible, monitor and encourage intakes of foods and fluids, offer alternate if intakes are less than adequate, offer snacks per policy, provide assistance with meals and snack if needed, and provide diet as ordered by physician. The care plan further noted on 01/09/25 Resident #92 was NPO. Record review of Resident #92's dietary order revealed a received and start date of 01/09/25 of NPO with special instructions for feeding tube. (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 #92's progress notes dated 01/22/25 and covering the period of time from admission on 01/08/25 to 11:52 AM on 01/22/25 revealed a total of 29 progress notes. 16 of which mentioned Resident #92 was NPO. During an interview and observation on 01/21/25 at 10:38 AM Resident #92 was in bed with HOB raised to 45 degrees receiving a feeding through his feeding tube. He stated he had the feeding tube for about 2 months. During an interview and observation on 01/22/25 at 12:33 PM Resident #92 was in his bed with HOB raised to seated position. His family member was in the room with him. Resident #92 indicated by shaking his head that he had not eaten anything by mouth since arriving at the facility. Resident #92's family member confirmed this was true. During an interview on 01/23/25 at 09:57 AM MDS LVN and MDS RN stated they were responsible for writing care plans. They stated they did not know why Resident #92's care plan said he was to be assisted to eat and encouraged to eat in the dining room and to have snack. MDS LVN stated that information must be dietary care plan, I may have not looked it (dietary care plan) over. MDS RN stated a possible negative outcome of an inaccurate medical record was somebody actually feeding him when he is NPO. MDS LVN stated a possible negative outcome of an inaccurate care plan was the resident might receive care/treatment that was contraindicated. MDS RN and MDS LVN stated they looked at a resident's orders, progress notes, and vital signs when completing MDS assessments to ascertain whether the resident was receiving O2. When asked why Resident #68's care plan did not mention his oxygen therapy they stated they were not sure. MDS LVN stated a possible negative outcome of an inaccurate care plan was there would be no communication between different nurses as far as consistency in care if (the treatment was) not in (the) care plan. During an interview on 01/23/25 at 10:10 AM ADON B stated ADON A was over Resident #92's hall. She stated a possible negative outcome of an inaccurate care plan was a lack of documentation for staff to refer to regarding resident care. During an interview on 01/23/25 at 10:14 AM ADON A stated Resident #92 was not to be assisted to eat because he has problems swallowing. She stated a possible negative outcome of the inaccurate care plan for Resident #92 was, He can aspirate. During an interview on 01/23/25 at 10:23 AM DON stated Resident #92 was not to be assisted to eat due to being NPO. She stated a possible negative outcome of an inaccurate care plan in this case was aspiration. DON stated a possible negative outcome of Resident #68's care plan not mentioning his oxygen therapy was hypoxia for patient; change in mental status. Record review of facility policy titled Care Plan Process, Person-Centered Care and dated 5/5/2023 revealed the following: . The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The person-centered care plan includes: . E. Interventions, discipline specific services, and frequency .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31882 Based on observation, interview, and record review, the facility failed to ensure the residents received treatment and care in accordance with professional standards of practice for 1 of 24 residents (Resident #25) reviewed for physician orders for treatments. In eight observations over three days, the facility failed to follow physician orders and apply TED hose as ordered for Resident # 25. (Thrombo-Embolic Deterrent hose which are medical stockings designed to prevent blood clots to the legs). The failure could affect residents currently residing in the facility resulting in not receiving needed care to maintain optimum health and placing them at risk for injury and/or deterioration in their condition. Findings include: Record review of Resident # 25's face sheet printed 01/21/2025 revealed a [AGE] year-old male. Resident #25 was admitted on [DATE] with the following diagnoses: dementia, unspecified,(a group of thinking and social symptoms characterized by impairment of at least two brain function such as memory loss and judgement) type 2 diabetes mellitus (chronic condition where the body does not use insulin properly)with diabetic neuropathy (condition where nerves in the body are affected)legs or , acquired absence of right leg below knee, weakness, depression, and heart failure (a condition where the heart cannot pump as much blood as is needed). Record review of Resident # 25's MDS, dated [DATE] revealed a BIMS of 10 indicating no cognitive impairment. His functionality per his last MDS revealed he required substantial/maximal assistance to complete bathing, toileting, and lower body dressing. Resident # 25 needed partial/moderate assistance with upper body dressing, and supervision or touch assistance with eating and oral hygiene. Record review of Resident #25's Care Plan dated 12/10/24 documented Resident #25 needed the assistance of 1 to 2 staff for ADLs. He was at risk for pain, had peripheral vascular disease and had right below knee amputation. Record review of Resident #25's physician's orders dated 12/22/24, documented TED hose to left leg while awake, off at bedtime. Once a day 8:00 am Order start date was 06/25/2024 with no discontinue date. In an observation on 01/21/2025 at 10:40 am, Resident # 25 was sitting in a wheelchair in his room. There were no TED hose observed on his leg. In an observation on 01/21/2025 at 12:25 pm , Resident # 25 was sitting in a wheelchair in his room,. There were no TED hose observed on his leg. In an observation on 01/21/2025 at 2:15 pm, Resident # 25 was sitting in a wheelchair in his room. There were no TED hose observed on his leg. (continued on next page)

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	675498	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Heights Rehabilitation Suites	6650 South Soncy Road Amarillo, TX 79119

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 01/22/2025 at 10:00 am, Resident # 25 was sitting in a wheelchair in his room. There were no TED hose observed on his leg. Resident #25 stated he was supposed to wear TED hose, but he did not know where they were. Resident # 25 stated staff did not put the TED hose on his leg all the time. He stated it had been a long time since he had the hose on. He stated he thought the staff forgot he was supposed to wear the hose. Resident #25 stated he had not had them on at all this week. He stated he usually had some TED hose in his drawer and if he had some, he would put them on himself, but they were hard to get on and he could not get them on by himself. He stated the hose were supposed to help his leg not swell. He stated his leg had been swelling . Observations of his leg by this writer did not reveal his leg was swollen at this time. In an observation on 01/22/2025 at 3:40 pm, Resident # 25 was sitting in a wheelchair in his room, and there were no TED hose observed on his leg. In an observation and interview on 01/23/2025 at 9:15 am, Resident # 25 was sitting in a wheelchair in his room, and there were no TED hose observed on his leg. Resident #25 stated he was supposed to wear TED hose, but he did not know where they were. He stated no one came to put them on this week and if he had some, he would put them on himself. He stated the hose were usually in his drawer. He stated the hose were to help his leg not swell. In an interview on 01/23/2025 at 9:31 am LVN E stated she usually works with Resident #25 and is well acquainted with his needs. She stated Resident #25 has an order for TED hose to be on all day every day. When asked why Resident #25 did not have TED hose on this week during the day she stated she thought he had the hose on. She stated a negative outcome for not having the hose on could be he could get a blood clot. She stated she was trained by the other nurses in the facility. She stated the CNAs should have put the TED hose on Resident #25 every day that he was out of bed. In an observation and interview on 01/23/2025 at 9:31 am, CNA F stated she was aware Resident #25 had an order for TED hose when out of bed. She stated she was not aware he did not have the TED hose on at this time. She stated she would put the hose on Resident #25 at this time. CNA F got the TED hose out of Resident #25's drawer and put the hose on. Resident #25 stated his foot was really swollen. CNA F commented to Resident #25 his foot was swollen. Resident #25 stated to CNA F he had not had the hose on all week, and he would have put the hose on himself, but he did not know where they were, and he had a hard time putting the hose on by himself. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 01/23/2025 at 10:10 am, the DON stated she expected all staff follow the physicians' orders. She stated an order would be put into the charting system after it is written by a physician. The order then would be listed on the Treatment Administration Record. The DON stated an order for TED hose would be listed on the Treatment Administration Record and the system would trigger the staff to put the hose on the resident. She stated she expected the LVNs to put TED hose on a resident, but they could allow the CNAs to put TED hose on. The DON stated she and the ADON's would review the documentation every morning to monitor whether physician orders were being followed. If physician orders were not followed, she would follow up with staff for explanations for why the orders were not followed. The DON stated the morning review had not pulled up Resident #25. The DON stated she was not aware Resident #25 had not had his TED hose on this week. The DON printed the 14 Day Administrative History and stated Resident #25 had not had TED hose on every day as ordered. She stated she trained the nurses to do their jobs and expects physicians' orders were followed 100 percent for all orders and all residents. The DON stated she had not done any trainings on TED hose in the facility. She stated the consequences of not wearing the TED hose for a resident would be blood clots and circulation issues. In an interview on 1/23/25 at 10: 55 am the ADM stated she could not locate any policies on TED hose, Quality of Care, following physician orders or documentation of treatment administration.

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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** 39813 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 3 (Resident #68, Resident #78, and Resident #246) of 24 residents reviewed for respiratory care. -The facility failed to have orders for oxygen administration for Resident #68 who was receiving oxygen therapy via NC. -The facility failed to change nebulizer tubing for Resident #79 for 4 months. -The facility failed to have orders for oxygen administration for Resident #246 who was receiving oxygen therapy via NC. This failure could affect residents on respiratory therapy by placing them at risk for respiratory compromise and associated complications such as shortness of breath, confusion, respiratory failure, and exacerbation of their condition. Findings include: Resident #68 Record review of Resident #68's admission record dated 01/21/25 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, wheezing (shrill whistle or coarse rattle heard when the airway is partially blocked), cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), and chronic combined congestive heart failure (a type of progressive heart disease where both aspects of the heart's pumping mechanism are significantly impaired over a prolonged period resulting in shortness of breath, swelling, fatigue, wheezing, and confusion or forgetfulness). Record review of Resident #68's admission MDS completed on 12/26/24 revealed the following: Section C: Resident #68 had a BIMS of 9 which indicated moderately impaired cognition. Section O: Resident #68 received oxygen therapy While a Resident. Record review of Resident #68's care plan last reviewed and revised by MDS RN on 01/21/25revealed no mention of Resident #68 receiving oxygen therapy. He was to be monitored for signs of respiratory distress, shortness of breath, difficulty breathing, fast/shallow breaths, crackling breath sounds, and oxygen saturation below 95%. No mention made in the care plan regarding how to address any of these concerns, should they arise. Record review of Resident #68's order report dated 12/21/24 to 01/21/25 revealed no order for oxygen administration. (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 #68's EMAR dated 01/21/25 and covering his entire stay in the facility revealed no mention of oxygen therapy. Record review of Resident #68's vitals report regarding his oxygen saturation dated 01/21/25 revealed during his stay in the facility his oxygen saturation was checked 66 times and he was receiving oxygen 47 of those times. During an observation on 01/21/25 at 09:55 AM Resident #68 was seated in his w/c in his room receiving O2 via NC at 3.5 lpm. During an observation and interview on 01/21/25 at 02:04 PM Resident #68 was seated in his w/c in his room receiving O2 via NC at 3.5 lpm. He stated he had used O2 24/7 for three years. During an observation on 01/21/25 at 08:24 AM Resident #68 was lying on his bed with his eyes closed receiving O2 via NC at 3.5 lpm. Resident #78 Record review of Resident #78's clinical record revealed an [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), muscle wasting (the loss of muscle mass and strength due to disease, injury, or lack of use), and shortness of breath. Record review of Resident #78's clinical record revealed her last MDS was a quarterly completed 12/10/24 listing her with a BIMS of 9 indicating she was moderately cognitively impaired, and she had a functionality of requiring supervision or touching assistance with most of her activities of daily living. Record review of Resident #78's Medications Administration History: 1/1/25 - 1/23/25 revealed the following administration: Resident #78 received Ipratropium-albuterol solution for nebulization; 0.5mg-3mg (2.5mg base)/3ml inhalation every 6 hours-received daily 1/1/25 through 1/23/25 via nebulizer. Record review of Resident #78's clinical record revealed a care plan with last conference date of 12/18/24 revealed the following: Problem: Resident requires oxygen therapy R/T COPD. Start Date: 6/18/24. Approach: -No approaches were listed related to nebulizer care. During an observation and interview on 01/21/25 at 10:28 AM Resident #78 was observed in her room sitting at the side of her bed. Resident #78 had a nebulizer on her bedside dresser with the mask stored in a small bag. The nebulized tubing was dated 9/2/24 and the mask was noted to be slightly white/discolored with particulates on the inside of the mask. Resident #78 reported that the staff provide for her respiratory care but was unable to remember when the tubing or mask had been changed. (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 observation and interview on 01/23/25 at 08:01 AM Resident #78's nebulizer tubing was still marked 9/2/24. Resident #78 stated that she used the nebulizer quite a bit and that it helped her a lot with her breathing. During an interview on 01/23/25 at 08:02 AM LVN E (the nurse responsible for Resident #78 this shift) reported that Resident #78 received her nebulizer on a scheduled dose daily every 6 hours. LVN E entered Resident #78's room, observed the nebulizer tubing, and stated, Oh my gosh. That should have been changed by night shift. I believe it is supposed to be changed every Sunday. LVN E observed the tubing and stated, It is either dated 9/2/24 or 9/7/24, that second number is a little difficult to read. LVN E immediately removed the mask and tubing and threw them in the trash. LVN E reported that not changing the tubing per policy could result in the tubing becoming clogged or the resident getting and infection. During an interview on 01/23/25 at 09:52 AM the DON reported that respiratory equipment should be checked q shift for issues such as kinking, becoming dirty, or found on the floor, or something like that. If any issues were found, then mask or tubing should be replaced. The DON reported the facility policy was that all respiratory equipment to include the nebulizer masks and tubing were to be changed weekly by the night shift. The DON reported that if the tubing or mask was not changed as it should then the resident was at risk for infection. Resident #246 Record review of Resident #246's admission record dated 01/21/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, combined congestive heart failure (a progressive heart disease that affects the pumping action of the heart muscles resulting in shortness of breath and fatigue) and anxiety disorder (serious mental illness characterized by extreme mood swings such as extreme excitement or extreme depressive feelings). Record review of Resident #246's EHR revealed no MDS assessment completed. Record review of Resident #246's care plan last reviewed and revised by ADON A on 01/17/25 revealed no mention of oxygen therapy. Record review of Resident #246's order report dated 12/21/24 to 01/21/25 and thereby covering her entire stay in the facility revealed no order for oxygen administration. Record review of Resident #246's EMAR dated 01/21/24 and covering her entire stay in the facility revealed no mention of oxygen administration. Record review of Resident #246's vitals report regarding her oxygen saturation dated 01/21/25 revealed during her stay in the facility her oxygen saturation was checked 13 times and she was receiving oxygen 8 of those times. During an observation on 01/21/25 at 09:43 AM Resident #246 was lying her bed receiving O2 via NC at 5 lpm. (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 observation and interview on 01/21/24 at 02:07 PM Resident #246's family member was seated in Resident #246's room. Resident #246 was in the bathroom being assisted by staff. Her oxygen tubing extended from the oxygen concentrator into the bathroom. The concentrator was set on 5 lpm. Resident #246's family member stated Resident #246 had been receiving O2 therapy for 10-[AGE] years. During an interview on 01/23/25 at 09:47 AM CNA C stated nurses were responsible for setting oxygen levels. During an observation and interview on 01/23/25 at 09:52 AM LVN D, a nurse on Resident #68 and Resident #246's hall, stated nurses were responsible for setting oxygen levels based on physician's orders. When asked to find the orders for Resident #68 and Resident #246 he sat down at his computer and began to search. After 2-3 minutes had passed, LVN D stated he could not find the orders for either Resident. He stated, Neither one is in the system. LVN D stated a possible negative outcome of administering oxygen therapy without a physician's order was hyperoxygenation (condition where the body has too much oxygen in its tissues and organs, can lead to oxygen toxicity), could create confusion. During an interview on 01/23/25 at 09:57 AM MDS LVN and MDS RN stated care plans should include details regarding oxygen therapy. They stated they looked in physician's orders, progress notes, and vital signs in the EHR to determine if oxygen therapy should be included in care plan. MDS RN stated administering oxygen therapy without a physician's order could negatively affect a resident. MDS LVN stated, Acting without physician's orders . is not a good thing. During an interview on 01/23/25 at 10:10 AM ADON B stated nurses were responsible to set oxygen levels according to physician orders. She stated she did not know why Resident #68 and Resident #246 were receiving oxygen without physician's orders. She stated the facility had standing orders for oxygen from 2-4 lpm for oxygen saturations below 90%. ADON B stated receiving oxygen without orders could negatively affect a resident. She stated, Not everybody needs oxygen, there is such a thing as too much oxygen. If they are breathing fine on their own, it is not good for them to have oxygen. During an interview on 01/23/25 at 10:23 AM DON stated nurses were responsible for setting oxygen levels. She stated they knew what level to set the oxygen to by referring to physician's orders. She stated a resident receiving oxygen without physician's orders could experience hypoxia (not enough oxygen in the body) or a change in mental status. She stated the facility did not have standing orders for oxygen because she did away with them. She stated, We really don't do standing orders because everybody is an individual and I do not like them (standing orders). They (facility) had them in the past, but I said, 'No.' Record review of facility policy titled Respiratory Policies and Procedures and dated 2024 revealed the following: Subject: Oxygen Therapy . A. Maintain the patient's/resident's target oxygen saturation level within the provider's recommended range. Oxygen therapy will be used to raise the patient's/resident's PaO2 to an acceptable baseline using the lowest FIO2. The licensed nurse is to check the oxygen outlet port to verify flow in accordance with provider's order. Verify the provider's order for the oxygen therapy; all orders for oxygen therapy will include administration modality, liter flow, continues our as needed (PRN). PRN orders will include the specific guidelines as to when the patient/resident is to use oxygen. Select the most appropriate oxygen delivery device based on the provider's order . (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 facility policy titled Physician's Orders and dated 2023 revealed the following: . Upon admission the Facility has physician orders for the resident's immediate care to include but not limited to . B. Medications, if necessary C. Routine care orders to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an appropriate care plan. The facility should not administer medications or biologicals except upon the order of a physician/prescriber lawfully authorized to prescribe them. Record review of the facility provided policy titled Respiratory Policy and Procedures revised 2-12-2024, revealed the following: Subject: Oxygen Therapy -no information related to nebulizer equipment therapy/maintenance. 46534

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31882 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with the professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure freezer items were properly stored, labeled, and dated. 2. The facility failed to ensure proper hand hygiene and glove use was practiced. These failures could place residents who ate food served by the kitchen at risk of food-borne illness. Findings include: Observation of the walk-in freezer on 1/21/25 at 9:50 am, revealed a large plastic bucket with the following foods thrown into the bucket: 1. (1) Ziplock bag of [NAME], no label or date, not in original box. 2. (1) bag of frozen okra, no label or date, not in original box. 3. (1) bag of frozen hash brown patty triangles, no label or date, not in original box. 4. (2) bags of biscuits, no label or date, not in original box. 5. (2) bags of frozen unidentifiable brown food, no label or date, not in original box. In an observation on 1/22/25 at 11:00 am, of the walk-in freezer revealed the following was observed: 1. (1) Ziplock bag of [NAME], no label or date, not in original box. 2. (1) bag of frozen okra, no label or date, not in original box. 3. (1) bag of frozen hash brown patty triangles, no label or date, not in original box. 4. (2) bags of biscuits, no label or date, not in original box. 5. (2) bags of frozen unidentifiable brown food, no label or date, not in original box. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 1/22/25 at 12: 15 pm, the DM was observed with gloved hands to touch food trays, picked up the serving utensils, put the serving utensils down on the counter, removed the lids off the food on the tray line, picked up the serving utensils and placed them into the food items, picked up tray tickets and put them down, picked up a plate, put the plate down, picked up tray tickets again and then picked up a plate. The DM began plating the food. The DM then picked up a roll with her gloved hands and placed it on the plate. The DM then picked up another plate, plated the food and picked up another roll with her gloved hand and placed the roll on the plate. The DM was asked if she realized she had touched various surfaces in the kitchen and then used her hand to pick up the roll. The DM smiled and said oops. Then went to get the tongs. The DM did not change her gloves. In an observation on 1/22/25 at 3:20 pm, of the walk-in freezer revealed the following was observed: 1. (1) Ziplock bag of [NAME], no label or date, not in original box. 2. (1) bag of frozen okra, no label or date, not in original box. 3. (1) bag of frozen hash brown patty triangles, no label or date, not in original box. 4. (2) bags of biscuits, no label or date, not in original box. 5. (2) bags of frozen unidentifiable brown food, no label or date, not in original box. 6. (1) baggie of frozen cookie dough, no label or date, not in original box. In an interview and a walk through of the kitchen on 1/23/25 at 9:50 am, the DM stated she knew she should have changed her gloves and used tongs to serve the bread at lunch, but she just forgot. She stated the consequences of not washing hands and changing gloves and not using tongs to serve the bread would be cross contamination for the resident. The DM stated of the bucket of frozen food items the staff just throw everything that is leftover in the bucket. She stated everything should be labeled and dated and that she expected all staff to label and date all food items when used and stored. She stated if foods were not properly wrapped up or labeled and dated this could cause food contamination and sickness to residents. The DM stated she trained the kitchen staff and she had been trained by the dietician in labeling and dating as well as hand hygiene and using tongs to serve bread. Record Review of the facility policy and procedure, dated 9/19/24, titled Safe Food Handling documented employees wash hands prior to handling food. Follow all local state and federal regulations when handling food. Refrigerated foods are properly covered, labeled, and dated. Food is served with clean sanitized utensils. There is no bare hand contact. All foods removed from the original packaging are stored in a closed container and labeled with the common name of the product and the date it was opened. Record Review of the facility policy and procedure, dated 9/9/24, titled Indications for Glove Use documented employees must wash hands before putting on gloves, when changing into fresh gloves and immediately after removing gloves. Change gloves when an unsanitary item is touched. Examples include making sandwiches, handling flatware, putting rolls on plates, .Change gloves when beginning a different task. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of the facility policy and procedure, dated 9/19/24, titled Safe Food Preparation documented Avoid touching ready to eat foods with bare hands. Use tongs or other utensils instead. When gloves are worn , they are clean and changed between tasks. Record Review of the facility policy and procedure, dated 9/19/24, titled Food Safety in Receiving and Storage documented Tightly seal opened packages. Refrigerated food items are properly covered, labeled, and dated clearly marked to indicate a use by date. Containers holding food or food ingredients that are removed from the original packaging are identified with the common name of the food and labeled and dated.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 48491 Based on observation, interview, and record review the facility failed to, in accordance with accepted professional standards and practices, maintain medical records that were complete, accurately documented, readily accessible, and systematically organized for 2 (Resident #79 and Resident #92) of 24 residents reviewed for accuracy of medical records. 1. The facility failed to maintain orders regarding Resident #79's indwelling catheter care. 2. The facility failed to maintain MDS, care plan, CNA documentation, and orders that were in agreement regarding Resident #92's feeding tube and NPO status. This failure placed all residents requiring care at risk for incorrect or omitted treatment, duplicated treatments, poor self-esteem and self-worth, and a failure to ensure continuity of care. Findings Included: 1. Record review of Resident #79's admission record, dated 01/22/2025, revealed an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses to include urinary tract infection, acute kidney failure, unspecified dementia (cognitive loss), muscle weakness, and difficulty walking. Record review of Resident #79's admission MDS completed on 11/02/24 revealed the following: Section C: Resident #79 had a BIMS score of 11 which indicated moderately impaired cognition. Section GG 0100: Resident #79 was documented as independent in self-care, indoor mobility, stairs, and functional cognition. Section GG0110: Resident #79 used none of the devices listed which were manual w/c, motorized w/c, mechanical lift, walker, or orthotics/prosthetics. Section H H0100: Resident #79 used an indwelling catheter. Record review of Resident #79's care plan last review and revised on 11/12/24 revealed a focus area of Enhanced Barrier Precautions due related to an indwelling catheter. Record review of Resident #79's order summary dated 12/22/2024-01/22/2025, revealed no orders for an indwelling catheter. Record review of Resident #79' progress notes dated 01/16/2025 revealed foley catheter was changed by RN I. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #92's admission record dated 01/22/25 revealed an [AGE] year-old male admitted to the facility on [DATE]with diagnoses that included, but were not limited to, pneumonitis due to inhalation of other solids and liquids (lung inflammation caused by breathing in foreign substances like food, liquids, or other solid particles) and dysphagia oropharyngeal phase (swallowing disorder that makes it difficult or unsafe to move food from the mouth to the esophagus). Record review of Resident #92's admission MDS completed 01/13/25 revealed the following: Section C: Resident #92 had a BIMS score of 7 which indicated severely impaired cognition. Section G: The activity of Eating was Not applicable. Section K: Resident #92 had a Swallowing Disorder which included Loss of liquids/solids from mouth when eating or drinking; Holding food in mouth/cheeks or residual food in mouth after meals; Coughing or choking during meals or when swallowing medications; Complaints of difficulty or pain with swallowing. Resident #92 had a feeding tube On Admission, While Not a Resident, and While a Resident and he received 51% or more of his calories through tube feeding. Section O: Resident was to receive suctioning as needed. Record review of Resident #92's care plan last reviewed and revised on 01/17/24 by DON revealed a statement created on 01/13/25 Resident #92 was dependent on staff for feeding via peg tube. The dietary goals were started on 01/10/25 and included staff were to encourage (Resident #92) to dine in the dining room as is appropriate, honor food preferences as feasible, monitor and encourage intakes of foods and fluids, offer alternate if intakes are less than adequate, offer snacks per policy, provide assistance with meals and snack if needed, and provide diet as ordered by physician. The care plan noted on 01/09/25 Resident #92 was NPO. Record review of Resident #92's dietary order revealed a received and start date of 01/09/25 of NPO with special instructions for feeding tube. Record review of Resident #92's point of care history report dated 01/16/25-01/22/25 revealed documentation by 6 different CNAs (CNA C, CNA J, CNA K, CNA L, CNA M and CNA N) over the course of the 5 days covered by the report. The documentation indicated Resident #92 ate independently, dependently, or with supervision. The same 6 CNAs documented 5 instances of Resident #92 needing set up assistance to eat and 3 instances of him needing one-person physical assistance to eat. Record review of Resident #92's progress notes dated 01/22/25 and covering the period of time from admission on 01/08/25 to 11:52 AM on 01/22/25 revealed a total of 29 progress notes. 16 of which mentioned Resident #92 was NPO. During an observation on 01/21/25 at 9:48 AM, Resident #79 was lying on his back on his bed and resident's catheter bag was in a privacy bag next to his bed. During an interview and observation on 01/21/25 at 10:38 AM Resident #92 was in bed with HOB raised to 45 degrees receiving a feeding through his feeding tube. He stated he had the feeding tube for about 2 months. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/22/25 at 11:46 AM, LVN G stated she has worked in the facility for 5 years and was well acquainted with Resident #79 and his care. She stated that she would know how often to change Resident #79's catheter and the size needed by looking at his orders. Surveyor asked LVN G to find catheter orders for Resident #79 in his EHR. LVN G stated she could not find anything in his orders that had to do with catheters or catheter care. She stated it was the admitting nurse's responsibility to make sure that orders were in place and correct when the resident was admitted . LVN G stated a possible negative outcome for not having correct orders for a resident could be that staff would not know Resident #79 was receiving catheter care or they would not check on his catheter to see if there was an issue with it. During an interview and observation on 01/22/25 at 12:33 PM Resident #92 was in his bed with HOB raised to seated position. His family member was in the room with him. Resident #92 indicated by shaking his head that he had not eaten anything by mouth since arriving at the facility. Resident #92's family member confirmed this was true. During an interview on 01/22/25 at 03:50 PM the ADM was asked for a policy addressing accuracy of medical records. During an interview on 01/23/25 at 08:49 AM the DON was asked for a policy addressing accuracy of medical records. During an interview on 01/23/25 at 08:57 AM the ADM asked for clarification regarding medical records policy. Survey staff clarified a policy addressing complete and accurate medical records. During an interview on 01/23/25 at 09:47 AM CNA C stated she had not assisted Resident #92 to eat during his stay in the facility. During an interview on 01/23/25 at 09:57 AM the MDS LVN and MDS RN stated they were responsible for writing care plans. They stated they did not know why Resident #92's care plan said he was to be assisted to eat and encouraged to eat in the dining room and to have snack. MDS LVN stated that information must be dietary care plan, I may have not looked it (dietary care plan) over. The MDS RN stated a possible negative outcome of an inaccurate medical record was somebody actually feeding him when he is NPO. The MDS LVN stated a possible negative outcome of an inaccurate medical record was the resident might receive care/treatment that was contraindicated. During an interview on 01/23/25 at 10:10 AM ADON B stated ADON A was over Resident #92's hall. During an interview on 01/23/25 at 10:13 AM, ADON B stated that it was her responsibility or the other ADON to put orders in the EHR's of the residents. ADON B stated that once a week she meets with the DON and the wound care nurse to make sure orders were up to date and correct. ADON B stated a possible negative outcome for not having orders in a resident's chart could be medication errors and just a lot of errors could happen as a result. During an interview on 01/23/25 at 10:14 AM ADON A stated Resident #92 was not to be assisted to eat because he has problems swallowing. She stated a possible negative outcome of inaccurate records was, He can aspirate. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/23/25 at 10:17 AM, the DON stated that there was a chain of command when it comes to who puts the orders into the residents EHR's. She stated the floor nurse gets the orders and then the ADON makes sure they are correct then all new orders are printed every morning and the ADON's go over the orders with the nurses during the morning meeting. The DON stated a possible negative outcome for not having orders for a resident who had a catheter could be problems with infection, pain, or discomfort. During an interview on 01/23/25 at 10:23 AM the DON stated Resident #92 was not to be assisted to eat due to being NPO. She stated she did not know why 6 CNAs in the last 5 days had documented assisting him with set up to eat or actual eating. She stated a possible negative outcome of an inaccurate medical record in this case was aspiration. A medical records policy was not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 48491 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (CNA H) of 5 staff observed for resident care and 2 (Resident #79 and #18) of 24 residents observed for infection control. CNA H did not change her gloves or wash her hands when providing incontinent care for Resident #18. Resident #79's catheter bag was on the floor. These failures have the potential to affect residents in the facility receiving incontinent care and/or having catheters by exposing them to care that could lead to the spread of infections, tissue breakdown, and feelings of isolation related to poor hygiene. Findings included: Record review of Resident #79's face sheet, not dated, revealed an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses to include urinary tract infection, acute kidney failure, unspecified dementia (cognitive loss), muscle weakness, and difficulty walking. Record review of admission MDS assessment dated [DATE] revealed Resident #79 had a BIMS score of 11 out of 15 which indicated resident's cognition was moderately impaired. In section GG 0100, Resident #79 was documented as independent in self-care, indoor mobility, stairs, and functional cognition. In section GG0110, Resident #79 used none of the devices listed which were manual w/c, motorized w/c, mechanical lift, walker, or orthotics/prosthetics. Record review of a care plan for Resident #79 dated 11/12/24 revealed a focus area of Enhanced Barrier Precautions due related to an indwelling catheter but nothing in his care plan that revealed he was educated about his catheter bag and tubing being off the floor. Record review of Resident #18's clinical record revealed she was an [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include Alzheimer's (a progressive disease that destroys memory and other important mental functions), and neurogenic bladder (the nerves and muscles of the bladder do not work well resulting in the bladder not filling or emptying well). Record review of Resident #18's last MDS was a quarterly assessment completed 1-6-2025 listing her with a BIMS score of 13 indicating she was cognitively intact, and she had a functionality of requiring substantial/maximal assistance with toileting hygiene. During an observation on 01/21/25 at 9:48 AM, Resident #79 was lying on his back on his bed and resident's catheter bag was lying on the floor next to his bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/21/25 at 2:13 PM, Resident #79 was in activity room, sitting in a chair with catheter bag in privacy bag lying on the floor. During an observation on 01/22/25 at 8:31 AM, Resident #79 was sitting in the dining room eating breakfast with catheter bag in privacy bag on the floor next to his chair. During an observation on 01/22/25 at 11:32 AM, Resident #79 was sitting in the dining room having coffee with catheter bag in privacy bag on the floor with part of the tubing from the catheter on floor next to his chair. During an observation on 01/22/25 at 02:18 PM CNA H cleaned Resident #18's rectal area twice with wipes, then each buttock with a wipe, then placed a new brief on the resident without changing her gloves or washing her hands. During an interview on 01/22/25 at 02:24 PM CNA H reported that she did not change her gloves after cleaning the resident's rectal area and stated, she (the resident) had a little BM, and I should have changed my gloves before placing the new brief to prevent contamination. CNA H reported that not completing handwashing and glove changes correctly could result in the resident developing an infection. During an observation on 01/22/25 at 2:40 PM, Resident #79 was in the rehabilitation room using an exercise bike with his catheter bag in a privacy bag lying on the floor beside him. During an interview and observation on 01/22/25 at 3:08 PM, Resident #79 stated that he had been educated by the nursing staff to not put his catheter bag on the floor, especially in the dining room, but that his family member spoke to a specialist, and he told his family member it was ok to have his catheter bag on the floor. During the conversation with Resident #79, he demonstrated this by putting the catheter bag on the floor and poking it with his cane during the interview. During an interview on 01/22/25 at 3:40 PM, the ADM was asked for catheter care policy. During an interview and record review on 01/23/25 at 9:09 AM, the ADM brought a single piece of paper to the conference room with the following on it: Subject: Catheter - Urinary Catheter, Cleaning and Maintenance - Lippincott Nursing Procedures 9th Ed., pages 432-435. Pages 432-435 were not attached. During an interview on 01/23/25 at 9:44 AM, RN I stated that Resident #79 had been educated many times about having his catheter bag off the floor and that daily they have put the privacy bag back onto his catheter bag because he had taken it off. RN I stated that the education for the resident would have been documented in the nurse's notes and also in his care plan and that the DON, ADON, and the charge nurses are responsible for documentation. RN I could not find documentation of education for Resident #79, she stated that a possible negative outcome for not having documentation of education of resident would be staff not knowing what care to provide to the resident. She stated a possible negative outcome for having the catheter bag and tubing on the floor would be infections and dignity issues. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/23/25 at 09:50 AM the DON reported that when providing incontinent care, she expects her staff to provide handwashing and glove changes upon entering the resident's area for care, between the dirty and clean portion of the care, and upon completing the resident's care. The DON reported that if handwashing and glove changes were not completed correctly then infection control was violated, and the resident would be at risk for infection. During an interview on 01/23/25 at 10:17 AM, the DON stated that Resident #79 had been educated numerous times on not having his catheter bag on the floor. She stated a possible negative outcome for having a resident's catheter bag/tubing on the floor could be that the catheter could back up causing further urinary issues, pain, or infection. During an interview on 01/23/25 at 10:13 AM, ADON B stated that Resident #79 had been educated on keeping his catheter bag off the floor and it has been a continuous educating process with him. She stated that documentation of education should be in his EHR. ADON B could not find education documentation notes and stated that because of that, it looked like we did not educate him about the issues with having a catheter bag on the floor. ADON B also stated a possible negative outcome of having a catheter bag/tubing on the floor could be that it could pull out of the resident and create pressure as well as trauma to the penis. During an interview on 01/23/25 at 10:47 AM, the DON stated that they did not have a facility policy specific for Catheter Care except the one from the Lippincott Nursing Book. Record review of Indwelling Catheter Care and Removal pages from Lippincott Nursing Procedures, 9th Edition, pages 432-435. Nothing in these pages stated anything about keeping catheter or tubing off floor. Record review revealed CNA H was trained on hand hygiene and alcohol-based hand rub (ABHR) on 8-19-2024. Record review of the facility provided policy titled Hand Hygiene/Handwashing revised 5/15/2023, revealed the following: Procedures: 1. Hand hygiene/handwashing is done- After- a. After contact with soiled or contaminated articles, such as articles that are contaminated with body fluids. c. After contact with a contaminated object or source where there is a concentration of microorganisms . d. After toileting or assisting other with toileting . Record review of the facility provided policy titled, Infection Prevention and Control, dated 02/17/21, revealed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Purpose: To establish a facility wide program that incorporates a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. The program covers all residents, staff, volunteers, visitors, and other individuals providing services under a contractual agreement and is based on the individual facility assessment following accepted national standards .