STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675502	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasanton North Nursing and Rehabilitation	404 Goodwin St Pleasanton, TX 78064

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on interview and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 8 residents (Resident #11) reviewed for abuse. The facility failed to ensure CNA A was suspended pending an allegation of abuse or neglect when Resident #11 became combative with care. CNA A did not discontinue care or call for help when Resident #11 became combative. Resident #11 sustained skin tears to his hands, bruising to hands, skin tears to his forearms, and a left-hand fracture. On 6/5/24 at 7:15 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 6/7/24 at 09:15 PM, the facility remained out of compliance at a severity level of potential for more than minimal harm that was not immediate jeopardy and a scope of Isolated due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. This failure could place residents at risk of continued victimization, abuse, humiliation, intimidation, fear, shame, agitation, and decreased quality of life. Findings included: Record Review of Resident #11's Admission record revealed an [AGE] year-old male initially admitted [DATE] and readmitted on [DATE] with diagnoses to include neurogenerative disorder with Lewy bodies (It is characterized by the presence of Lewy bodies-abnormal protein deposits-in the brain. These deposits affect brain chemicals, leading to problems with thinking, movement, behavior, mood, and other bodily functions), dementia (loss of thinking, remembering, and reasoning skills) without behaviors, and atherosclerotic heart disease (Plaque build-up in the arteries). Record Review of Resident #11's care plan, last updated 4/4/24, stated [Resident #11] has behaviors which include taking the linens off of his bed. He will put them on the chair at the end of his bed and cover himself with items such as the pink pad or other items that are not linens. He also puts his call light on the floor or behind his bed. He can also become combative with care at times. He does not always understand what you are trying to do. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[Resident #11] will have 2 people assist them at all times. The interventions included administer medications as doctor has ordered, attempt intervention before resident behavior begins by checking frequently, fall mat at bedside while in bed, make sure resident is not in pain or uncomfortable, [Resident #11] will have two CNAs assisting him at all time, and please tell residents what you are going to do before you begin. 5/2/24 [Resident #11] has potential to demonstrate physical behaviors related to dementia. [Resident #11] can be argumentative, become agitated/ combative with care at times. With interventions to analyze key times, places, circumstance, triggers, and what escalates behavior and document, Assess and anticipate resident needs: move, thirst, toileting needs, comfort level, body positioning, pain ETC., Provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out staff member when agitated, Modify environment: reduce noise, dim light, place familiar objects in room, monitor/document/ report to MD/ hospice/ VA of danger to self or others. 3/32/23 [Resident #11] has impaired cognitive function/ dementia or impaired thought process related to diagnosis of Lewy body dementia. With interventions to ask yes/ no questions in order to determine the residence needs, communication: use the resident preferred name, identify yourself at each interaction, face the revenant in speaking and make eye contact, reduce any distractions- turn off TV, radio, closed door ETC, the resident understands consistent, simple, directive sentences, Provide the resident with necessary cues-stop and return if agitated, cue, reorient and supervise as needed. Record Review of Resident #11's quarterly MDS assessment, dated 5/16/24, reflected Resident #11 had a severely impaired cognition for daily decision making. The MDS indicated Resident #11 did not exhibit rejection of care or physical or verbal behaviors towards others such as hitting or screaming. The MDS indicated the resident was always incontinent of bowel and bladder. The MDS indicated he was dependent for ADLS including oral hygiene, toileting hygiene, shower or bathe, dressing, and personal hygiene. The MDS indicated the resident needed substantial assistance (the helper does more than half the effort) to sit to lying, lying to sit, sit to stand, and did not attempt to walk due to medical condition or safety concerns. Record review of nursing progress notes, dated 3/28/24 through 4/4/24, for Resident #11's stated the following: - 3/28/24 at 10:38 p.m. patient not cooperating with aide during brief change, patient gave himself a skin tear to right lower forearm, top of left hand, left 4th finger cleaned with wound cleanser, and covered with [bandage]. Written by LVN B. - 3/29/24 at 9:45 a.m. Skin tear top of LT (left) hand, ST (skin tear) LT (left) 4th index finger, ST to RT (right) FA (forearm), bruising to Lt hand 1st finger and pinky-finger, swelling to Rt hand .Assessed areas, limited ROM to Rt hand, X-ray ordered to hand/wrist pending X-ray, Patients description of event: unable to verbalize . written by LVN C -3/30/24 at 1:58 p.m.X-Ray to rt. hand done on 3/29/24. Tx (treatment) to all skin issues as ordered. Xray results: No acute fx (fracture/break). Or dislocation seen. mild interphalangeal (finger joints) arthrosis (degenerative arthritis that causes the breakdown of the joints) shown by small degenerative spurring (growth) . written by LVN R (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- 3/31/24 at 3:57 p.m. Rt hand/wrist swelling, multiple skin tears RFA, top of L hand, Lt 4TH finger .applied steri-strips (Wound closure strips are porous surgical tape strips which can be used to close small wounds. They are applied across the laceration in a manner which pulls the skin on either side of the wound together.) to all skin tears - 4ss (steri-strips) to top Lt hand and 7ss to RT FA . written by LVN C. - 4/1/24 at 2:00 p.m. Late Entry . [Hospice]RN is here with [hospice company] and ordered an x-ray to [Resident #11]'s left hand. I heard her notify [Hospice doctor], [RP], and call in the x-ray. She noted swelling and bruising to [Resident #11]'s hand. Written by the DON. - 4/2/24 at 11:50 a.m. resident presents with discoloration to both upper bilateral extremities and scratched . written by LVN S. - 4/2/24 at 4:30 p.m. Late Entry .I overheard [hospice RN] on the phone with [Hospice Doctor] and then [Medical Director] and she stated that both physicians declined to get further diagnostics. She stated that {Hospice Doctor] told her that the treatment would be the same meaning the hand splint. Written by the DON - 4/2/24 at 7:07 p.m.FX to left hand . Hospice ordered splint stabilizer for left hand fx . written by LVN S - 4/2/24 at 11:06 p.m.left hand fx with splint; multiple skin tears left hand; right hand edema . written by LVN T. -4/3/24 at 9:13 a.m. selling and bruising to the left hand. THERE IS NO CONFIRMED FRACTURE . written by the DON. Record review of x-ray results, dated 4/2/24, stated .Impression: The bones are osteoporotic (a condition where bones become thin and lose their strength, resulting in increased fragility and a higher risk of fractures.). The distal (farthest away from the center) radial (a long bone that extends from the lateral (outside) side of the elbow to the thumb side of the wrist) diametaphyseal (specific region of a long bone or wrist area) irregularity is visualized, the focal (point of) tender (where it was hurting on the resident) correlation (was the same area) and follow up are recommended to exclude a fracture. The moderate wrist and hand osteoarthritis (disorder of the joints characterized by progressive deterioration of cartilage or of the entire joint) is visualized. Record review of the NP's notes, dated 4/3/24, stated Resident #11 was seen for follow up on change in condition to his left wrist for swelling and redness. The note stated .aggressive/combative with care last week, caused some skin tears to left-hand, left-hand X-ray ordered by Hospice for swelling . X-ray resulted-cannot rule out distal radius fracture (distal radius fracture versus chronic osteoarthritis), [Hospice Dr.] Ordered splint . swelling and redness noted to left wrist. The NP ordered 500 mg of cephalexin three times a day for 10 days for cellulitis (bacterial skin infection) to the left upper arm. The medical director reviewed the notes and agreed on 4/24/24. On 6/4/24 at 4:51 p.m. LVN B was attempted by phone an interview and did not answer. On 6/5/24 at 12:00 p.m. LVN T was attempted by phone for an interview and did not answer. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/6/24 at 2:00 p.m. The Administrator stated LVN S no longer worked for the facility and was a disgruntled employee. During an interview on 6/5/24 at 11:02 a.m. the DON stated she became aware of the incident the morning of 3/29/24 where Resident #11 became combative during care with CNA A. She stated CNA A was interviewed by phone on 4/3/24 at 4:11 p.m. and told her the resident was combative during care and beat her up, she continued with care because he was naked. CNA A noticed the skin tears after, and reported it the charge nurse or LVN B. The DON stated the other staff working did not witness the incident and the resident was non-interviewable. The DON stated they ordered an x-ray of his right hand on 3/29/24 because most of the swelling and injuries were to his right hand. The DON stated the resident had a history of being combative with care and staff was instructed to just stop care if a resident became combative. The DON stated CNA A did not stop care and finished changing him. The DON stated CNA A still worked at the facility. The DON stated it was treated more like an injury of unknown origin than abuse and neglect because the resident had a history of arthritis and she did not think the CNA A did anything to the resident. The DON stated on 4/2/24 they did an x-ray to his left hand due to new onset swelling and it showed a possible fracture, they reported it to the state on 4/2/24. During an interview on 6/5/24 at 3:59 p.m. CNA A described Resident #11's recent behavior with care as okay after the incident on 3/28/24. CNA A stated she continued to work with Resident #11 at the nursing facility after the incident but mostly worked on the woman's side now. CNA A stated she began working for the facility in March of 2024 and Resident #11 was really combative with care but since then was more familiar with her. CNA A stated on 3/28/24 she was providing incontinent care to Resident #11. CNA A stated this resident's bed was against the wall. CNA A stated she told Resident #11 what she was about to do for care and stated, I went to turn him and put on his brief he did not want to me to change him he kept getting out of the bed. CNA A stated Resident #11 was upset that she was providing peri care and she had to keep him in the bed. CNA A stated Resident #11 let her remove his pants but when she went to put on the clean brief it went on from there. CNA A stated Resident #11 got out of the bed, grabbed her scrub top, ripped her top, and pulled her hair. The CNA A stated she kept helping Resident #11 put his legs back in the bed. She stated, I would explain to him about putting his legs back in the bed. CNA A stated she never left or called for help because she usually could get them to calm down on her own. CNA A stated the resident had no injuries after the incident. CNA A stated she did not know how the resident had injuries to his hands or arms. CNA A stated she was not suspended pending an investigation. CNA A stated she did not know why she would be suspended because that would make it sound like she did something to the resident. CNA A stated she did not have specific training after this incident for handling combative residents. She stated she had recent training after another incident at the facility not related to this resident or her. She stated they also had annual training for abuse and neglect. CNA A stated she should have called for help to have a witness for the resident's safety and her safety. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/5/24 at 3:10 pm. the Administrator stated the DON reported this incident, but she was aware of it. She stated they concluded that because CNA A told them Resident #11 was combative during care, she concluded he hit his hand on the wall possibly causing a fracture. The Administrator stated she could not recall if she saw the resident's injuries but if she did it was nothing she would suspect was abuse or neglect. The Administrator stated they made a police report on 4/2/24 to rule out any potential abuse. The Administrator stated they did not feel there was any abuse and there had never been any other allegation made against CNA A so she continued to work for the facility. The Administrator stated staff should take a break if a resident was resistant to care and call for help. Record review of a police report, dated 4/2/24, stated on April 2nd 2024 I officer . was dispatched . for a information report. Upon arrival I made contact with [the DON] who's stated [Resident #11] was injured sometime in the last couple of days. The [DON] when stated on the 28th staff was dealing with [Resident #11] when he suffered multiple skin tears. The [DON] stated that on this said day X-rays were taken. Results showed that [Resident #11] had a possible fractured left hand. I attempted to speak with [Resident #11], due to [Resident #11's] diagnosis I wasn't able to get side of the story. I photographed [Resident #11]'s injuries which were later uploaded to the . evidence server. The [DON] could not confirm if an assault occurred. The [DON] stated she would conduct an interview over the next few days. due to the [DON] still having to investigate the incident report is for information purposes only pending follow up by the reporting party. Record review CNA A's employee records did not contain any disciplinary forms, suspension, misconduct, or coaching forms. Record review of a document titled in service-abuse, dated 4/2/24, did not contain CNA A or LVN B's signature. Record review of the facility's policy, titled Facility Responsibilities for Reporting Allegations, dated 9/22, stated The following addresses facility responsibilities for reporting allegations/occurrences involving staff-to-resident abuse; resident-to-resident altercations; injuries of unknown source; and misappropriation of resident property/exploitation. Reporting Staff-to-Resident Abuse All allegations/occurrences of all types of staff-to-resident abuse must be reported to the administrator who serves as the facility abuse coordinator and to other officials, including the State Survey Agency and adult protective services, where state law provides for jurisdiction in nursing homes [see S 483.12(c)]. This includes, but is not limited to: All allegations/occurrences of physical, sexual, mental, and verbal abuse, including deprivation of goods and services by staff, and involuntary seclusion perpetrated by staff (See F600 and F603 for examples of types of abuse); Staff taking or distributing demeaning or humiliating photographs or recordings of residents through social media or multimedia messaging; and All reports from residents of abuse perpetrated by staff; allegations must not be dismissed on the basis of a resident's cognitive impairment(s). Record review of the Texas HHSC Long-Term Care Regulatory Provider Letter, issues July 10,2019, reflected for an abuse incident the facility was to report immediately, but not later than two hours after the incident occurs or is suspected. An Immediate Jeopardy (IJ) was identified on 6/5/24 at 7:15 p.m. and presented to the Administrator, a plan of removal was requested. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The following Plan of Removal submitted by the facility was accepted on 6/6/24 at 2:45 PM. PLAN OF REMOVAL FOR IMMEDIATE JEOPARDY To Whom it May Concern, Summary of details which leads to outcomes. On 6/5/2024 an investigation on a self-report was initiated at [Nursing Facility and address]. On 6/5/2024 at 7:15 pm, a surveyor provided an IJ Template notification that the Survey Agency has determined that the conditions at the center constitute immediate jeopardy to resident health. The Immediate Jeopardy findings were identified in the following areas: F600 Freedom from Abuse. The Facility neglected to put measures in place to prevent Resident #1 from abuse. IMMEDIATE CORRECTIVE ACTIONS FOR REMOVAL OF IMMEDIATE JEOPARDY: On June 5, 2024, at approximately 6:00pm the following actions were initiated upon facility identification of concern: Patient care plan was updated to show Resident #1 has potential to demonstrate physical behaviors related to dementia. Resident #1 can become combative/agitated with care at times. IDT team reviewed and updated patient #1 Care plan on 6/5/2024 to ensure patient had an appropriate focus, goal, and patient specific interventions specific to behaviors. On 6/5/24 100% audit all patients with current behaviors had care plan updated appropriately to ensure appropriate focus goal and interventions are in place. DON/designee completed psychosocial assessment on resident #1, on 6/5/2024, patient exhibited no signs or symptoms of psychosocial distress, nor any residual psychosocial or harm or distress was related to this. CNA A contract terminated on 6/5/2024. IDENTIFICATION OF OTHER AFFECTED: DON/Designee completed an audit of all residents on 6/5/202 through head-to-toe assessments and resident interviews conducted to validate all were free from signs and symptoms of abuse. No residents were identified to have any signs or symptoms of abuse at the completion of this audit. SYSTEMIC CHANGES AND/OR MEASURES: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator/designee will provide education to all staff regarding identifying types of abuse by 6/6/2024. Administrator/Designee provided education to all staff on residents' right to be free from abuse and neglect by 6/6/2024. The Administrator/Designee will provide education to all staff regarding challenging behavior care and interventions for individuals experiencing dementia by 6/6/2024. All staff to include agency and contract staff, will be in-serviced upon assignment via phone and/or in person by the Director of Nursing/Designee before taking assignment in facility regarding resident with combative behaviors. On 6/5/2024, the Clinical Corporate Resource provided education to the Director of Nursing and Administrator regarding the expectation that any staff member involved in allegations of abuse will be suspended immediately pending the outcome of further investigation. Administrator/Designee will utilize a signed staff roster to track those who have received education and to determine those who still require it. Anyone not in attendance at education sessions, as evidenced by missing signatures on the staff roster sheet, due to vacation, sick leave, or casual work status will be educated upon their return, prior to their first shift worked. Ad hoc QAPI meeting held on 6/5/2024 905 PM with IDT team and MD to review findings for immediate jeopardy. TRACKING AND MONITORING: Administrator/Designee will conduct audits of all residents for 7 days, beginning 6/5/2024 to validate that they are free of signs and symptoms of abuse in collaboration with nursing through interviews and examination. Administrator/Designee will implement interventions and education immediately if any concerns are identified with monitoring. Administrator/Designee will conduct staff interviews to determine knowledge of and competence related to: Types of Abuse. Challenging behavior care and interventions for individuals experiencing dementia. Monitoring will occur every shift for 7 days, beginning 6/5/2024, to validate staff knowledge related to Abuse and dealing with residents with challenging behaviors. The Director of Nursing/Designee will track, on a printed staff roster, evaluation of staff interview outcomes and will document corrective actions taken if it is determined that knowledge deficits exist related to types of abuse, abuse/neglect reporting requirements and/or who the designated Abuse Coordinator is. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Any trends or concerns will be addressed with the Quality Assurance Performance Committee and monitoring will continue until a lessor frequency is deemed appropriate. Results of audits will be presented by the Administrator or designee at the monthly QAPI meeting with the IDT and Medical Director on or before 6/19/2024 then monthly and as needed thereafter to identify trends and sustainability, If ongoing deficiencies or concerns are noted through these audits, resident interventions and staff education will be implemented immediately. The Administrator/designee will conduct monitoring of all cases of alleged/suspected/confirmed abuse to validate that proper, timely notifications have been made to resident representatives and providers through review of nursing documentation and that involved staff have been suspended timely pending further investigation. Any concerns identified will be corrected with prompt notifications, suspension and staff education/re-education as applicable. Monitoring will occur 7 days a week by Administrator/Designee Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. Additional interventions, education and monitoring will be implemented, as needed, based on the recommendations of the QAPI committee for any negative trends identified to ensure sustainability. Administrator The POR verification was accepted on 6/7/24 at 4:15 p.m. as follows: Record review of an in service dated 6/6/24 revealed 42 of 43 staff signed the in-service. LVN T had not completed the inservice because she was returning to work that night and would complete it before her shift per the Administrator. Interview on 06/07/2024 at 9:30 a.m., the Activity Director stated she received an in-service yesterday evening delivered by the ADM related to different types of abuse, the protocol of who to report to, and example of potential abuse and neglect. The Activity Director stated examples included suspicious bruising and noticing aggressive residents the expected protocol when that occurs. The Activity director affirmed understanding of the content. Interview on 06/07/2024 at 9:33 a.m., LVN F stated she received an in-service by the DON in-person yesterday that described who the ANE coordinator was, what example of abuse include, and the expected protocol when noticing potential abuse and neglect. She stated she had received training related to this same content a week prior but was trained on it frequently. She confirmed she understood the training. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/07/2024 at 9:39 a.m., PTA J stated he received an in-service by the ADON in-person yesterday regarding abuse, resident rights, and combative residents. He stated the in-service included types of abuse and what to observe for in potential abuse allegations. He stated suspicious bruising was described as a potential concern to inform the ANE coordinator. He stated they also described the expected protocol when providing services to a combative resident was to walk away and come back with help. PTA J stated he understood the in-service. Interview on 06/07/2024 at 9:41 a.m., LVN C stated she received an in-service on abuse and types of abuse from the DON in-person. LVN C stated the in-service included types of abuse, what to look for, and expected protocol when a combative resident requires care. LVN C stated suspicious bruising was a sign to look for and to notify the ADM about. LVN C stated she understood the in-service. Interview on 06/07/2024 at 9:46 a.m., CNA K stated she was an agency CNA who had not worked at the facility in several months but stated she did receive an in-service today. CNA K stated the in-service was provided to her by the DON and discussed protocols when working with residents with behaviors. CNA K stated she was described the expected protocol was to walk away and potentially attempt care again with another staff but first to ensure the resident was safe prior to leaving. CNA K stated she understood the training. Interview on 06/07/2024 at 10:01 a.m., NA L stated she started at the facility two weeks ago but was in-serviced this morning by the DON and ADM regarding abuse, combative residents, and protocols when attempting care with these residents. NA L stated the in-service included the expected protocol to walk away during a combative episode and ensure an additional staff member was present to bear witness in the instance the resident was hurt to confirm what occurred. Interview on 06/07/2024 at 10:24 a.m., CNA H stated she received an in-service today and also last Sunday regarding abuse and neglect, but also regarding protocols when providing care to aggressive or combative residents. CNA H stated the in-service described walking away from the resident and coming back later with another staff member to provide assistance. CNA H stated the in-service also discussed example of abuse and what the expected protocol was when noticing suspicious bruising. Interview on 06/07/2024 at 10:49 a.m., COTA M stated she received an in-service this morning regarding abuse and neglect, as well as expected protocol when providing care to a resident with combative behaviors. COTA M stated she felt confident on the training and stated she received a similar training last month as well. COTA M stated the in-service gave specific description on not attempting care when a resident was aggressive and to return with another staff such as her OT at the facility. COTA M stated she had provided care to aggressive residents as recently as today and stated her action was to inform the DOR and the charge nurse of the aggressive resident so it could be monitored. Interview on 6/7/24 at 12:23 p.m. LVN G stated she received the in service on 6/6/24. She stated they went over signs of abuse, resident right, and if a resident is having an issue with staff she would go into the room to help and report anything that happened to the Administrator. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/07/2024 at 12:27 p.m., PTA N stated she received an in-service yesterday related to abuse and neglect, and protocols when providing care to aggressive or combative residents. PTA N stated the in-service included content on the types of abuse, what action to take when noticing potential signs of abuse and neglect, and what expected protocol was when a resident begins to respond physically. PTA N stated the described practice was to attempt to redirect the resident and to return at a later time with another staff member. Interview on 6/7/24 at 12:35 p.m. CNA O stated they received the Inservice on 6/7/24. They talked to her about abuse and neglect, resident rights, and who to report abuse and neglect to. Reports it to Admin. Give the resident space if they get combative and talk to them in a low voice. Interview with LVN P at 12:45 p.m. stated she received the in service on 6/7/24. She stated she only worked at the facility about once a week and was agency. She stated they went over the types of abuse and signs of abuse. She stated they also went over resident rights. She stated when they encounter a combative resident they will try to deescalate and if that does not work then they would take a break and get a second staff. She stated because she does not have an established rapport with all the residents, she will normally get a 2nd person at all times to help. Interview on 06/07/2024 at 12:57 p.m., LVN Q, stated she worked as an agency LVN at the facility for the last two nights during the 6PM - 6AM shift and stated yesterday at the end of her shift she received an in-service regarding abuse and neglect along with protocols while providing care to residents with behaviors. LVN Q stated she understood the content of the in-service and stated she felt it was a sufficient time to discuss the content, in addition to discussing examples of non-explicit resident abuse or neglect that would require reporting to the abuse and neglect coordinator. Interview on 6/7/24 at 1:22 p.m. CNA E stated they had one Inservice over abuse and neglect her last in service was a couple days ago. While giving care to a resident if they are refusing stop your care, make sure they are safe, notify your nurse, and have a second aide with you. She would report abuse and neglect to her nurse and the Admin. Interview on 6/7/24 at 1:06 p.m. the SW stated she completed the in-service on 6/5/24. She stated the admin was the abuse coordinator and report any concerns or incidents to her. If someone was combative, we make sure they are safe and we go get help from a charge nurse. Interview on 06/07/2024 at 1:17 PM, the ADON, the ADM completed an in-service with her on the types of abuse, what the expected protocols when providing care with combative residents, ensure safety, and then to go redirect and get someone else to assist in the care. She stated the general types of abuse but included examples of potential abuse like restraints and chemical restraints. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasanton North Nursing and Rehabilitation	404 Goodwin St Pleasanton, TX 78064

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the DON on 6/7/24 at 1:26 p.m. the in-service she received was over abuse and neglect, resident rights, challenging behaviors, reporting, and investigating. If she sees or suspect any abuse to report it to the Administrator and get more details on her risk management assessments. They covered training and in servicing staff. Also, in service on the provider letter for reportable, and not reportable. For example, if the injuries are bruises, if we were not there watching it, then it's reportable. We covered distraction techniques, offering snacks, if a resident is combative make sure you leave them in a safe position and let them be, report it to the charge nurse, and try to go back at another time. It depends on what the resident was doing if they go back alone and they are fine then that was ok, or they have a resident who will not eat but will for someone else, so try different people. She will make sure everyone was in serviced before they start their shifts, and we keep asking them what they do if someone was refusing care, she was documenting the interviews or in service with staff. If she has staff involved in an incident, she will immediately suspend them pending investigation. The DON stated they canceled CNA A's contract. Interview with the Administrator 6/7/24 1:59 p.m. she did receive the services they went over resident rights, abuse, and neglect, and caring for challenging residents with behaviors. Residents have the right to be free from abuse and neglect. This was the resident's home, and we need to treat this like this is their home. The types of abuse and listed examples like physical or chemical restraints. If they do not want, you in the room or are having behaviors you make sure they are safe and step away. The clinical nurse went over reporting with them if the resident cannot tell them what happened, and we did not see and if there was an injury, they should report it. If staff is involved in an incident they will suspend them, have a verbal suspension, and they have a suspension form they can use. They plan on using a form to document if someone gets suspended now. After an allegation they will do a 1 to 1 in-service with the staff member over what the allegation was and training and document it with their signature. She will continue with knowledge checks, rounds to assess residents for abuse, and interviews of the resident for abuse and neglect. She has a couple of residents she can interview, and she also physically look at them [TRUNCATED]

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on record review and interview the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect and exploitation for of 8 residents (Resident #1) reviewed for neglect and abuse, in that; The facility failed to implement its abuse policy and procedures when Resident #11 obtained skin tears, brusising to hands, skin tears to his forearms, and a left-hand fracture after peri-care with CNA A. On 6/5/24 at 7:15 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed prior to exit on 6/7/24, While the IJ was removed on 6/7/24 at 09:15 PM, the facility remained out of compliance at a severity level of potential for more than minimal harm that was not immediate jeopardy and a scope of Isolated due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. This failure could place residents at risk of continued victimization, abuse, humiliation, intimidation, fear, shame, agitation, and decreased quality of life. Findings included: Record review of the facility's policy, titled Facility Responsibilities for Reporting Allegations, dated 9/22, stated The following addresses facility responsibilities for reporting allegations/occurrences involving staff-to-resident abuse; resident-to-resident altercations; injuries of unknown source; and misappropriation of resident property/exploitation. Reporting Staff-to-Resident Abuse All allegations/occurrences of all types of staff-to-resident abuse must be reported to the administrator who serves as the facility abuse coordinator and to other officials, including the State Survey Agency and adult protective services, where state law provides for jurisdiction in nursing homes [see S 483.12(c)]. This includes, but is not limited to: All allegations/occurrences of physical, sexual, mental, and verbal abuse, including deprivation of goods and services by staff, and involuntary seclusion perpetrated by staff (See F600 and F603 for examples of types of abuse); Staff taking or distributing demeaning or humiliating photographs or recordings of residents through social media or multimedia messaging; and All reports from residents of abuse perpetrated by staff; allegations must not be dismissed on the basis of a resident's cognitive impairment(s). Record Review of Resident #11's Admission record revealed an [AGE] year-old male initially admitted [DATE] and readmitted on [DATE] with diagnoses to include neurogenerative disorder with Lewy bodies (It is characterized by the presence of Lewy bodies-abnormal protein deposits-in the brain. These deposits affect brain chemicals, leading to problems with thinking, movement, behavior, mood, and other bodily functions), dementia (loss of thinking, remembering, and reasoning skills) without behaviors, and atherosclerotic heart disease (Plaque build-up in the arteries). (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of Resident #11's care plan, last updated 4/4/24, stated [Resident #11] has behaviors which include taking the linens off of his bed. He will put them on the chair at the end of his bed and cover himself with items such as the pink pad or other items that are not linens. He also puts his call light on the floor or behind his bed. He can also become combative with care at times. He does not always understand what you are trying to do. [Resident #11] will have 2 people assist them at all times. The interventions included administer medications as doctor has ordered, attempt intervention before resident behavior begins by checking frequently, fall mat at bedside while in bed, make sure resident is not in pain or uncomfortable, [Resident #11] will have two CNAs assisting him at all time, and please tell residents what you are going to do before you begin. 5/2/24 [Resident #11] has potential to demonstrate physical behaviors related to dementia. [Resident #11] can be argumentative, become agitated/ combative with care at times. With interventions to analyze key times, places, circumstance, triggers, and what escalates behavior and document, Assess and anticipate resident needs: move, thirst, toileting needs, comfort level, body positioning, pain ETC., Provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out staff member when agitated, Modify environment: reduce noise, dim light, place familiar objects in room, monitor/document/ report to MD/ hospice/ VA of danger to self or others. 3/32/23 [Resident #11] has impaired cognitive function/ dementia or impaired thought process related to diagnosis of Lewy body dementia. With interventions to ask yes/ no questions in order to determine the residence needs, communication: use the resident preferred name, identify yourself at each interaction, face the revenant in speaking and make eye contact, reduce any distractions- turn off TV, radio, closed door ETC, the resident understands consistent, simple, directive sentences, Provide the resident with necessary cues-stop and return if agitated, cue, reorient and supervise as needed. Record Review of Resident #11's quarterly MDS assessment, dated 5/16/24, reflected Resident #11 had a severely impaired cognition for daily decision making. The MDS indicated Resident #11 did not exhibit rejection of care or physical or verbal behaviors towards others such as hitting or screaming. The MDS indicated the resident was always incontinent of bowel and bladder. The MDS indicated he was dependent for ADLS including oral hygiene, toileting hygiene, shower or bathe, dressing, and personal hygiene. The MDS indicated the resident needed substantial assistance (the helper does more than half the effort) to sit to lying, lying to sit, sit to stand, and did not attempt to walk due to medical condition or safety concerns. Record review of nursing progress notes, dated 3/28/24 through 4/4/24, for Resident #11's stated the following: - 3/28/24 at 10:38 p.m. patient not cooperating with aide during brief change, patient gave himself a skin tear to right lower forearm, top of left hand, left 4th finger cleaned with wound cleanser, and covered with [bandage]. Written by LVN B. - 3/29/24 at 9:45 a.m. Skin tear top of LT (left) hand, ST (skin tear) LT (left) 4th index finger, ST to RT (right) FA (forearm), bruising to Lt hand 1st finger and pinky-finger, swelling to Rt hand .Assessed areas, limited ROM to Rt hand, X-ray ordered to hand/wrist pending X-ray, Patients description of event: unable to verbalize . written by LVN C (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-3/30/24 at 1:58 p.m.X-Ray to rt. hand done on 3/29/24. Tx (treatment) to all skin issues as ordered. Xray results: No acute fx (fracture/break). Or dislocation seen. mild interphalangeal (finger joints) arthrosis (degenerative arthritis that causes the breakdown of the joints) shown by small degenerative spurring (growth) . written by LVN R - 3/31/24 at 3:57 p.m. Rt hand/wrist swelling, multiple skin tears RFA, top of L hand, Lt 4TH finger .applied steri-strips (Wound closure strips are porous surgical tape strips which can be used to close small wounds. They are applied across the laceration in a manner which pulls the skin on either side of the wound together.) to all skin tears - 4ss (steri-strips) to top Lt hand and 7ss to RT FA . written by LVN C. - 4/1/24 at 2:00 p.m. Late Entry . [Hospice]RN is here with [hospice company] and ordered an x-ray to [Resident #11]'s left hand. I heard her notify [Hospice doctor], [RP], and call in the x-ray. She noted swelling and bruising to [Resident #11]'s hand. Written by the DON. - 4/2/24 at 11:50 a.m. resident presents with discoloration to both upper bilateral extremities and scratched . written by LVN S. - 4/2/24 at 4:30 p.m. Late Entry .I overheard [hospice RN] on the phone with [Hospice Doctor] and then [Medical Director] and she stated that both physicians declined to get further diagnostics. She stated that {Hospice Doctor] told her that the treatment would be the same meaning the hand splint. Written by the DON - 4/2/24 at 7:07 p.m.FX to left hand . Hospice ordered splint stabilizer for left hand fx . written by LVN S - 4/2/24 at 11:06 p.m.left hand fx with splint; multiple skin tears left hand; right hand edema . written by LVN T. -4/3/24 at 9:13 a.m. selling and bruising to the left hand. THERE IS NO CONFIRMED FRACTURE . written by the DON. Record review of x-ray results, dated 4/2/24, stated .Impression: The bones are osteoporotic (a condition where bones become thin and lose their strength, resulting in increased fragility and a higher risk of fractures.). The distal (farthest away from the center) radial (a long bone that extends from the lateral (outside) side of the elbow to the thumb side of the wrist) diametaphyseal (specific region of a long bone or wrist area) irregularity is visualized, the focal (point of) tender (where it was hurting on the resident) correlation (was the same area) and follow up are recommended to exclude a fracture. The moderate wrist and hand osteoarthritis (disorder of the joints characterized by progressive deterioration of cartilage or of the entire joint) is visualized. Record review of the NP's notes, dated 4/3/24, stated Resident #11 was seen for follow up on change in condition to his left wrist for swelling and redness. The note stated .aggressive/combative with care last week, caused some skin tears to left-hand, left-hand X-ray ordered by Hospice for swelling . X-ray resulted-cannot rule out distal radius fracture (distal radius fracture versus chronic osteoarthritis), [Hospice Dr.] Ordered splint . swelling and redness noted to left wrist. The NP ordered 500 mg of cephalexin three times a day for 10 days for cellulitis (bacterial skin infection) to the left upper arm. The medical director reviewed the notes and agreed on 4/24/24. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/4/24 at 4:51 p.m. LVN B was attempted by phone an interview and did not answer. On 6/5/24 at 12:00 p.m. LVN T was attempted by phone for an interview and did not answer. On 6/6/24 at 2:00 p.m. The Administrator stated LVN S no longer worked for the facility and was a disgruntled employee. During an interview on 6/5/24 at 11:02 a.m. the DON stated she became aware of the incident the morning of 3/29/24 where Resident #11 became combative during care with CNA A. She stated CNA A was interviewed by phone on 4/3/24 at 4:11 p.m. and told her the resident was combative during care and beat her up, she continued with care because he was naked. CNA A noticed the skin tears after, and reported it the charge nurse or LVN B. The DON stated the other staff working did not witness the incident and the resident was non-interviewable. The DON stated they ordered an x-ray of his right hand on 3/29/24 because most of the swelling and injuries were to his right hand. The DON stated the resident had a history of being combative with care and staff was instructed to just stop care if a resident became combative. The DON stated CNA A did not stop care and finished changing him. The DON stated CNA A still worked at the facility. The DON stated it was treated more like an injury of unknown origin than abuse and neglect because the resident had a history of arthritis and she did not think the CNA A did anything to the resident. The DON stated on 4/2/24 they did an x-ray to his left hand due to new onset swelling and it showed a possible fracture, they reported it to the state on 4/2/24. During an interview on 6/5/24 at 3:59 p.m. CNA A described Resident #11's recent behavior with care as okay after the incident on 3/28/24. CNA A stated she continued to work with Resident #11 at the nursing facility after the incident but mostly worked on the woman's side now. CNA A stated she began working for the facility in March of 2024 and Resident #11 was really combative with care but since then was more familiar with her. CNA A stated on 3/28/24 she was providing incontinent care to Resident #11. CNA A stated this resident's bed was against the wall. CNA A stated she told Resident #11 what she was about to do for care and stated, I went to turn him and put on his brief he did not want to me to change him he kept getting out of the bed. CNA A stated Resident #11 was upset that she was providing peri care and she had to keep him in the bed. CNA A stated Resident #11 let her remove his pants but when she went to put on the clean brief it went on from there. CNA A stated Resident #11 got out of the bed, grabbed her scrub top, ripped her top, and pulled her hair. The CNA A stated she kept helping Resident #11 put his legs back in the bed. She stated, I would explain to him about putting his legs back in the bed. CNA A stated she never left or called for help because she usually could get them to calm down on her own. CNA A stated the resident had no injuries after the incident. CNA A stated she did not know how the resident had injuries to his hands or arms. CNA A stated she was not suspended pending an investigation. CNA A stated she did not know why she would be suspended because that would make it sound like she did something to the resident. CNA A stated she did not have specific training after this incident for handling combative residents. She stated she had recent training after another incident at the facility not related to this resident or her. She stated they also had annual training for abuse and neglect. CNA A stated she should have called for help to have a witness for the resident's safety and her safety. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/5/24 at 3:10 pm. the Administrator stated the DON reported this incident, but she was aware of it. She stated they concluded that because CNA A told them Resident #11 was combative during care, she concluded he hit his hand on the wall possibly causing a fracture. The Administrator stated she could not recall if she saw the resident's injuries but if she did it was nothing she would suspect was abuse or neglect. The Administrator stated they made a police report on 4/2/24 to rule out any potential abuse. The Administrator stated they did not feel there was any abuse and there had never been any other allegation made against CNA A so she continued to work for the facility. The Administrator stated staff should take a break if a resident was resistant to care and call for help. Record review of a police report, dated 4/2/24, stated on April 2nd 2024 I officer . was dispatched . for a information report. Upon arrival I made contact with [the DON] who's stated [Resident #11] was injured sometime in the last couple of days. The [DON] when stated on the 28th staff was dealing with [Resident #11] when he suffered multiple skin tears. The [DON] stated that on this said day X-rays were taken. Results showed that [Resident #11] had a possible fractured left hand. I attempted to speak with [Resident #11], due to [Resident #11's] diagnosis I wasn't able to get side of the story. I photographed [Resident #11]'s injuries which were later uploaded to the . evidence server. The [DON] could not confirm if an assault occurred. The [DON] stated she would conduct an interview over the next few days. due to the [DON] still having to investigate the incident report is for information purposes only pending follow up by the reporting party. Record review CNA A's employee records did not contain any disciplinary forms, suspension, misconduct, or coaching forms. Record review of a document titled in service-abuse, dated 4/2/24, did not contain CNA A or LVN B's signature. Record review of the Texas HHSC Long-Term Care Regulatory Provider Letter, issues July 10,2019, reflected for an abuse incident the facility was to report immediately, but not later than two hours after the incident occurs or is suspected. An Immediate Jeopardy (IJ) was identified on 6/5/24 at 7:15 p.m. and presented to the Administrator, a plan of removal was requested. The following Plan of Removal submitted by the facility was accepted on 6/6/24 at 2:45 PM. PLAN OF REMOVAL FOR IMMEDIATE JEOPARDY To Whom it May Concern, Summary of details which leads to outcomes. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/5/2024 an investigation on a self-report was initiated at [Nursing Facility and address]. On 6/5/2024 at 7:15 pm, a surveyor provided an IJ Template notification that the Survey Agency has determined that the conditions at the center constitute immediate jeopardy to resident health. The Immediate Jeopardy findings were identified in the following areas: F600 Freedom from Abuse. The Facility neglected to put measures in place to prevent Resident #1 from abuse. IMMEDIATE CORRECTIVE ACTIONS FOR REMOVAL OF IMMEDIATE JEOPARDY: On June 5, 2024, at approximately 6:00pm the following actions were initiated upon facility identification of concern: Patient care plan was updated to show Resident #1 has potential to demonstrate physical behaviors related to dementia. Resident #1 can become combative/agitated with care at times. IDT team reviewed and updated patient #1 Care plan on 6/5/2024 to ensure patient had an appropriate focus, goal, and patient specific interventions specific to behaviors. On 6/5/24 100% audit all patients with current behaviors had care plan updated appropriately to ensure appropriate focus goal and interventions are in place. DON/designee completed psychosocial assessment on resident #1, on 6/5/2024, patient exhibited no signs or symptoms of psychosocial distress, nor any residual psychosocial or harm or distress was related to this. CNA A contract terminated on 6/5/2024. IDENTIFICATION OF OTHER AFFECTED: DON/Designee completed an audit of all residents on 6/5/202 through head-to-toe assessments and resident interviews conducted to validate all were free from signs and symptoms of abuse. No residents were identified to have any signs or symptoms of abuse at the completion of this audit. SYSTEMIC CHANGES AND/OR MEASURES: The Administrator/designee will provide education to all staff regarding identifying types of abuse by 6/6/2024. Administrator/Designee provided education to all staff on residents' right to be free from abuse and neglect by 6/6/2024. The Administrator/Designee will provide education to all staff regarding challenging behavior care and interventions for individuals experiencing dementia by 6/6/2024. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All staff to include agency and contract staff, will be in-serviced upon assignment via phone and/or in person by the Director of Nursing/Designee before taking assignment in facility regarding resident with combative behaviors. On 6/5/2024, the Clinical Corporate Resource provided education to the Director of Nursing and Administrator regarding the expectation that any staff member involved in allegations of abuse will be suspended immediately pending the outcome of further investigation. Administrator/Designee will utilize a signed staff roster to track those who have received education and to determine those who still require it. Anyone not in attendance at education sessions, as evidenced by missing signatures on the staff roster sheet, due to vacation, sick leave, or casual work status will be educated upon their return, prior to their first shift worked. Ad hoc QAPI meeting held on 6/5/2024 905 PM with IDT team and MD to review findings for immediate jeopardy. TRACKING AND MONITORING: Administrator/Designee will conduct audits of all residents for 7 days, beginning 6/5/2024 to validate that they are free of signs and symptoms of abuse in collaboration with nursing through interviews and examination. Administrator/Designee will implement interventions and education immediately if any concerns are identified with monitoring. Administrator/Designee will conduct staff interviews to determine knowledge of and competence related to: Types of Abuse. Challenging behavior care and interventions for individuals experiencing dementia. Monitoring will occur every shift for 7 days, beginning 6/5/2024, to validate staff knowledge related to Abuse and dealing with residents with challenging behaviors. The Director of Nursing/Designee will track, on a printed staff roster, evaluation of staff interview outcomes and will document corrective actions taken if it is determined that knowledge deficits exist related to types of abuse, abuse/neglect reporting requirements and/or who the designated Abuse Coordinator is. Any trends or concerns will be addressed with the Quality Assurance Performance Committee and monitoring will continue until a lessor frequency is deemed appropriate. Results of audits will be presented by the Administrator or designee at the monthly QAPI meeting with the IDT and Medical Director on or before 6/19/2024 then monthly and as needed thereafter to identify trends and sustainability, (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	If ongoing deficiencies or concerns are noted through these audits, resident interventions and staff education will be implemented immediately. The Administrator/designee will conduct monitoring of all cases of alleged/suspected/confirmed abuse to validate that proper, timely notifications have been made to resident representatives and providers through review of nursing documentation and that involved staff have been suspended timely pending further investigation. Any concerns identified will be corrected with prompt notifications, suspension and staff education/re-education as applicable. Monitoring will occur 7 days a week by Administrator/Designee Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. Additional interventions, education and monitoring will be implemented, as needed, based on the recommendations of the QAPI committee for any negative trends identified to ensure sustainability. Administrator The POR verification was accepted on 6/7/24 at 4:15 p.m. as follows: Record review of an in service dated 6/6/24 revealed 42 of 43 staff signed the in-service. LVN T had not completed the inservice because she was returning to work that night and would complete it before her shift per the Administrator. Interview on 06/07/2024 at 9:30 a.m., the Activity Director stated she received an in-service yesterday evening delivered by the ADM related to different types of abuse, the protocol of who to report to, and example of potential abuse and neglect. The Activity Director stated examples included suspicious bruising and noticing aggressive residents the expected protocol when that occurs. The Activity director affirmed understanding of the content. Interview on 06/07/2024 at 9:33 a.m., LVN F stated she received an in-service by the DON in-person yesterday that described who the ANE coordinator was, what example of abuse include, and the expected protocol when noticing potential abuse and neglect. She stated she had received training related to this same content a week prior but was trained on it frequently. She confirmed she understood the training. Interview on 06/07/2024 at 9:39 a.m., PTA J stated he received an in-service by the ADON in-person yesterday regarding abuse, resident rights, and combative residents. He stated the in-service included types of abuse and what to observe for in potential abuse allegations. He stated suspicious bruising was described as a potential concern to inform the ANE coordinator. He stated they also described the expected protocol when providing services to a combative resident was to walk away and come back with help. PTA J stated he understood the in-service. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/07/2024 at 9:41 a.m., LVN C stated she received an in-service on abuse and types of abuse from the DON in-person. LVN C stated the in-service included types of abuse, what to look for, and expected protocol when a combative resident requires care. LVN C stated suspicious bruising was a sign to look for and to notify the ADM about. LVN C stated she understood the in-service. Interview on 06/07/2024 at 9:46 a.m., CNA K stated she was an agency CNA who had not worked at the facility in several months but stated she did receive an in-service today. CNA K stated the in-service was provided to her by the DON and discussed protocols when working with residents with behaviors. CNA K stated she was described the expected protocol was to walk away and potentially attempt care again with another staff but first to ensure the resident was safe prior to leaving. CNA K stated she understood the training. Interview on 06/07/2024 at 10:01 a.m., NA L stated she started at the facility two weeks ago but was in-serviced this morning by the DON and ADM regarding abuse, combative residents, and protocols when attempting care with these residents. NA L stated the in-service included the expected protocol to walk away during a combative episode and ensure an additional staff member was present to bear witness in the instance the resident was hurt to confirm what occurred. Interview on 06/07/2024 at 10:24 a.m., CNA H stated she received an in-service today and also last Sunday regarding abuse and neglect, but also regarding protocols when providing care to aggressive or combative residents. CNA H stated the in-service described walking away from the resident and coming back later with another staff member to provide assistance. CNA H stated the in-service also discussed example of abuse and what the expected protocol was when noticing suspicious bruising. Interview on 06/07/2024 at 10:49 a.m., COTA M stated she received an in-service this morning regarding abuse and neglect, as well as expected protocol when providing care to a resident with combative behaviors. COTA M stated she felt confident on the training and stated she received a similar training last month as well. COTA M stated the in-service gave specific description on not attempting care when a resident was aggressive and to return with another staff such as her OT at the facility. COTA M stated she had provided care to aggressive residents as recently as today and stated her action was to inform the DOR and the charge nurse of the aggressive resident so it could be monitored. Interview on 6/7/24 at 12:23 p.m. LVN G stated she received the in service on 6/6/24. She stated they went over signs of abuse, resident right, and if a resident is having an issue with staff she would go into the room to help and report anything that happened to the Administrator. Interview on 06/07/2024 at 12:27 p.m., PTA N stated she received an in-service yesterday related to abuse and neglect, and protocols when providing care to aggressive or combative residents. PTA N stated the in-service included content on the types of abuse, what action to take when noticing potential signs of abuse and neglect, and what expected protocol was when a resident begins to respond physically. PTA N stated the described practice was to attempt to redirect the resident and to return at a later time with another staff member. Interview on 6/7/24 at 12:35 p.m. CNA O stated they received the Inservice on 6/7/24. They talked to her about abuse and neglect, resident rights, and who to report abuse and neglect to. Reports it to Admin. Give the resident space if they get combative and talk to them in a low voice. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LVN P at 12:45 p.m. stated she received the in service on 6/7/24. She stated she only worked at the facility about once a week and was agency. She stated they went over the types of abuse and signs of abuse. She stated they also went over resident rights. She stated when they encounter a combative resident they will try to deescalate and if that does not work then they would take a break and get a second staff. She stated because she does not have an established rapport with all the residents, she will normally get a 2nd person at all times to help. Interview on 06/07/2024 at 12:57 p.m., LVN Q, stated she worked as an agency LVN at the facility for the last two nights during the 6PM - 6AM shift and stated yesterday at the end of her shift she received an in-service regarding abuse and neglect along with protocols while providing care to residents with behaviors. LVN Q stated she understood the content of the in-service and stated she felt it was a sufficient time to discuss the content, in addition to discussing examples of non-explicit resident abuse or neglect that would require reporting to the abuse and neglect coordinator. Interview on 6/7/24 at 1:22 p.m. CNA E stated they had one Inservice over abuse and neglect her last in service was a couple days ago. While giving care to a resident if they are refusing stop your care, make sure they are safe, notify your nurse, and have a second aide with you. She would report abuse and neglect to her nurse and the Admin. Interview on 6/7/24 at 1:06 p.m. the SW stated she completed the in-service on 6/5/24. She stated the admin was the abuse coordinator and report any concerns or incidents to her. If someone was combative, we make sure they are safe and we go get help from a charge nurse. Interview on 06/07/2024 at 1:17 PM, the ADON, the ADM completed an in-service with her on the types of abuse, what the expected protocols when providing care with combative residents, ensure safety, and then to go redirect and get someone else to assist in the care. She stated the general types of abuse but included examples of potential abuse like restraints and chemical restraints. Interview with the DON on 6/7/24 at 1:26 p.m. the in-service she received was over abuse and neglect, resident rights, challenging behaviors, reporting, and investigating. If she sees or suspect any abuse to report it to the Administrator and get more details on her risk management assessments. They covered training and in servicing staff. Also, in service on the provider letter for reportable, and not reportable. For example, if the injuries are bruises, if we were not there watching it, then it's reportable. We covered distraction techniques, offering snacks, if a resident is combative make sure you leave them in a safe position and let them be, report it to the charge nurse, and try to go back at another time. It depends on what the resident was doing if they go back alone and they are fine then that was ok, or they have a resident who will not eat but will for someone else, so try different people. She will make sure everyone was in serviced before they start their shifts, and we keep asking them what they do if someone was refusing care, she was documenting the interviews or in service with staff. If she has staff involved in an incident, she will immediately suspend them pending investigation. The DON stated they canceled CNA A's contract. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Administrator 6/7/24 1:59 p.m. she did receive the services they went over resident rights, abuse, and neglect, and caring for challenging residents with behaviors. Residents have the right to be free from abuse and neglect. This was the resident's home, and we need to treat this like this is their home. The types of abuse and listed examples like physical or chemical restraints. If they do not want, you in the room or are having behaviors you make sure they are safe and step away. The clinical nurse went over reporting with them if the resident cannot tell them what happened, and we did not see and if there was an injury, they should report it. If staff is involved in an incident they will suspend them, have a verbal suspension, and they have a suspension form they can use. They plan on using a form to document if someone gets suspended now. After an allegation they will do a 1 to 1 in-service with the staff member over what the allegation was and training and document it with their signature. She will continue with knowledge checks, rounds to assess residents for abuse, and interviews of the resident for abuse and neglect. She has a couple of residents she can interview, and she also physically look at them. She will assess if they are at their baseline if they are not able to be in [TRUNCATED]

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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** 45857 Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused result in serious bodily injury for 2 of 9 Residents (Resident #11 and Resident #35) whose records were reviewed for abuse and neglect., in that; 1. The facility failed to report to the state reporting agency (HHSC) in a timely manner possible neglect or abuse of Resident #11 when he sustained injuries after care from CNA A. 2. The facility failed to report to the state reporting agency (HHSC) an injury of unknown origin when Resident #35 suffered a laceration to her head and was not able to say what happened. These deficient practices could affect residents by contributing to further abuse and neglect. The findings were: 1. Record Review of Resident #11's Admission record revealed an [AGE] year-old male initially admitted [DATE] and readmitted on [DATE] with diagnoses to include neurogenerative disorder with Lewy bodies (It is characterized by the presence of Lewy bodies-abnormal protein deposits-in the brain. These deposits affect brain chemicals, leading to problems with thinking, movement, behavior, mood, and other bodily functions), dementia (loss of thinking, remembering, and reasoning skills) without behaviors, and atherosclerotic heart disease (Plaque build-up in the arteries). Record Review of Resident #11's care plan, last updated 4/4/24, stated [Resident #1] has behaviors which include taking the linens off of his bed. He will put them on the chair at the end of his bed and cover himself with items such as the pink pad or other items that are not linens. He also puts his call light on the floor or behind his bed. He can also become combative with care at times. He does not always understand what you are trying to do. [Resident #11] will have 2 people assist them at all times. The interventions included administer medications as doctor has ordered, attempt intervention before resident behavior begins by checking frequently, fall mat at bedside while in bed, make sure resident is not in pain or uncomfortable, [resident #11] will have two CNAs assisting him at all time, and please tell residents what you are going to do before you begin. 5/2/24 [Resident #11] has potential to demonstrate physical behaviors related to dementia. [Resident #11] can be argumentative, become agitated/ combative with care at times. With interventions to analyze key times, places, circumstance, triggers, and what escalates behavior and document, Assess and anticipate resident needs: move, thirst, toileting needs, comfort level, body positioning, pain ETC., Provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out staff member when agitated, Modify environment: reduce noise, dim light, place familiar objects in room, monitor/document/ report to MD/ hospice/ VA of danger to self or others. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/32/23 [Resident #11] has impaired cognitive function/ dementia or impaired thought process related to diagnosis of Lewy body dementia. With interventions to ask yes/ no questions in order to determine the residence needs, communication: use the resident preferred name, identify yourself at each interaction, face the revenant in speaking and make eye contact, reduce any distractions- turn off TV, radio, closed door ETC, the resident understands consistent, simple, directive sentences, Provide the resident with necessary cues-stop and return if agitated, cue, reorient and supervise as needed. Record Review of Resident #11's quarterly MDS assessment, dated 5/16/24, reflected Resident #11 had a severely impaired cognition for daily decision making. Record review of nursing progress notes, dated 3/28/24 through 4/4/24, for Resident #11's stated the following: - 3/28/24 at 10:38 p.m. patient not cooperating with aide during brief change, patient gave himself a skin tear to right lower forearm, top of left hand, left 4th finger cleaned with wound cleanser, and covered with [bandage]. Written by LVN B. - 3/29/24 at 9:45 a.m. Skin tear top of LT (left) hand, ST (skin tear) LT (left) 4th index finger, ST to RT (right) FA (forearm), bruising to Lt hand 1st finger and pinky-finger, swelling to Rt hand .Assessed areas, limited ROM to Rt hand, X-ray ordered to hand/wrist pending X-ray, Patients description of event: unable to verbalize . written by LVN C -3/30/24 at 1:58 p.m.X-Ray to rt. hand done on 3/29/24. Tx (treatment) to all skin issues as ordered. Xray results: No acute fx (fracture/break). Or dislocation seen. mild interphalangeal (finger joints) arthrosis (degenerative arthritis that causes the breakdown of the joints) shown by small degenerative spurring (growth) . written by LVN R - 3/31/24 at 3:57 p.m. Rt hand/wrist swelling, multiple skin tears RFA, top of L hand, Lt 4TH finger .applied steri-strips (Wound closure strips are porous surgical tape strips which can be used to close small wounds. They are applied across the laceration in a manner which pulls the skin on either side of the wound together.) to all skin tears - 4ss (steri-strips) to top Lt hand and 7ss to RT FA . written by LVN C. - 4/1/24 at 2:00 p.m. Late Entry . [Hospice]RN is here with [hospice company] and ordered an x-ray to [Resident #11]'s left hand. I heard her notify [Hospice doctor], [RP], and call in the x-ray. She noted swelling and bruising to [Resident #11]'s hand. Written by the DON. - 4/2/24 at 11:50 a.m. resident presents with discoloration to both upper bilateral extremities and scratched . written by LVN S. - 4/2/24 at 4:30 p.m. Late Entry .I overheard [hospice RN] on the phone with [Hospice Doctor] and then [Medical Director] and she stated that both physicians declined to get further diagnostics. She stated that {Hospice Doctor] told her that the treatment would be the same meaning the hand splint. Written by the DON - 4/2/24 at 7:07 p.m.FX to left hand . Hospice ordered splint stabilizer for left hand fx . written by LVN S (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 4/2/24 at 11:06 p.m.left hand fx with splint; multiple skin tears left hand; right hand edema . written by LVN T. -4/3/24 at 9:13 a.m. selling and bruising to the left hand. THERE IS NO CONFIRMED FRACTURE . written by the DON. Record review of x-ray results, dated 4/2/24, stated .Impression: The bones are osteoporotic (a condition where bones become thin and lose their strength, resulting in increased fragility and a higher risk of fractures.). The distal (farthest away from the center) radial (a long bone that extends from the lateral (outside) side of the elbow to the thumb side of the wrist) diametaphyseal (specific region of a long bone or wrist area) irregularity is visualized, the focal (point of) tender (where it was hurting on the resident) correlation (was the same area) and follow up are recommended to exclude a fracture. The moderate wrist and hand osteoarthritis (disorder of the joints characterized by progressive deterioration of cartilage or of the entire joint) is visualized. Record review of the NP's notes, dated 4/3/24, stated Resident 11 was seen for follow up on change in condition to his left wrist for swelling and redness. The note stated .aggressive/combative with care last week, caused some skin tears to left-hand, left-hand X-ray ordered by Hospice for swelling . X-ray resulted-cannot rule out distal radius fracture (distal radius fracture versus chronic osteoarthritis), [Hospice Dr.] Ordered splint . swelling and redness noted to left wrist. The NP ordered 500 mg of cephalexin three times a day for 10 days for cellulitis (bacterial skin infection) to the left upper arm. The medical director reviewed the notes and agreed on 4/24/24. During an interview on 6/5/24 at 11:02 a.m. the DON stated she became aware of the incident the morning of 3/29/24 where Resident #11 became combative during care with CNA A. She stated CNA A was interviewed by phone on 4/3/24 at 4:11 p.m. and told her the resident was combative during care and beat her up, she continued with care because he was naked. The CNA noticed the skin tears after, and reported it the charge nurse or LVN B on 3/28/24. The DON stated the other staff working did not witness the incident and the resident was non-interviewable. The DON stated it was treated more like an injury of unknown origin than abuse and neglect because the resident had a history of arthritis, and she did not think the CNA A did anything to the resident. The DON stated because she did not suspect abuse they did not report it right away. The DON stated on 4/2/24 they did an x-ray to his left hand due to new onset swelling and it showed a possible fracture. The DON stated because of the new finding of a possible fracture they reported it to the state on 4/2/24. (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 6/5/24 at 3:59 p.m. CNA A described Resident #11's recent behavior with care as okay after the incident on 3/28/24. CNA A stated she continued to work with Resident #11 at the nursing facility but mostly work on woman's side now. CNA A stated she began working for the facility in March of 2024 and Resident #11 was really combative with care but since then was more familiar with her. The CNA stated on 3/28/24 she was providing incontinent care to Resident #11. CNA A stated this resident's bed was against the wall. CNA A stated she told Resident #11 what she was about to do for care and stated, I went to turn him and put on his brief he did not want to me to change him he kept getting out of the bed. CNA A stated Resident #11 was upset that she was providing peri care and she had to keep him in the bed. CNA A stated Resident #11 let her remove his pants but when she went to put on the clean brief it went on from there. CNA A stated Resident #11 got out of the bed, grabbed her scrub top, ripped her top, and pulled her hair. The CNA A stated she kept helping Resident #11 put his legs back in the bed. This surveyor asked how she put the resident's legs back in the bed and CNA A stated, I would explain to him about putting his legs back in the bed. CNA A stated she never left or called for help because she usually could get them to calm down on her own. CNA A stated the resident had no injuries after the incident. CNA A stated she did not know how the resident had injuries to his hands or arms. CNA A stated she was not suspended pending an investigation. CNA A stated she did not know why she would be suspended because that would make it sound like she did something to the resident. CNA A stated she did not have specific training after this incident for handling combative residents. She stated she had recent training after another incident at the facility not related to this resident or her. She stated they also had annual training for abuse and neglect. CNA A stated she should have called for help to have a witness for the resident's safety and her safety. During an interview on 6/5/24 at 3:10 pm. the Administrator stated the DON reported this incident to the state, but she was aware of it. During a follow up interview on 6/7/24 at 1:59 p.m. the Administrator stated in the future if a resident cannot tell them what happened, and they did not see what happened, and there was an injury, they should report it. 2. Record Review of Resident #35's Admission record, dated 6/3/24, revealed a [AGE] year-old female initially admitted [DATE] and readmitted on [DATE] with diagnosis to include dementia (loss of thinking, remembering, and reasoning skills), hypertension (high blood pressure), and hyperlipidemia (high cholesterol). Record Review of Resident #35's care plan, last updated 5/22/24, stated she had Impaired Communication due to: Alzheimer's disease, Dementia, and cognitive impairment and had an actual fall on 5/22/24 poor balance, unsteady gait, poor coordination with interventions to ensure nonskid socks are on at time of ambulation, ensure stability once complete with care, and resident #35 will not be left in her room unattended. Record Review of Resident #35's quarterly MDS assessment, dated 3/5/24, reflected Resident #11 had severely impaired cognition for daily decision making. Record review of nursing progress notes, for May 2024 for Resident #35's stated: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5/21/24 at 5:29 p.m. Event Type: Unwitnessed fall with laceration to Rt eye . Resident found lying on rt (right) side on her floor with knees bent and arms tucked in, lying in front of bathroom door and next to manual w/c (wheelchair) beside bed. Wearing nonskid socks. Unable to assess vitals due laceration to rt eye kept bleeding (applying pressure) .Patients' description of event: unable to verbalize written by LVN C. - 5/22/24 at 12:17 a.m. patient arrived via stretcher around 1210am. received report from ER nurse ., patient has 6 stitches to right temporal dressed with pressure dressing and to remain on for a day, bruising to right shoulder, patient had hypokalemia, was given supplements in er, hospice nurse called, was given order for acetaminophen 325mg 2 tabs prn q6hrs for pain, [RP] was called and made aware gave patient scheduled meds along with acetaminophen. Written by LVN B. During an observation on 6/4/24 at 1:58 p.m. Resident #35 was noted with a bruise over her right eyebrow area. During an interview on 6/4/24 at 5:47 p.m. LVN A stated the housekeeper found Resident #35 on the floor in her room. LVN A stated she was at the nurses station when the housekeeper called for her and LVN C. LVN A stated Resident #35 was on her right side, bleeding, next to her wheelchair. LVN A stated her family had just visited her. LVN A stated the family had asked the aide to transfer her to her wheelchair earlier. LVN A stated the family later left, she assumed they left her in her wheelchair, and left a drink on the side of the wheelchair was on the ground. LVN A stated she assumed the family had left her in her wheelchair and she fell out of the chair reaching for the soda. LVN A stated the resident would sometime answer simple questions. She stated they were not able to get details about the injury from the resident. LVN A stated when she asked the resident if she was reaching for her drink she did not respond. LVN A stated she had never seen the family transfer the resident to her bed and leave her there. During an interview on 6/4/24 at 5:56 p.m. LVN C stated Resident #35's family came to visit her that day in her room. LVN C recalled they had an agency aide working that day and they family left without telling anyone. LVN C stated the resident was sitting in the wheelchair and housekeeping found her on her right side and there was a drink on the floor next to her. LVN C stated she did not know if the resident tried to grab the drink, but she assumed she had. LVN C they were not able to get details about the injury from the resident. LVN C stated she had a laceration to her right eye, so they sent her to the ER. LVN C stated they put 6 sutures and they had since been taken out. During an interview on 6/5/24 at 11:29 a.m. the DON stated they did not report the incident because her CT was clear of negative findings, no other resident would be capable of injuring the resident so bad that she would end up on the floor, and the agency CNA working that day had worked with them several times before and they never had any concerns about the CNA. The DON stated the resident was not able to be interviewed due to her cognitive conditions. The DON stated it was suspicious they would have reported it but because she had a history of falls they concluded she fell . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/24 at 3:30 p.m. the Administrator stated they did an incident report, and they did not report it because they knew what happened. The Administrator stated they were able to figure out what happened to the resident by talking to the family and they left her on the side of the bed. The Administrator stated the CT, and everything came back clear, she came back from the ER with six sutures. The administrator stated they could figure out what happened and if the CT had said she had a fracture they would have reported it. The administrator stated moving forward their plan was to report just in case although she still did not think it met criteria, but it was better to be safe. Record review of the facility's policy, titled Facility Responsibilities for Reporting Allegations, dated 9/22, stated The following addresses facility responsibilities for reporting allegations/occurrences involving staff-to-resident abuse; resident-to-resident altercations; injuries of unknown source; and misappropriation of resident property/exploitation. Reporting Staff-to-Resident Abuse All allegations/occurrences of all types of staff-to-resident abuse must be reported to the administrator who serves as the facility abuse coordinator and to other officials, including the State Survey Agency and adult protective services, where state law provides for jurisdiction in nursing homes [see S 483.12(c)] . Reporting Suspicious Injuries of Unknown Source An injury should be classified as an injury of unknown source when ALL of the following criteria are met: The source of the injury was not observed by any person; and, The source of the injury could not be explained by the resident; and, The injury is suspicious because of:, The extent of the injury, or, The location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), or, The number of injuries observed at one particular point in time, or, The incidence of injuries over time Injuries of Unknown Source Required to Report, Unobserved/unexplained fractures, sprains or dislocations . Unobserved/unexplained lacerations with or without bleeding .NOTE: Any injury that is explained and appears to be a result of abuse must be reported. Record review of the Texas HHSC Long-Term Care Regulatory Provider Letter, issues July 10,2019, reflected for an abuse incident the facility was to report immediately, but not later than two hours after the incident occurs or is suspected.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on interview and record review, the facility failed to ensure individuals with mental health disorders were provided an accurate Preadmission Screening and Resident Review (PASARR) Screening for 2 of 8 residents reviewed for PASRR (Residents #11 and Resident #29). 1. The facility failed to ensure Residents #11 had an accurate PASARR Level 1 Screenings indicating diagnoses of mental illness and refer the residents to the state designated authority. 2. The facility failed to ensure Residents #29 had an accurate PASARR Level 1 Screenings indicating diagnoses of mental illness and refer the residents to the state designated authority. This failure could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs. Findings included: 1. Record Review of Resident #11's Admission record, dated 6/3/24, revealed a [AGE] year-old male initially admitted [DATE] and readmitted on [DATE] with diagnoses to include post-traumatic stress disorder (PTSD) and age related physical debility. Record Review of Resident #11's care plan, last updated 5/1/24, stated he received antidepressant medication because he has depression, had a psychosocial well-being problem related to Lewy body Dementia and PTSD. Record Review of Resident #11's quarterly MDS assessment, dated 5/16/24, reflected Resident #11 had severely impaired cognition for daily decision making and had PTSD. Record review of Resident #11's a physician's order dated 6/3/24 indicated Resident #16 took lorazepam for agitation and anxiousness and sertraline for depression. Record review of Resident #11's PASARR Level 1 Screening completed on 9/10/21 indicated in section C0100 there was no evidence of this individual having mental illness. 2. Record Review of Resident #29's Admission record, dated 6/3/24, revealed a [AGE] year-old male admitted [DATE] with diagnoses to include anorexia, depression, PTSD, and insomnia. Record Review of Resident #29's care plan, last updated 3/26/24, stated he verbalized or demonstrates sadness at times and had depression, and would get nervous and anxious at times. Resident #29 had a diagnosis of PTSD. Resident #29 was risk for sleep pattern disturbance: Resident #29 has a diagnosis of Insomnia. Resident #29 was underweight as related to: Anorexia. Record Review of Resident #29's quarterly MDS assessment, dated 5/15/24, reflected Resident #29 cognition was intact for daily decision making and had PTSD, depression, and anorexia. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #29's a physician's order dated 6/3/24 indicated Resident #29 took mirtazapine for depression and anorexia, trazodone for insomnia, and melatonin for insomnia. Record review of Resident #11's PASARR Level 1 Screening completed on 6/2/23 indicated in section C0100 there was no evidence of this individual having mental illness. During an interview on 6/3/24 at 12:02 p.m. the MDS nurse stated someone else completed the PASARR assessment for Resident #11 and #29, but she was responsible for them now. The MDS nurse stated she did not believe they needed to have another PASARR assessment, but she would contact her resource and see if they needed to be redone. During a follow up interview on 6/4/24 at 11:03 a.m. the MDS nurse stated Resident #11's primary diagnosis was dementia, so he did not need a PASARR assessment to be redone and Resident #29 was negative (did not qualify) for PASARR so they did not need to indicate yes for mental illness on the assessment. Record review of the facility's policy titled Admission Criteria, dated 3/2019, stated .Policy Interpretation and Implementation . 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD. b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. (1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority. c. Upon completion of the Level II evaluation, the State PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate. d. The State PASARR representative provides a copy of the report to the facility. e. The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation. f. Once a decision is made, the State PASARR representative, the potential resident and his or her representative are notified .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307 Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental needs that are identified in the comprehensive assessment, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 21 residents (Resident #23, Resident #27, and Resident #39) reviewed for care plans. The facility failed to ensure Resident #23's code status was reflected within the care plan. The facility failed to ensure Resident #27's code status was reflected within the care plan. The facility failed to ensure Resident #39's psychotropic used was reflected within the care plan. This deficient practice could place residents at risk for not receiving proper care and services due to inaccurate or incomplete care plan interventions. The findings included: Resident #23 Record review of Resident #23's quarterly MDS assessment, dated 05/17/2024, reflected a [AGE] year-old male admitted to the facility on [DATE] with a primary diagnosis of Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and was assessed to have severe cognitive impairment. Record review of Resident #23's physician's orders, dated 06/07/2024, reflected an active DNR order with an order date of 05/07/2024. Record review of Resident #23's care plan, dated 06/01/2024, reflected no indication of code status. Resident #27 Record review of Resident #27's quarterly MDS assessment, dated 05/08/2024, reflected a [AGE] year-old male admitted to the facility on [DATE] with a primary diagnosis of Parkinsonism, unspecified (a collection of movement symptoms associated with several conditions - including Parkinson's disease (PD), and was assessed to have moderate cognitive impairment. Record review of Resident #27's physician's orders, dated 06/07/2024, reflected an active full code order with an order date of 03/11/2024. Record review of Resident #27's care plan, dated 06/01/2024, reflected no indication of code status. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #39 Record review of Resident #39's discharge MDS assessment, dated 04/01/2024, reflected a [AGE] year-old female admitted to the facility on [DATE] with a primary diagnosis of Chronic obstructive pulmonary disease with (acute) exacerbation (A group of lung diseases that block airflow and make it difficult to breathe), and was assessed to have severe cognitive impairment. It additionally reflected Resident #39 was not taking antianxiety or antipsychotic medications during the look-back period. Record review of Resident #39's physician's orders, dated 06/05/2024, reflected active orders for: -Haldol (an antipsychotic medication used to treat certain types of mental disorders such as schizophrenia and Tourette Syndrome) 5mg/ml with direction to inject 2ml intramuscularly one time only for agitation and aggression for 1 Day, started on 03/07/2024 and ended on 03/08/2024. -Compound: ABH (Ativan, Benadryl, and Haldol) (A topical gel made from a combination of lorazepam (Ativan(R)), diphenhydramine (Benadryl(R)), and haloperidol (Haldol(R)) that is typically applied to the volar surface of the wrist.) 1mg/25mg/1mg gel with direction to apply to upper arms & back topically every 6 hours as needed for agitation and aggression apply topically, started on 03/07/2024 and ended on 03/14/2024 -Lorazepam (A sedative that can treat seizure disorders, such as epilepsy. It can also be used before surgery and medical procedures to relieve anxiety.) injection solution 2MG/ML with direction to inject .25mg intramuscularly every 12 hours as needed for severe agitation, started on 03/08/2024 with no end date noted. -Compound: ABH (Ativan, Benadryl, and Haldol) 1mg/25mg/1mg gel with direction to apply to upper arms & back topically every 6 hours as needed for agitation and aggression apply topically, started on 03/14/2024 and ended on 03/28/2024 -Compound: ABH (Ativan, Benadryl, and Haldol) 1mg/25mg/1mg gel with direction to apply to upper arms & back topically every 6 hours as needed for agitation and aggression apply topically, started on 03/29/2024 and ended on 04/12/2024 Record review of Resident #39's MAR, dated March 2024, reflected the Haldol 5MG/ML was administered on 03/07/2024 at 4:52 PM. It further reflected the ABH gel was administered on 03/08/2024 at 8:06 PM, 03/10/2024 at 9:39 AM and 3:55 PM, 03/11/2024 at 1:02 PM, 03/12/2024 at 7:59 AM, and 03/13/2024 at 6:03 AM, 03/14/2024 at 1:24 PM, 03/15/2024 at 1:00 PM, 03/17/2024 at 4:19 PM, 03/23/2024 at 5:34 AM and 8:15 PM, 03/24/2024 at 9:49 PM, 03/25/2024 at 3:49 AM and 03/29/2024 at 7:15 PM. Record review of Resident #39's care plan reflected no indication or any related information of: antipsychotic use, psychotropic use, injections, or monitoring for side effects and behaviors of psychotropic or antipsychotic use. Record review of the medication review regimen, dated 03/14/2024, reflected Resident #39's medication regimen was review by the contracted pharmacist who recommended to limit the ABH gel and IM Lorazepam orders to 14 days and to obtain consents for both the ABH and Lorazepam medications. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/02/2024 at 3:10 PM, the DON stated she was not aware of Resident #23 or Resident #27 not having their code status reflected in their respective care plans. The DON stated it was her expectation that all resident's code status be reflected within their care plans to ensure planning and effective changes in the future are made, along with review by the IDT. The DON stated the responsibility for updating the care plans was held by the entirety of the IDT and no one in particular, but the final reviewer of the care plans was herself as the DON. The DON stated the risk associated with not reflecting the code status within the care plan was that the IDT might not be able to plan appropriately and review the code status at future care plan meetings. Telephone interview on 06/05/2024 at 10:28 AM, Resident #39's RP stated she recalled being invited to the care plan meetings occasionally but specifically recalled not being familiar with all of the medications that Resident #39 was receiving including the ABH cream or any injection medications. Resident #39's RP stated she did not review the care plan thoroughly herself but stated she generally did not feel the psychotropic medications were being observed and administered properly while Resident #39 was at the facility before being discharged . Interview on 06/05/2024 at 12:43 PM, the DON stated she was unaware of Resident #39's medications not having been reflected in the care plan and stated any high-risk medications including psychotropics were required to be reflected in the care plan to monitor for changes in behavior and protocol when administering the PRN doses. The DON stated the risk associated with not reflecting the psychotropic medications within the care plan could be the nursing staff might not be familiar with what appropriate signs and symptoms or behaviors to observe for after Resident #39 had received the medication.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, for 2 of 2 residents (Resident #34 and Resident #11) 1. The facility failed to ensure LVN C followed facility policy while providing wound care to a resident by not dating and initialing the dressing. 2. The facility failed to ensure LVN C completed treatment orders for Resident #11. LVN C documented she completed wound care orders and did not complete them. These deficient practices could place residents at risk for injury, infection, and harm. The findings included: 1. During an observation on 6/4/24 at 3:39 p.m. LVN C provided wound care to Resident #34. LVN C covered the residents wounds on her feet with a wound dressing and covered the bandage with an ace wrap. LVN C did not date or initial the bandage when she was done. During an interview on 6/4/24 at 3:52 p.m. LVN C stated she did not date the wound dressing because she can not write on the ace wrap. LVN C stated she normally never dates the wound dressing, but she should so other staff know the last time it was changed. LVN C stated when she gives report at shift change, she would let them know she changed it. During an interview on 6/4/24 at 4:00 p.m. the DON stated LVN C should date bandages, so they are aware of when the bandage was changed last. The DON stated staff could add a label to wound dressing with their date and initials. 2. Record Review of Resident #11's Admission record, dated 6/3/24, revealed a [AGE] year-old male initially admitted [DATE] and readmitted on [DATE] with diagnosis to include neurogenerative disorder with Lewy bodies (It is characterized by the presence of Lewy bodies-abnormal protein deposits-in the brain. These deposits affect brain chemicals, leading to problems with thinking, movement, behavior, mood, and other bodily functions), dementia (loss of thinking, remembering, and reasoning skills) without behaviors, and atherosclerotic heart disease (Plaque build-up in the arteries). Record Review of Resident #11's quarterly MDS assessment, dated 5/16/24, reflected Resident #11 had a severely impaired cognition for daily decision making. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #11's care plan, last updated 5/3/24, stated Resident #11 had potential for skin integrity due to resistance, combativeness, and had thin fragile skin. Intervention were bilateral arms please as resident allows to mitigate risk for skin concerns, environmental modifications to remove night stand, to prevent injury due to history of resisting care including striking out arms, notify appropriate health care provider, maintain clean, dry skin provides a barrier to infection, pattern skin dry instead of rubbing reduces risk of dermal trauma to fragile skin, not notify MD as needed, perform actions to prevent drying of the skin, encourage a fluid intake of 2500 ML per day unless contraindicated provide a mild soap for bathing apply moisturizing lotion and or emollient to skin Record review of Resident #11's physician orders dated, 6/3/24, revealed orders for: - Monitor scab to Lt 3rd finger every day shift for until healed/resolved, with a start date of 4/12/24, and not end date. - Monitor Scab to LT 4th finger every shift for until resolved/healed, with a start date of 4/11/24, and no end date. - Monitor Scab to RT FA every day shift for until healed/resolved, with a start date of 4/12/24, and no end date. - Monitor site q shift for s/s of infection and replace PRN excessive drainage or dislodgement. every shift for until healed/resolved, with a start date of 4/17/24, and no end date. - Monitor ST to Lt posterior forearm every shift for until healed/resolved, with a start date of 4/14/24, and no end date. - Monitor steri-strips to RT FA every shift for until healed/resolved notify MD of any changes or s/s of infection, with a start date of 5/24/24, and no end date. Record review of Resident #11's MAR/TAR, dated 6/4/24, revealed LVN C marked orders to monitor the left elbow/back of upper arm, the left 3rd finger, the right forearm, scab to the left 4th finger, skin tear to the left posterior forearm, and a bruise to the right forearm on the morning of 6/3/24 and 6/4/24. Record review of Resident #11's skin assessment dated [DATE], was document by LVN C and showed as in progress on 6/4/24. The assessment had no information about the resident's skin. During an interview on 6/4/24 at 5:08 p.m. LVN C stated she did not think Resident #11 had any bandages, wounds, or needed any wound treatments. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 6/4/24 at 5:10 p.m. Resident #11 had a 2x2 bandage to his right wrist area. The bandage had a date of 6/1/24 and no initials. LVN C lifted the bandage slightly and stated there were 3 or 4 steri-strips under the bandage. LVN C stated she was not aware the resident had the bandage prior to then and was not sure who placed the bandage or strips on the resident. LVN C stated she did document on the MAR that she had monitored the resident's wounds but she had not actually monitored them she only marked it off in the electronic medical record. LVN C stated the skin assessment from 5/30/24 showed as in progress because she had not done it and did not want to document something she did not do. LVN C stated they were given till the end of their shift to document wound assessments, and she did not complete Resident #11's skin assessment and it was not done. LVN C stated she had marked the MAR for to monitor the residents skin conditions on 6/3/24 and 6/4/24 but had not looked at the resident. LVN C stated she was going to strike out the documentation she had documented on the morning of 6/4/24 and redo the documentation for 5:10 p.m. During an interview on 6/5/24 at 11:38 p.m. the DON stated LVN C and her did skin assessments on every resident in the building. The DON stated they removed Resident #11's steri-strips the night prior because they were dirty and not sticking, The DON stated if staff was not completing wound assessments or wound orders the wounds could become infected, they could need cleaning, and could miss signs and symptoms of an infection. The DON stated when stated did not complete skin assessments they would not what was happening with the resident's skin. The DON stated they had an action plan to perform skin audits where she would randomly pick residents and perform a skin assessment herself to see if it matched what staff documented. Record review of the facility's policy titled Wound Care, dated 10/2010, stated Purpose, the purpose of this procedure is to provide guidelines for the care of you to promote healing . steps in the procedure .13. Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time, and date and apply to dressing .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, for 1 of 3 residents (Resident #6) reviewed for oxygen therapy in that: Residents #6 oxygen tubing was dated as 4/15/24 and had not been changed weekly as ordered. These deficient practices could place residents who received oxygen therapy at risk for an increase in respiratory complications and or infections. The findings were: Record review of Resident # 6's face sheet dated 6/2/24 revealed an [AGE] year-old female admitted to the facility on [DATE] with the diagnosis that included Chronic systolic (congestive) heart failure (is also called heart failure with reduced ejection fraction and other seasonal allergic rhinitis. Record review of Resident # 6's Quarterly MDS dated [DATE] revealed her cognition was severely impaired for daily decision making and indicated she received oxygen therapy. Record review of Resident #6's care plan, last updated on 3/27/24, stated Alteration in Respiratory Status related to Congestive Heart Failure. [Resident #6] has an order for oxygen but sometimes she takes it off because she states she does not want it on. The interventions were administering oxygen as needed per Physician order, Monitor oxygen saturations on room air and/or oxygen, Monitor oxygen flow rate and response, diet as ordered, elevate HOB to alleviate shortness of breath, and observe for shortness of breath upon exertion. Record review of Resident #6's Physician monthly orders, dated 6/3/24, revealed: -an order start date of 11/21/23, for Oxygen at 2-5 Liters per minute via nasal cannula as needed for shortness of breath /hypoxia related to chronic systolic (congestive) heart failure, and no end date. -an order for Change Oxygen tubing weekly and PRN every night shift every Sunday for Supply management, with a start date of 11/21/23, and no end date. -An order for Change Oxygen tubing weekly and PRN every night shift every Saturday for PRN (as needed) oxygen use, with a start date of 12/4/23 and no end date. Record review of Resident #6's TAR, dated 6/6/24, for 4/1/24 through 4/30/24 showed the oxygen orders were checked off as completed on the 6th, 7th, 13th, 14th, 20th, 21st, and 27th. Record review of Resident #6's TAR, dated 6/6/24, for 5/1/24 through 5/31/24 showed the oxygen orders were checked off as completed on the 4th, 5th, 11th, 12th, 18th, 19th, 25th, and 26th. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/2/24 at 3:59 a.m. Revealed Resident # 6's was wearing a nasal cannula to receive oxygen. The oxygen was set at 2 liters per a minute. The tubing on the oxygen tube was dated 4/15/24. During an interview on 6/2/24 at 4:12 p.m. the DON stated night shift was responsible for changing the oxygen tube weekly as ordered. The DON stated the resident never used the oxygen. The DON stated staff should be replacing the oxygen tubing as ordered to prevent complications. Record review of the facility's policy titled Oxygen Administration, dated 10/201, stated .3. Assemble the equipment and supplies as needed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological's) to meet the needs of each resident, for 1 of 10 residents (Resident #26) reviewed for medication administration, in that: The facility failed to ensure LVN C followed facility policy while administering insulin to a resident in a muscle instead of subcutaneous tissue (uses a short needle to inject a medication into the fatty tissue layer between your skin and muscle. Typically, medication delivered this way is absorbed by your body slowly) as ordered for Resident #26. These deficient practices could affect residents who received medication and place them at risk of an adverse reaction or a decline in health. Findings included: Record review of Resident #26's admission record, dated 6/4/24, revealed at [AGE] year-old male resident was admitted on [DATE] with diagnosis that included type 2 diabetes and chronic kidney disease. Record review of Resident #26's physician orders, dated 6/4/24, showed an order for insulin lispro injection 100 units per milliliter pen-injector, inject as per sliding scale . subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH DIABETIC CHRONIC KIDNEY DISEASE, with a start date of 9/5/23, and no end date. During an observation on 6/4/24 at 11:24 a.m. LVN C administered insulin to Resident #26's right arm. LVN C cleaned the resident's deltoid area (the muscle forming the rounded contour of the human shoulder) with an alcohol swab. LVN C then injected 16 units of insulin into the resident's deltoid muscle at a 90-degree angle and not to the back of the arm where the subcutaneous tissue was. During an interview on 6/4/24 at 5:23 p.m. LVN C stated she did not inject the insulin to the fatty area of the back of Resident #26's arm. She stated normally she would just inject the insulin into the resident's abdomen area, but she asked him and he stated he wanted it in his arm. LVN C stated if she did not inject the insulin into the subcutaneous tissue, it could create a hard spot and not absorb properly. During an interview on 6/5/24 at 11:48 a.m. the DON stated injecting insulin into the deltoid muscle was wrong. The DON stated insulin should be injected subcutaneously not intramuscularly because it would talk longer to absorb into the muscle, could form a knot in the muscle, and would not be the accurate amount of insulin if it takes longer to absorb. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Insulin Administration, 2018, stated Purpose to provide guidelines for the safe administration of insulin to residents with diabetes .Insulin Delivery the forms of insulin delivery include .3. Pens- containing insulin cartridges deliver insulin subcutaneously through a needle .Steps in the procedure .16. Select an injection site. a. Insulin maybe injected into subcutaneous tissue of the upper arm . 18. Lightly grasp a fold of skin and insert the needle into the skin at a 90 angle. For very thin resident, insert at a 45 angle to avoid intramuscular injection .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307 Based on interview, and record review, the facility failed to inform residents in advance of the risks and benefits of proposed care and treatment for 3 of 16 residents (Resident #12, Resident #14, and Resident #20) reviewed for resident rights, in that: 1. The facility failed to ensure Resident #12 had a documented psychiatric diagnosis for a psychotropic drug, Quetiapine, he was receiving daily. 2. The facility failed to ensure Resident #12 had orders for no longer than 14 days for lorazepam PRN (as needed). The orders were written for 90 days or no end date. 3. The facility failed to obtain an updated and signed consent for antipsychotic medication, Quetiapine fumarate that was administered to Resident #12. 4. The facility failed to ensure Resident #14 had a documented psychiatric diagnosis for a psychotropic drug, Mirtazapine (a medication primarily used to treat depression), he was receiving daily. 5. The facility failed to ensure Resident #20 had a documented psychiatric diagnosis for a psychotropic drug, Mirtazapine, he was receiving daily. The failure could affect residents who received psychoactive medications without informed consents, could place residents at risk of receiving unnecessary psychotropic medications, and placed them at risk of receiving treatments without informed consent. Findings include: Resident #12 1. Record Review of Resident #12's Admission record, dated 6/6/24, revealed a [AGE] year-old male initially admitted on [DATE] with diagnosis to include senile degeneration of brain, dementia without behavioral disturbances, psychotic disturbances, mood disturbances, or anxiety, need for assistance with personal care, anxiety disorder, and depression. Further review of the admission record revealed there was no diagnoses of schizophrenia, bipolar disorder, or major depressive disorder was noted. Record Review of Resident #12's quarterly MDS assessment, dated 2/28/24, reflected Resident #12 had severely impaired cognition for daily decision making and took antipsychotic, anxiety, and antidepressant medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #12's care plan, last updated 3/27/24, stated he had potential for drug related complications associated with psychotropic medication related to senile degeneration of brain. Resident #12 took quetiapine as indicated and has PRN Haldol. Interventions included monitor for side effects and report to physicians: antipsychotic medication-sedation, drowsiness, dry mouth, Constipation, blurred vision, EPS, weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention. Resident #12 got nervous and anxious at times related to anxiety disorder he took lorazepam as indicated with interventions to administer medications that help resident with anxiety and please avoid things that make resident more anxious. 2. Record review of Resident #12's a physician's order, dated 6/6/24, indicated the following: - Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) Give 0.25 ml by mouth every 4 hours as needed for Agitation, with a start date of 5/24/24, and no end date. - Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) Give 0.25 ml by mouth every 4 hours as needed for Agitation for 90 days, with a start date of 5/24/24, and an end date of 8/22/24. - Lorazepam Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth three times a day for agitation for 14 Days, with a start date of 5/30/24, and an end date of 6/13/24. - Seroquel Oral Tablet (Quetiapine Fumarate) Give 125 mg by mouth at bedtime for increased hallucinations, with a start date of 5/24/24, and no end date. 3. Record review of Resident #12's medication consent forms indicated the following: -On 11/21/23 a state 3713 was signed by the DON and Hospice RN, and the RP for 100 mg of Quetiapine QHS. There was no doctor's/prescriber's signature. -On 11/21/23 a form titled Psychoactive Medication Consent, was signed by the RP, and an RN, for lorazepam 0.5 mg three time a day and Lorazepam intensol 2mg.ml 0.25-0.5 milliliters every 4 hours as needed for 6 months. -On 11/21/23 a form titled Psychoactive Medication Consent, was signed by the RP, and an RN, for lorazepam 0.5 mg three time a day and Lorazepam 0.5 mg 1-2 tabs every 4 hours as needed for 6 months. -On 5/23/24 a form titled Psychoactive Medication Consent, was signed by an LVN, another unknown staff, and the RP's name was written in on the verbal consent received line for lorazepam 0.5 mg tab PO Q4 PRN for 90 days. There was no doctor's/prescriber's signature. -On 5/24/24 a state 3713 form was signed by the DON and an LVN for 125 mg of Quetiapine. It did not have a doctor's/prescriber's signature on it and stated telephone consent for the Resident or Resident representative's signature. -On 05/24/24 a form titled Psychoactive Medication Consent, was signed by an LVN, and stated [RP] via telephone in the area for verbal consent for Quetiapine 125 mg PO QHS. There was no doctor's/prescriber's signature on the form. Resident #14 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of Resident #14's quarterly MDS assessment, dated 04/25/2024, reflected a [AGE] year-old male admitted on [DATE] with a primary diagnosis of heart failure, unspecified, and assessed to be have severe cognitive impairment. Record review of Resident #14's physician order summary, dated 06/04/2024, reflected an order for Mirtazapine, indicated as used for Appetite Stimulant, administered by mouth once daily, beginning 08/09/2022 with no end date. Record review of Resident #14's medication regimen review, dated 02/17/2024, reflected the contracted pharmacist reviewed Resident #14's medications and recommended a GDR of the Mirtazapine but was declined by Resident #14's physician on the basis for appetite stimulation, no change and resident continues to have poor appetite @ times. Leave dosage . Resident #20 5. Record review of Resident #20's significant change MDS assessment, dated 02/21/2024, reflected a [AGE] year-old female admitted on [DATE] with a primary diagnosis of unspecified dementia (a group of thinking and social symptoms that interfere with daily function) and was assessed to have sever cognitive impairment. Record review of Resident #20's physician order summary, dated 06/06/2024, reflected an order for Mirtazapine, indicated as used for Appetite Stimulant, administered by mouth once daily, beginning 05/13/2023 with no end date. Record review of Resident #20's medication regimen review, dated 05/23/2024, reflected the contracted pharmacist reviewed Resident #20's medications and recommended a GDR of the Mirtazapine but was declined by Resident #20's physician on the basis GDR is contraindicated as non-pharmacological interventions have been insufficient in treating mood symptoms and behaviors. Dose reduction can lead to potential deterioration of psychiatric condition. Interview on 06/03/2024 at 2:53 PM, the DON stated she was aware of Resident #14 and Resident #20's Mirtazapine orders being utilized for the purpose of appetite stimulant. The DON stated she had forgotten the requirement to have a specific diagnosis for psychotropic medications such as Mirtazapine. The DON stated neither Resident #14 or Resident #20 had diagnosis of loss of appetite, malnutrition, protein loss, or related diagnosis. The DON stated the risk associated with not indicating a precise diagnosis for psychotropics could be that medications be administered unnecessarily, and residents could receive extraneous medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/7/24 at 1:27 p.m. the DON stated she had known Resident #12 needed a psychiatric diagnosis to be on the quetiapine and already had a diagnosis of dementia. The DON stated the resident's family refused to pay for psychiatric services for him to see a psychiatrist for psychoactive medications. The DON stated they tried a GDR (gradual dose reduction) in March of 2024, and he failed. The DON stated he failed because the hospice nurse stated he pulled his wife's leg and tried to pull her out of bed. The DON also stated Hospice and the family did not want to take the resident off the medication. The DON stated they planned for him to see psych services and the psych NP would be coming the following week. The DON stated they never documented the family's refusals in the facility's medical records, but she did think Hospice had documented the refusals. The DON stated the family had finally agreed for him to see psych services because she spoke to them again about trying an alternative. The DON stated she was aware that lorazepam should only be written for 14 days, and it had been written longer for 14 days because the hospice doctor insisted on it. The DON stated she was responsible for the orders for the residents while at the facility. The DON stated she was not aware a physical signature was needed on the state consent forms and had written it was a verbal consent because the family was hard to get ahold of. The DON stated she never thought to mail them to form to sign. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Psychotropic Medication Use, dated 7/2022, stated policy statement, residents will not receive medications that are not clinically indicated to treat a specific condition. Policy interpretation and implementation. 1. A psychotropic medication is any medication that affects brain activity associated with mental process and behavior. 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specified to psychotropic medications: a. Anti-psychotic, b. antidepressant, c. anti anxiety medications; and, d. hypnotics. 3. Residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes: a. indications for use; b. dose (including duplicate therapy); c. duration; d. adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying and responding to adverse consequences 5. Use of psychotropic medications (other than antipsychotics) are not increased when efforts to decrease antipsychotic medications are being implemented . 8. Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. Use of psychotropic medications may be considered appropriate in specific circumstances, as specified in FUSS. These include: a. acute or emergency situations; b. enduring conditions; and/or c. new admissions where the resident is already on a psychotropic medication . 10. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. 11. Residents on psychotropic medications received gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications. 12. Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days. (1) For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order (2) For psychotropic medications that ARE antipsychotics: PRN orders cannot be renewed unless the attending physician or prescriber evaluates the resident and documents the appropriateness of the medication .3. When determining whether to initiate, modify, or discontinue medication therapy, the IDT conducts an evaluation of the resident. The evaluation will attempt to clarity whether: a. other causes for symptoms (including symptoms that mimic a psychiatric disorder) have been ruled out b. signs and symptoms are clinically significant enough to warrant medication therapy: c. a particular medication is clinically indicated to manage the symptoms or condition: and d. the actual or intended benefit of the medication is understood by the resident/representative. 4. Residents (and/or representatives) have the right to decline treatment with psychotropic medications. a. The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives. 45857

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45857 Based on observation, interview, and record review the facility failed to assure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, for 1 of 1 medication cart reviewed for labeling and storage, in that: The facility failed to ensure the medication cart was clean, free of unknown debris, loose pills, a dirty pill cutter, a sticky pill [NAME], and a bottle of medication without label with an expiration date. These deficient practices could affect residents prescribed medications in the facility and place them at risk for not receiving the correct medications. The findings were: During an observation on 6/4/24 at 2:19 p.m. revealed the facility's one medication cart had a loose pill in the bottom drawer of the cart, a loose pill in the top left drawer with shreds of paper, foil, other pieces of broken pills, an earring, and other unknown debris. There was a pill [NAME] with white powder on it and an unknown brown sticky substance. The pill cutter was covered in white powder. A bottle of polyethylene glycol was missing a part of the back label where the expiration date may have been listed. There was loose white powder in the top drawer where over the counter bottles were stored. The powder was on the outside of some of the bottles. During an interview on 6/4/24 at 2:24 p.m. LVN F stated the cart was dirty and should be cleaned. LVN F stated she was not aware of the loose pills and did not know who they were for or what the pills were. LVN F stated she never used the pill cutter or pill [NAME] but if someone did residue could get on the next pill. LVN F stated she had used the bottle of polyethylene glycol and should check for an expiration date on all medications before administering them. During an interview on 6/4/24 at 4:37 p.m. the DON stated no staff was assigned to clean the medication cart, but they should all keep the cart clean. The DON stated if staff finds loose pills, they should destroy it and do an incident report if they do not know whose pill it was. The DON stated they did not use the pill cutter or pill [NAME] so she would throw it away. The DON stated it was possible the bottle of polyethylene glycol was torn off because there was a plastic cover that covered the label and could tear off. The DON stated it should be removed from the cart and not used if they could not find an expiration date on the bottle. Record review of the Facility's policy titled Storage of Medications, dated 12/21, stated Policy Statement, the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. 1. Drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. 3. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the Pharmacy for proper labeling before storing .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 45307 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 safely for 1 of 1 kitchen reviewed for kitchen sanitation. 1. Failed to ensure food was not expired in dry storage. 2. Failed to ensure food was maintained at freezing temperatures in the freezer. 3. Failed to ensure that the icemaker was sufficiently cleaned. 4. Failed to ensure all food storage items were labeled and dated. 5. Failed to ensure dry grains storage bins remained closed when not in use. These deficient practices could place residents at risk for cross-contamination and foodborne illness. The findings included: Observation on [DATE] at 10:15 AM revealed the following: 1 unit of Hershey's cocoa mix dated best by 2023. Freezer internal temperature gauge of 52 degrees with boxes of unfrozen, thawed food. 2 open bins containing rice and white flour in the dry storage area of the kitchen. Interview on [DATE] at 10:28 AM, the DM stated she was not aware of the expired Hershey's cocoa mix and confirmed it was past the best by date. The DM stated her expectation for any past dated items to be disposed of as they pose a potential risk of food-borne illness and poor taste. The DM additionally stated the freezer unit had been inconsistently operating over the last several months and stated a service appointment had taken place approximately 2 weeks prior (~[DATE]). The DM stated food had been intermittently freezing and not freezing and were told in the most recent service appointment that the freezer would operate appropriately based on whether the freezer was overfilled or not. The DM stated she has submitted multiple requests to maintenance, only verbally, to complete additional inspections of the reach in freezer unit but had been assured it was functional. The DM stated food had still been served from the freezer, but the food was below an acceptable temperature to maintain quality and safety. The DM stated that it was her expectations that dry grain bins be closed when not in use to prevent debris from falling in and contaminating the dry grains. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview on [DATE] beginning at 10:38 AM revealed within the deep freezer was a single bag of circular bread dough without a label or a date. The DM stated she was aware of the bag of circular bread dough in the deep freezer and stated that they were biscuits, and they were placed in storage yesterday. The DM stated that it was her expectation that all food have a label and date. Observation and interview on [DATE] at 11:01 AM revealed the ice maker to contain white powdery buildup around the perimeter of the unit's door hatch. Inside of the unit was revealed to have dark brown and black sludge on the inside of the unit adjacent to ice drop point. The DM stated she was not certain of what the dark brown and black substance inside of the unit was, but that it could be mold or rust. The DM stated the responsibility to inspect and clean the ice maker was held by the MS. The DM stated a mock inspection from a sister facility was held two months ago ([DATE]) that included an inspection of the ice maker and did not hold concerns. Interview at [DATE] at 11:08 AM, the MS stated he had been working as the MS at the facility for [AGE] years and stated his last inspection of the unit was on [DATE]. The MS stated he did not have this cleaning documented and stated he completed cleanings monthly but does not include cleaning inside the ice maker or any disassembly of the ice maker to clean the underside of the inside storage compartment at any point. The MS stated he had never been instructed to clean any more thoroughly than the outside of the unit or what his arm could reach inside the unit. The MS stated that the white powdery substance outside the unit's perimeter had been attempted to be cleaned prior but was unsuccessful due to the hard water content available to the facility. He stated the white powdery substance could be limescale buildup. The MS stated the potential risk associated with the buildup inside of the compartment would be contamination of the ice, and the ice causing resident sickness. Interview on [DATE] at 4:26 PM, the ADM stated she was not aware of the expired cocoa mix, the freezer operating above freezing temperatures, the cleanliness of the ice maker, or unlabeled food in the kitchen. The ADM stated the reach-in freezer unit to still be non-operational since the last inspection from their contracted service vendor. The ADM stated it was her expectation that all food items that were past dated were to be disposed of, and that food items requiring freezing to be in a freezing temperatures. The ADM further stated the ice maker was expected to be cleaned thoroughly and all food items to be labeled and dated. Record review of email to MS, dated [DATE], reflected a date of service visit on [DATE] at 12:15 PM stated Work completed onsite: [MS] requesting service for reach in freezer temping high. On arrival found unit on and dropping temp. Checked operations on unit and it's operating as it should. Kitchen staff is using indoor thermometer to record temps but found it to be faulty as reach in freezer actually temping lower than what their thermometer reads. Verified digital thermometer on unit was good and let [MS] know it's best for then [them] to use that one. Did see freezer was overpacked to door could have been slightly open causing condensation in unit. No other issues found at this time. Unit left running according to manufactures specifications. Record review of policy titled, Food Receiving and Storage, dated revised October/2017 reflected: 1. Food Services, or other designated staff, will maintain clean food storage areas at all times . 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date) . 11. The freezer must keep frozen foods frozen solid . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of FDA Food Code 2022 Section ,d+[DATE].17 Ready to Eat/Temperature Control for Safety Food, Date Marking: (A) (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S ,d+[DATE].12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675502	A. Building B. Wing	06/07/2024

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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. 45857 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 to help prevent the development and transmission of infections for 1 of 2 staff (LVN C) reviewed for infection control, in that: The facility failed to ensure LVN C washed her hands properly prior to wound care on a resident. These deficient practices could place residents at-risk for infections. The findings included: During an observation on 6/4/24 at 3:48 p.m. LVN C washed her hands in the residents restroom prior to wound care. LVN C turned on the water, washed her hand with soap, rinsed them, and then touched the paper towel dispenser with her bare hand to dispense a paper towel. During an interview on 6/4/24 at 3:59 p.m. LVN C stated she contaminated her hands after she washed them by touching the handle on the paper towel dispenser to get a paper towel. LVN C stated someone told her if she dispensed the paper towel prior to washing her hands she would not be able to use the paper towel to turn off the water without contaminating her hands. LVN C stated she would speak with the DON for clarification. LVN C stated it was an infection control risk if she contaminated her hands after washing them to perform wound care. During an interview on 6/4/24 at 4:45 p.m. the DON stated staff should dispense a paper towel prior to washing their hands, then wash their hands, tear off the paper towel, dry their hands, and then turn off the faucet with the paper towel. The DON stated if staff touched the paper towel dispenser after they washed their hands then they would have contaminated their hands. Record review of the facility's policy titled Handwashing/Hand Hygiene, dated 8/2019, stated Policy Statement This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation . Procedure Equipment and Supplies 1. The following equipment and supplies are necessary for hand hygiene: a. Alcohol-based hand rub containing at least 62% alcohol; b. Running water; C. Soap (liquid or bar, anti-microbial or non -antimicrobial), d. Paper towels; e. Trash can; f. Lotion; and g. Non-sterile gloves. Washing Hands Wet hands first with water, then apply an amount of product recommended by the manufacturer to hands. 2. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 3. Rinse hands with water and dry thoroughly with a disposable towel. 4. Use towel to turn off the faucet .

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307 Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 dishwasher and 1 of 1 vent hood observed for safely functioning equipment. -The chemical dishwasher was not operating at the manufacturer's minimum requirements for rinsing and sanitization. -The vent hood was not inspected and cleaned on the appropriate timeframe. This deficient practice could result in residents not having access to hygienically clean dishes creating a potential for foodborne illness and create a risk of fire exposure in the kitchen. The findings included: Observation and Interview on 06/03/2024 at 10:38 AM revealed a singular over-head kitchen vent hood which contained an inspection sticker that reflected the last service on 02/2024 and the next service on 05/2024. The DM stated the vent hood was inspected by a contracted vendor who was coordinated to visit by the MS. The DM stated she has not had a vent hood inspection since 02/2024 as the sticker described. Additionally revealed was the chemical dishwasher, after a singular complete cycle to have reached a maximum wash temperature of 112 degrees Fahrenheit and a maximum rinse temperature of 123 degrees Fahrenheit. The data plate was revealed to list both a minimum wash and rinse temperature of 120 degrees Fahrenheit, respectively. The DM stated she was not aware of the dishwasher not reaching a minimum of 120 degrees Fahrenheit wash temperature and stated she and her staff record the temperatures on the dishwasher temperature log and would have submit a maintenance request to the MS. Interview on 06/03/2024 at 11:08 AM, the MS stated he has not received work order requests from the DM related to the dishwasher. The MS stated he had not observed concerns with the chemical dishwasher and stated that a contracted vendor came to inspect the unit frequently and last visited in the last few months. The MS stated he had not viewed the chemical dishwasher to be operating below 120 Degrees Fahrenheit. The MS stated the vent hood was inspected every 3 months and the contracted vendor that came to inspect it came automatically without his request for visit. The MS stated he was not aware the contracted vendor had not visited in May of 2024 as per the indicated sticker on the vent hood. The MS stated he would investigate why they have not visited. Interview on 06/04/2024 at 2:42 PM, Vendor Technician X stated he was the contracted technician for this precise chemical dishwasher, the chemical dispensers in the three-compartment sink, and the chemicals in the laundry room. Technician X stated he had not received service requests from the facility related to the dishwasher and in his last visit in 03/2024 a concern related to the dishwasher reaching wash temperature had not been observed. Technician X stated the dishwasher only needed to reach 120 Degrees Fahrenheit on the rinse cycle to confirm sanitization and that the unit reaching 120 degrees Fahrenheit wash temperature was purely for the sake of removing food content and quality of life. Technician X stated the chemical dishwasher was operating as intended according to the manufacturer specifications. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/04/2024 at 4:34 PM, the ADM stated she was not aware of the vent hood inspection not having been completed in May of 2024 or the dishwasher not reaching appropriate temperature. The ADM stated her expectation was that the MS contact the vent hood cleaning vendor on the appropriate basis to ensure the vent hood is clean or it could otherwise risk fire. The ADM stated her expectation for the dishwasher was to follow the manufacturers data plate and that otherwise residents could be exposed to non-sanitized dishes and be at risk for foodborne illness. Record review of the chemical dishwasher's owner's manual, titled ES SERIES DOOR TYPE, CHEMICAL SANITIZING, AND SINGLE AND DUAL RACK MACHINES . INSTALLATION & OPERATION MANUAL, dated 12/05/2007, reflected TEMPERATURES . WASH---[DEGREES FAHRENHEIT] (MINIMUM) 120 . RINSE---[DEGRESS FAHRENHEIT] (MINIMUM) 120 . WATER REQUIREMENTS . INLET TEMPERATURE (MINIMUM) 120 [DEGREE FAHRENHEIT] . INLET TEMPERATURE (RECOMMENDED) 120 [DEGREES FAHRENHEIT] . Some problems, however, may having nothing to do with the machine itself and no amount of preventative maintenance is going to help. A common problem has to do with temperatures being too low. Verify that the water temperatures coming to your dish machine match the requirements listed on the machine data plate. There could be a variety of reasons why your water temperature could be too low and you should discuss it with your [Dishwasher Manufacturer] representative to determine what can be done. By following the operating and cleaning instructions in this manual, you should get the most efficient results from your machine. As a reminder, here are some steps to take to ensure that you are using the machine the way it was designed to work: 1. Ensure that the water temperatures match those on the machine data plate . Record review of kitchen dishwasher temperature logs, dated June 2024, reflected both wash and rinse temperatures to be 120 Degrees Fahrenheit every day from 06/01/2024 through 06/03/2024. Record review of vent hood cleaning invoice dated 02/20/2024 reflected, Spraying and cleaning of vent hoods, ducts, filters, and exhaust fans; next service [DATE] Record review of undated, untitled manufacturer's guidance for the dishwasher reflected, The ADC conveyors are rated in both methods of sanitizing, and NSF lists these dish machines as dual sanitizers. This means the machine design can serve in both roles without modification. The final rinse manifold will accomplish the task of applying chemical sprays or high temperature sprays with the same water consumption rates and systems. The only difference is the type of chemical dispenser application (min. 50 ppm chlorine) or the boosted incoming hot water (min. 180-degree Fahrenheit) for final rinse. Record review of facility dishwashing policy, titled Dishwashing Machine Use, dated revised 03/2010, reflected if hot water temperatures or chemical sanitization concentrations do not meet requirements, cease use of dishwashing machine immediately until temperatures or PPM are adjusted.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307 Based on interview and record review, the facility failed to provide a minimum of 80 square feet per resident in 20 of 46 resident rooms as required for (Rooms #1, #2, #3, #4, #5, #6, #7, #8, #11, #13, #15, #16, #17, #18, #19, #20, #21, #22, #23, and #25) reviewed for the 80 square feet per resident requirement. The facility failed to ensure all resident rooms met the minimum size requirements. This deficient practice could affect residents who may reside in these rooms and not allow sufficient room to carry out activities of daily living care, or have the room furnished as they would like and place them at risk for decreased quality of life. The findings included: Record review of HHSC Form-3740, dated 06/02/2024, reflected rooms #1-23 and #25 were indicated as Title 18/19 beds with a total facility occupancy of 46 beds. Record review of HHSC Form-3763, dated 06/05/2024, reflected rooms #1-23 and #25 as rooms that did not meet the justification criteria on the basis that they did not meet the 72 square feet per resident requirement Interview on 06/04/2024 at 4:34 PM, the ADM stated she had not herself reviewed the sizes of all of the rooms but had understood that all of the rooms were under an existing size waiver. Review of the facility daily census dated 06/02/2024 revealed the following rooms were dually occupied: - Rooms #1-4 - room [ROOM NUMBER] - room [ROOM NUMBER] - Rooms #10-14 - room [ROOM NUMBER] - room [ROOM NUMBER] - room [ROOM NUMBER]