STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675587	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Manor Healthcare Center	3011 W Adams Ave Temple, TX 76504

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interviews, and record reviews, the facility failed to ensure the resident's right to secure and confidential personal and medical records for one (unknown resident) of 28 residents . The facility failed to ensure the privacy of the unknown resident by not locking the laptop screen, so the resident's information could not be seen by someone walking by. This failure put residents at risk for confidential health information exposure, psychosocial harm and decreased quality of life. Findings included: Observation on 6/16/2025 at 12:05 PM during lunch service revealed that the tablet on the medication cart was open and the screen had the resident's information on the laptop screen. The surveyor was watching lunch service and walked around the corner, and the laptop was open. The surveyor waited five minutes, and the staff member did not return to the medication cart. The laptop screen timed out, and the screen went dark after five minutes. In an interview on 6/19/2025 at 1:53 p.m., MA A stated you cannot leave the laptop screen open with residents' information on it. MA A stated this is a HIPAA violation. MA A stated anyone walking by would be able to see the residents' medical information if the laptop were open. MA A said she has not seen any co-workers leaving their laptops open with resident information on the screen. MA A stated if she sees a laptop open showing resident information, then she closes the laptop and reminds the person they need to close the laptop. MA A said she has been in-serviced on resident rights and privacy. In an interview on 6/19/2025 at 2:03 p.m., MA B stated she is aware of the facility's policy on resident rights and privacy. MA B said when you walk away from the cart, you need to lock the laptop screen so that residents' information is not showing. MA B said if a resident's information is showing, then anyone would be able to get the resident's medical records. MA B said if she sees a lap open, she will close it and let the person know that it was open. MA B said she has not seen anyone leave their laptop open with resident information showing. MA B said if she saw an open tablet, then she would close it and remind the worker that they cannot leave the laptop open so anyone can see. MA B said it is a violation of HIPAA and resident rights to leave resident information visible for people walking by to see. (continued on next page)

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

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/19/2025 at 3:18 p.m., the ADM stated staff are trained on HIPAA laws. The ADM stated when staff walk away from the medication cart the laptop screen should be locked or minimized. He stated if the screen is left open then someone passing by could get the resident's information. The ADM said he has never seen any staff leave the laptop open with the resident's information on the screen. The ADM said that if staff leave the laptop opened, then he would shut it, talk to the staff. The whole facility would be inserviced on resident rights and privacy. In an interview on 6/19/2025 at 4:18 p.m., with DON said that staff should not walk away from the medication cart with the laptop open that has a resident's information on it. Staff are in serviced on HIPAA law and residents' privacy rights. The DON said that she has not seen any staff leave the laptops open with residents' info on the laptop. The DON stated that if she sees an open laptop then she would close it and talk to the staff member. The DON stated that she would do Inservice. Review of the Job description (undated) revealed staff were to follow their Job Description - Understand, comply with, and promote all rules regarding residents' rights.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, interviews, and record reviews, the facility failed to provide a safe, clean, comfortable, and homelike environment for 2 residents (Resident #1 and Resident #2) of 28 residents observed for a clean environment. The facility failed to ensure Resident #1 and Resident #2 had a homelike environment . These deficient practices could place residents at risk of a decreased quality of life. Findings included: Observations on 06/17/25 at 10:19 a.m., in Resident #1's room. Resident #1 was not in the room at the time. There were several pieces of trash on the floor. The bed sheets were dirty with several stains. It appeared the sheets had not been changed in several days. The bathroom had several pieces of trash on the floor. The toilet had fecal stains on the seat. The toilet appeared not to have been cleaned in a while. Observations on 06/17/25 at 10:19 a.m., in Resident #2's room. The armoire in the room looked old, with paint peeling off and holes in it. Resident #2 said it has been like that for a while. Resident #2 said he has not asked for anyone to replace it. Observations on 06/17/25 at 1:58 a.m ., in Resident #1's room. Resident #1 was in the room, lying in bed. The room and the bathroom had been cleaned. The sheets on the bed had not been changed. Resident #1 said he cannot depend on the staff at the facility . Resident #1 said he did not want to talk anymore because he was going to sleep. In an interview on 6/19/2025 at 1:42 p.m., the HK said rooms are cleaned once a day. The HK said if the room needs to be cleaned more, she will do it. The HK stated Resident #1 is difficult and does not let people clean his room. The HK said she cleans the room when he is not in there. The HK said if a room is not cleaned, it will be unsanitary for the residents. In an interview on 6/19/2025 at 1:52 p.m., MA A stated rooms are cleaned once a day. MA A said if there is a spill, she will clean it up. MA A said if it's a bigger spill, she will get housekeeping to clean up the mess. CNA said sheets are changed on shower days. MA A feels there is enough staff to keep the residents' room cleaned. In an interview on 6/19/2025 at 2:03 PM, MA B stated that if a room is dirty, she tells housekeeping. MA B said housekeeping is fast cleaning rooms when there is a mess. MA B stated that Resident #1 can be difficult when it's time to get his room cleaned. MA B said Resident #1 gets his room cleaned when he is not in the room. CNA said sheets are changed on shower days . MA B feels there are enough staff to keep the rooms cleaned. MA B said Resident #1's room is cleaned when he is not in there. In an interview on 6/19/2025 at 2:10 p.m., CNA F stated that if she sees a dirty room, she will call for housekeeping, so they can clean it up. She stated if it is a small spill then she will clean it up. She said sheets are changed on shower days. She stated that when a room is not clean, it is not sanitary for the resident. She said Resident #1's room is cleaned when he is not in the room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 6/19/2025 at 3:18 p.m., the ADM said staff have a difficult time getting Resident #1's room cleaned and the sheets changed because of his behavior. The ADM stated that Resident #1's room sheets are changed when he is not in the room. The ADM said it happens when Resident #1 is outside smoking. The ADM did not know why Resident #1's room was not being cleaned when Resident #1 was not in the room. The ADM said residents' sheets are changed on shower days. In an interview on 6/19/2025 at 4:18 p.m., the DON said residents' rooms are cleaned daily and sheets are changed when a resident takes their shower. The DON said that Resident #1 can be difficult when staff go in there to change his sheets or clean his room. Resident #1 will often curse and yell at the staff who come in and try to help him. Resident #1 usually gets his sheets changed and his room cleaned when he goes out to smoke cigarettes. The DON said Resident #1's room should have been cleaned if the resident was not in the room at the time. Record Review of the facility's Policy Statement , Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation 1. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. Needs and preferences. 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment. e. clean bed and bath linens that are in good condition.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review the facility failed to ensure the resident assessments accurately reflected the resident's status for 2 (Resident # 10 and Resident #7) of 8 residents reviewed for accuracy of assessments. 1. The facility failed to ensure Resident #10's Significant Change MDS assessment, dated 12/31/2024, completed Resident #10's preferences for customary routine and activities. 2. The facility failed to ensure that Resident #7's Significant Change in Status MDS assessment on 05/21/2025 accurately reflected that she had an unhealed pressure ulcer at the time of the assessment. This deficient practice could have placed the residents at risk for inadequate care and diminish quality of life due to inaccurate assessments. Findings included: 1. Review of Resident #10's Face Sheet, dated 06/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses unspecified dementia, unspecified severity, with agitation (a group of symptoms affecting memory, thinking, and social abilities- its exact severity not determined- with state of restlessness), cognitive communication deficit (memory loss and trouble concentrating, completing tasks, understanding, remembering, following instructions, and solving problems), and reduced mobility (limitation in a person's ability to move around independently, due to physical disabilities, age, or other factors). Review of Resident #10's Significant Change MDS, dated [DATE], reflected Resident #10 had a BIMS score of a 2 indicating her cognition was severely impaired. Resident #10's staff assessment for activity preference had dashes. (Section F of the MDS indicated section F was not completed). It was certified by the RRN. Review of Resident #10's Comprehensive Care Plan, dated 04/10/2025, reflected Resident #10 was not at ease in joining other residents in activities. Resident #10 will yell and hit the table during group activities. Intervention: Activity Director will provide 1:1 activity session as needed. Place resident in position of almost certain success in an activity. Encourage resident to verbalize feelings and fears. Review of Resident #10's electronic medical record on 06/16/2025 reflected activity staff did not assess Resident #10's activity preferences for the MDS Assessment, dated 12/31/2024. Interview on 06/19/2025 at 8:00 AM requested the RRN's phone number from the Director of Nurses and it was not provided at time of exit. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/19/2025 at 8:30 AM The Activity Director stated she did not complete section F staff assessment (Activity Preferences of Resident #10). She stated Resident #10 was not interview able. She stated Resident #10 did not have family; however, she had a caregiver. The Activity Director stated she did not contact the care giver to obtain information about Resident #1's activity preferences. She stated she forgot to complete the staff assessment of Resident #10's activity preferences on the significant change MDS section, dated 12/31/2024. The Activity Director stated Resident #10's activity preferences were not documented anywhere in the electronic medical record. In an interview on 06/19/2025 at 9:27 AM The Regional MDS Consultant P stated she was responsible for monitoring MDS. She stated if there were dashes on the MDS, this indicated the MDS was not a completed assessment. The Regional MDS Consultant stated the Activity Director was expected to complete section F (Activity Preferences) of the significant change MDS of Resident #10. She stated if the resident was not capable of answering the questions, the Activity Director was required to answer the staff assessment. She stated it was very important for all sections of the MDS to be completed. The Regional MDS Consultant stated the care plan would be difficult to develop if a resident was not assessed on the MDS. In an interview on 06/19/2025 at 12:57 PM The Director of Nurses stated all sections of the MDS were expected to be completed by the appropriate staff. She stated all information was obtained prior to completing the MDS. The DON stated the Activity Director was expected to contact anyone with information on Resident #10 including the care giver. She also stated the staff also could have been interviewed to obtain information when the staff interacted with Resident #10. The DON stated Resident #10 enjoyed drinking coffee and talking to staff. She stated she had observed Resident #10 enjoying music in the common area and in her room. The Director of Nurses stated Resident #10 did not enjoy group activities and did respond more to one-on-one activities. She stated if the MDS assessment was not completely documented, there was a potential the resident's care plan may not be accurate and the resident's quality of life and quality of care may diminish. In an interview on 06/19/2025 at 1:30 PM requested the RRN's phone number from the Director of Nurses and it was not provided at time of exit. Review of Resident #7's Face sheet reflected a [AGE] year-old, female admitted to the facility on [DATE]. Diagnoses included: Schizoaffective Disorder, bipolar type (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), Vascular Dementia with anxiety (dementia related to blood flow to the brain that includes feelings of intense and excessive worry and fear), Pain, and Functional quadriplegia (inability to move all four limbs). Review of Resident #7's Significant Change MDS dated [DATE] reflected that the resident had a BIMS score of 14 (no cognitive impairment). Section M for Skin Condition reflected a 0 for M0210 (Unhealed Pressure Ulcers/Injuries), indicating that she did not have any unhealed pressure ulcers/injuries. The assessment was signed by RCMDS Q. Review of Resident #7's orders reflected an order for Wound Treatment Order: Location: mid-back/sacral area [region of skin between the mid-back and the bottom of the spine]-Clean with Normal Saline/Wound Cleanser Apply: Collagen powder and cover with Primary Dressing: Border Gauze Secure with Tape Once a Day: Mon, Wed, Fri 06:00AM-06:00PM started on 04/02/2025. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #7's Wound Evaluation and Management Summary from Wound Care Physician dated 05/15/2025 reflected a stage 3 pressure wound to the resident's sacrum with a Duration as greater than 164 days. Review of Resident #7's Care Plan reflected a Problem Area stating, Problem Start Date: 01/15/2025 Category: Pressure Ulcer/Injury Resident #7 has a pressure ulcer to sacrum. Edited: 06/16/2025. There was a related Approach intervention stating, Provide treatment as ordered. Observation of wound care with LVN M, CNA G, and CNA H for Resident #7 on 06/18/2025 at 10:30 AM revealed that the resident had a pressure wound to her sacrum with a diameter of approximately 0.2 cm and a depth of approximately 0.1 cm. In an interview with RCMDS P on 06/19/2025 at 06:20 PM, she stated that the significant change MDS dated [DATE] stated that Resident #7 was coded as having no pressure ulcers. She stated that she was responsible for overseeing the MDS assessments for the building. She stated that she does quarterly score cards with a random audit of residents in the facility to review for accuracy and timeliness. She stated that she had not audited Resident #7. She stated that the resident had wound care notes from the wound doctor at the time of the assessment stating that the resident had a pressure ulcer. She stated coding her as having no pressure ulcers was an error. She stated that the impact to the resident was that it could affect the care planning process and possibly the wound management or payment depending on the wound type. In an interview on 06/19/2025 at 06:30 PM with the ADM and DON, they both stated that they expected the MDS assessments to be accurate. They stated that the person responsible for the MDS assessments in May 2025 was RCMDS P. They stated that she was responsible for the oversight in the absence of a full time MDS staff. He stated that there was no impact to the resident regarding the MDS error because the supplies are paid for by Hospice services, not the reimbursements from the MDS. Review of a staff roster from 06/17/2025 reflected that RCMDS Q was not a current staff member for the facility. Review of the Facility's Policy on Certifying Accuracy of the Resident Assessment, dated November 2019, reflected Any person completing a portion of the Minimum Data Set/ MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. Any health care professional who participates in the assessment process is qualified to assess the medical, functional and/or psychosocial status of the resident that is relevant to the professional's qualifications and knowledge. Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment. The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment. Different items on the MDS may have different observation periods. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Assessment Coordinator is responsible for ensuring that an MDS assessment has been completed for each resident. Each assessment is coordinated and certified as complete by the Resident Assessment Coordinator, who is a registered nurse.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two of eight residents (Resident# 46, and Resident #59) reviewed for ADL care. The facility failed to ensure Resident #46's and Resident # 59's nails were cleaned, and did not have any rough edges. These failures could place residents at risk of not receiving services or care, diminished quality of life, and decreased self-esteem. Findings included: Review of Resident #46's face sheet, dated, 06/18/2025, reflected a [AGE] year-old male who was admitted on [DATE]. Resident #46 had diagnoses which included need for assistance with personal care (helping individuals with activities of daily living like bathing, dressing, toileting, grooming, and eating), personal history of traumatic brain injury (occurs when external force impacts the head, causing damage to the brain), presbyopia (gradual loss of the ability to focus on nearby objects), and seizures (a sudden, temporary surge in the brain that can cause changes in behavior, movement, awareness, or sensation). Review of Resident #46's Quarterly MDS, dated [DATE], reflected the resident had a BIMS score of 9, which indicated his cognition was moderately impaired. Resident #46 required partial/moderate assistance (helper does less than half the effort) with personal hygiene, lower body dressing, transfers, bed mobility, and toileting hygiene. He was dependent on staff for showers. Review of Resident #46's Comprehensive Care Plan, with revision date of 06/07/2025 reflected Resident # 46 required one staff assistance with bathing, dressing, grooming and hygiene. Observation and interview on 06/17/2025 at 8:45 AM, revealed Resident #46 was in his room lying in bed. He had a blackish/ brownish substance underneath the middle and ring fingernails on his right hand. Resident #46's middle fingernail on his right hand was uneven around the edges. Resident #46 did not respond to questions or conversation about his nails. Resident #46 stated yes when asked if he requested for his nails to be cleaned or trimmed. He did not elaborate on who or when he asked for assistance with his fingernails. Review of Resident # 59's face sheet, dated 06/18/2025, reflected a [AGE] year-old male admitted on [DATE] with diagnoses which included need for assistance with personal care (providing support for individuals who need help with personal hygiene, dressing, or toileting, etc.), depression, unspecified (a mood disorder that causes a persistent feeling of sadness and loss of interest), and scoliosis (a condition where the spine curves sideways, forming an S or C shape, rather than a straight line- can lead to back pain and difficulty with breathing). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #59's Quarterly MDS Assessment, dated 06/09/2025, reflected Resident #59 had a BIMS score of 14 indicating his cognitive status was intact. Resident #59 was dependent on staff for eating, oral hygiene, toileting hygiene, dressing, personal hygiene, transfers, bed mobility and showers. Review of Resident #59's Comprehensive Care Plan, dated 06/09/2025 reflected Resident #59 required assistance with all ADLs to include: transfers, feeding, dressing, bathing, and toileting, etc. Observation and interview on 6/17/2025 at 8:45 AM, revealed Resident #59 was in his room lying in bed. He had a blackish/ brownish substance underneath the middle ring and fore fingernails on his right hand. Resident #59's ring and middle fingernail on his right hand were uneven around the edges. He stated on Saturday (06/14/2025) he asked a nurse if she would clean his nails. Resident #59 did not recall the nurse's name and the nurse stated his nails would be cleaned and trimmed on Sunday (06/15/2025). He stated he was going to ask someone this week to clean and trim his nails. In an interview on 06/19/2025 at 9:00 AM, LVN L stated the nurses were responsible for residents with diagnosis of diabetes with nail care such as trimming, cleaning, filing. She stated the CNAs were responsible for all other residents' nail care. LVN L stated if a resident had brownish/blackish substance underneath their nails and if a resident swallowed the substance there was a possibility a resident may become ill such as stomach problems nausea and vomiting. LVN L stated if a resident refused any type of care, the nurse would document the refusal in the nurse's notes. She stated Resident #59 and Resident #46 did not refuse care. She stated no one had reported to her Resident #46 or Resident #59 refused nail care. LVN L stated she had worked with Resident #46 and Resident #59 for several weeks. She stated she had been in- serviced on nail care, however, she did not recall the date. In an interview on 06/19/2025 at 9:20 AM, CNA E stated the CNAs were responsible for cleaning, trimming, and filing all residents' nails except for the residents with a diagnosis of diabetes. He stated the nurses were responsible for all the residents' nails with a diagnosis of diabetes. CNA E stated the residents' nails were usually cleaned on Sundays, their shower days and as needed. He stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill such as vomiting and diarrhea. He stated a resident may cause a skin tear if their fingernails were not smooth. CNA E stated he was in-serviced on cleaning, filing, and trimming residents' nails but he did not recall the date. He stated he had given care to Resident # 59 and Resident #46, and they did not refuse nail care. CNA E stated he did not know the last time these residents' nails were trimmed or cleaned. He stated if any resident refused care it was reported to the nurse and the nurse would document the refusal in the nurses note. He stated he was in-serviced on nail care. CNA E stated he did not recall the date of the nail care in-service. In an interview on 06/19/25 at 10:30 AM, CNA C stated the nurses, and the CNAs were responsible for nail care. She stated the nurses were responsible to trim and clean all resident's nails with a diagnosis of diabetes. She stated it was the CNAs' responsibility to clean and trim all other residents' nails during showers or as needed. She stated if there was a blackish substance underneath the resident's nails, there was a possibility the substance had bacteria. CNA C stated if a resident swallowed the bacteria there was a possibility a resident may become ill with stomach problems such as vomiting. CNA C stated she was in-serviced on nail care; however, she did not recall the date. She stated she had given care to Resident #59 and Resident #46. She stated she was not aware of Resident #59 or Resident #46 refusing nail care. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/19/25 at 09:36 AM, the Director of Nurses stated if a resident ingested the blackish substance on their fingers or underneath their fingernails, there was a possibility the substance may be some type of bacteria, however it would be difficult to determine if the blackish/ brownish substance was bacteria. She stated it was a possibility a resident may become ill with stomach issues such as vomiting and diarrhea if they ingested the blackish/ brownish substance. She stated the CNAs were responsible for all residents' nails such as cleaning, trimming, and filing except for the residents with diabetes (a disease that occurs when your blood sugar, is too high) . She stated for any resident with a diagnosis of diabetes the nurse was responsible for these residents' fingernails. The Director of Nurses stated the nurse supervisor was responsible for monitoring CNAs giving ADL care including nail care and she was responsible for monitoring the nurse supervisors. Review of the Facility's Policy on Activities of Daily Living, dated 03/2018, reflected Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. The resident's response to interventions will be monitored, evaluated, and revised as appropriate.

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	675587	A. Building B. Wing	06/19/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed , to provide an ongoing activities program to support residents in their choice of activities, both facility sponsored group and individual activities, and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for two of five residents (Resident # 10 and Resident # 59) reviewed for activities. The facility failed to provide Resident # 10 in room activities during the months of April, May, and June of 2025. The facility failed to provide Resident # 59 in room activities twice per week during the months of April, May, and June 2025. This failure could place residents at risk for boredom, depression, and diminished quality of life. Finding included: Review of Resident #10's Face Sheet, dated 06/18/2025, reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses unspecified dementia, unspecified severity, with agitation (a group of symptoms affecting memory, thinking, and social abilities- its exact severity not determined- with state of restlessness), cognitive communication deficit (memory loss and trouble concentrating, completing tasks, understanding, remembering, following instructions, and solving problems), and reduced mobility (limitation in a person's ability to move around independently, either due to physical disabilities, age, or other factors). Review of Resident #10's Significant Change MDS, dated [DATE], reflected Resident #10 had a BIMS score of a 2 indicating her cognition was severely impaired. Resident #10's activity preference was not completed by staff. Review of Resident #10's Quarterly MDS Assessment, dated 05/13/2025, reflected Resident #10 had a BIMS score of a 2 indicating her cognition was severely impaired. (Activities does not fill out section F on the Quarterly MDS) Review of Resident #10's Comprehensive Care Plan, dated 04/10/2025, reflected Resident #10 was not at ease in joining other residents in activities. Resident #10 will yell and hit the table during group activities. Intervention: Activity Director will provide 1:1 activity session as needed. Place resident in position of almost certain success in an activity. Encourage resident to verbalize feelings and fears. Review of Resident #10's Activity Assessments revealed a Initial Activity Assessment was not completed. Review of Resident #10's Activity Participation Record during the months of April, May, and June from 06/01/2025 to 06/16/2025 reflected Resident #10 did not refuse one-on-one activities or receive one-on-one activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and Interview on 06/17/2025 at 1:16 PM, revealed Resident #10 was in her geri-chair sitting in the common area near the 200 hall. She was staring toward the wall. Resident #10 said hello. Resident #10 did not respond to any questions or conversation. She was not interview able. Observation and Interview on 06/17/2025 at 3:30 PM, revealed Resident #10 was sitting in her geri-chair in her room. There was no stimulation in the room, and she would not respond to any conversation or questions. Resident #10 was not interviewable. Review of Resident # 59's face sheet, dated 06/18/2025, reflected a [AGE] year-old male admitted on [DATE] with diagnoses which included depression, unspecified (a mood disorder that causes a persistent feeling of sadness and loss of interest), vascular dementia, moderate, with anxiety (significant decline in memory, thinking, and behavior. Anxiety- unease, worry or fear, often about things that might happen in the future), and insomnia, unspecified (a sleep disorder characterized by difficulty initiating or maintaining sleep, or waking up too early, without a specific underlying cause). Review of Resident #59's admission MDS Assessment, dated 03/04/2025, reflected Resident #59 had a BIMS score of 11 indicating his cognition was moderately impaired. Resident #59's activity preferences were the following: going outside to get fresh air when the weather permitted. Participating in religious services or practices, listening to music, and being around animals such as pets. Review of Resident #59's Comprehensive Care Plan, revised on 05/14/2025, reflected Resident #59 was in pain. Intervention: Offer non-drug interventions for my pain such as activities- conversation (since I love to talk). The care plan did not include any other activities. In an interview with the Activity Director on 06/18/2025 at 8:40 AM, requested Resident #59's Initial Activity Assessment and this was not provided at the time of exit. Review of Resident #59's Activity Quarterly Progress Note, dated 06/09/2025, reflected Resident #59 enjoyed one on one visits. He participated in two one-on-one activities per week. Resident #59 chose not to participate in group activities. He prefers to stay in his room. Resident #59 was alert and oriented to person, place, and time. He was assessed to need one to one interaction, intellectual stimulation, and sensory stimulation (did not specify what type of sensory stimulation). Resident #59's focus of programming was one-to one- activities, intellectually stimulating activities, outdoor activities, and relaxation activities (did not specify his preferences). Resident plan of care will be continued. Resident #59's activity assessment signed by the Activity Director. Review of Resident #59's one-on-one schedule on 06/17/2025, not dated, reflected Resident #59 was to receive one-on-one visits two times per week. Review of Resident #59's one-on-one activity records, on 06/18/2025, from the electronic medical records reflected the following: 1. Resident #59 received one-on-one visits on the following dates during the month of April: a. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/15/2025 b. 04/16/2025 c. 04/28/2025 2. Resident # 59 received one-on-one visits on the following dates during the month of May: a. 05/07/2025 b. 05/08/2025 c. 05/19/2025 d. 05/30/2025 3. Resident #59 received one-on-one visits on the following dates between 06/01/2025 to 06/16/2025: a. 06/09/2025 b. 06/10/2025 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 06/17/2025 at 9:15 AM, revealed Resident # 59 was in his room lying in bed. He was staring at the wall in front of him. There was not any stimulation in his room. Resident #59 stated he wanted someone to come to his room and talk to him approximately four times a week. He stated he did become lonely especially in the late afternoons. Resident #59 stated no one asked him if he wanted someone to visit with him. He stated some lady comes to his room and asks him to go to activities and will bring him some food from parties sometimes, however, he stated he wanted someone to sit with him and talk to him about different things. He stated he preferred to talk about whatever was on his mind at the time of the visit. Resident #59 stated he did not want to talk about his feelings he wanted to talk about happy things. In an interview on 06/18/2025 at 8:30 AM The Activity Director stated Resident #10 and Resident #59 were on the in-room activity program. She stated Resident #10 did not attend group activities and would sit in the common area near the 200 hall sometimes. She stated Resident #10 would refuse in room activities at least three times a month. The Activity Director stated she did not document when Resident #10 refused in room activities. She stated Resident #10 did not enjoy being in any size group. She stated Resident #59 preferred visits in his room. The Activity Director stated he was to receive in room activities two times per week. She stated she was not aware he wanted more in room visits. The Activity Director stated according to her documentation Resident #10 had not received in room activities for the months of April and May in 2025. She stated Resident #10 did not receive in room activities during the dates of June 1st to June 16th, 2025. She stated Resident #59 did not receive in room activities two times a week during April, May, and June 2025. She stated she did not have an explanation why Resident #59 did not receive the in room visits he needed to prevent him from becoming lonely. The Activity Director stated she had difficulty interacting with Resident #10 during in room activities. She did not elaborate when asked why she had difficulty interacting with Resident #10. She stated Resident #10 did not interact with other residents or watch television. The Activity Director stated she was expected to ensure all residents received activities based on their preferences and their physical abilities. She stated if a resident was not receiving any type of activities there was a possibility a resident may become bored, depressed or have a decline in their quality of life. She stated she did not know Resident #10's activity preferences. The Activity Director stated Resident #10 did not have any family, however, she did have a care giver. She stated the care giver may know Resident #10's activity preferences. She stated she did not interview the caregiver to determine Resident #10's activity preferences. In an interview on 06/19/25 at 09:04 AM, CNA C stated Resident #10 enjoyed sitting in the common area and sometimes covered her head with a blanket. She stated Resident #10 did not interact with other residents. CNA C stated Resident #10 enjoyed drinking coffee and would talk to staff when she was drinking coffee. She stated when she was in her room or in the common area if country music was playing, she would talk about country music with staff. She stated Resident #10 did not enjoy interacting with others for a very long period. In an interview on 06/19/2025 at 12:57 PM The Director of Nurses stated Resident #10 enjoyed drinking coffee and talking to staff. She stated she had observed Resident #10 enjoying music in the common area and in her room. She stated Resident #10 enjoyed talking about music. The Director of Nurses stated Resident #10 did not enjoy group activities and did respond more to one-on-one activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/19/2025 at 2:40 PM the Administrator stated he expected in room activities be provided to the residents needing these types of activities. He stated if a resident was not receiving in room activities there was a possibility a resident may become depressed, bored, and isolated. The Administrator stated the Activity Director was responsible for the activity programs and he was responsible to monitor the Activity Director. Review of the facility policy for Activity Programs, dated 11/2021, reflected Activity programs designed to meet the needs of each resident are available on a daily basis. Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. Activities participation for each resident is based on information in the resident's comprehensive assessment. Review of the facility policy for Activity Documentation, dated 01/2020, reflected The Activity Director is responsible for maintaining appropriate departmental documentation. Recordkeeping is a vital part of the activity program. The following records, at a minimum, are maintained by the Activity Department personnel: 1. Activities evaluation 2. Attendance records 3. Activity progress notes 4. Individualized Activities Care Plan or activities portion of the Comprehensive Care Plan.

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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** Based on observations, interviews, and record reviews the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive care plan for one (Resident #21) of one resident reviewed for nephrostomy care. The facility failed to ensure dressing changes were done for Resident #21's surgical sites on 06/18/2025 and 06/19/2025 and completed per the physician orders and with sterile technique per the facility policy. This failure puts residents at risk for infection and deterioration of the stoma site (a surgically created opening on the outside of your body that connects to an organ on the inside). Findings: Review of Resident #21's Face sheet revealed a [AGE] year-old, female admitted on [DATE]. Diagnoses included: Hydronephrosis (swelling of the kidneys from blockage of the flow of urine), Urinary Tract Infection, Chronic Kidney Disease, and Type 2 Diabetes (chronic disorder of abnormal blood sugar levels). Review of Resident #21's Quarterly MDS dated [DATE] reflected a BIMS score of 15 (no cognitive impairment). For Section H-Bowel and Bladder it reflected a 9 for Urinary Continence, indicating Not Rated, resident had a catheter (indwelling or condom), urinary ostomy, or no urine output for the entire 7 days. For Section M-Skin Conditions it was indicated that the Resident has a Surgical Wound with Surgical Wound Care. Review of Resident #21's Care Plan reflected a Problem Area indicating, Problem Start Date: 05/23/2023 Category: Indwelling Catheter has nephrostomy tube [a catheter placed into the kidney through an incision in the back to drain urine] in place d/t Chronic cystitis [inflammation of the bladder wall], Hydronephrosis [swelling of the kidneys from blockage of the flow of urine], CKD [chronic kidney disease], and obstructive uropathy [blockage of the urinary tract]. There was an Approach intervention reflecting, Care for tubes/drains: nephrostomy site care per order Created: 05/23/2023. Review of Resident #21's Orders reflected an order to, Clean nephrostomy site with NS and pat dry. Apply split bandage and secure with tape. Twice A Day Morning 07:00AM -10:00AM, Bedtime: 07:00PM-10:00PM with a start date of 04/09/2025. Review of Physician Progress Note for Resident #21 dated 06/16/2025 reflected a note stating, Resident is currently being treated for a UTI (urinary tract infection)-gentamycin 80 mg inj. Other chronic conditions stable at this time. Review of Resident #21's TAR reflected an order for, Clean nephrostomy site with NS and pat dry. Apply split bandage and secure with tape. Twice a Day. There were sign offs on the dressing changes for LVN M for 06/18/2025 and 06/19/2025 indicating that the dressing change was done. In an interview on 06/17/2025 at 10:45AM, Resident #21 stated that she had nephrostomy tubes to both kidneys. She stated that the staff monitored and cared for the tubing. She denied any concerns. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/18/2025 at 09:40 AM with LVN M, she stated that she had not done a dressing change on 06/18/2025 Resident #21. Observation on 06/18/2025 at 10:10AM of Resident #21 revealed that there was no dressing to either nephrostomy site. They were open to air. No redness or drainage was noted to the insertion sites for the nephrostomy tubes. In an interview with Resident #21 on 06/18/2025 at 10:10AM, she stated that the staff check the site every day, but they do not change a dressing to the site. She stated, they just put cream on my back. Observation on 06/19/2025 at 01:15PM revealed that there was no dressing to either nephrostomy site. They were open to air. No redness or drainage was noted to the insertion sites for the nephrostomy tubes. In an interview with Resident #21 on 06/19/2025 at 01:15PM, she stated all they have done is put some lotion on her back. She denied having any dressing added or changed to the nephrostomy sites. In an interview on 06/19/2025 at 11:53AM, the DON stated that she did a skin assessment on Resident #21 that morning prior to surveyor arrival at 08:00AM. In an interview with LVN M on 06/19/2025 at 01:58PM, she stated that the initials charted for 06/19/2025 for the dressing change to the nephrostomy sites for Resident #21 were hers, but that the dressing change was not yet done for that day. She stated that she had not done the dressing change on 06/18/2025 and that she did sign off that it was done that day also. She was knowledgeable of the ordered dressing change but stated that she did not know that the dressing change should be done with sterile technique per the facility policy. She stated that she does not use sterile equipment or sterile technique for dressing changes for the resident. She stated that she had been doing regular dressing changes for the resident prior to the last two days when she worked. She stated after reading the policy that she should be doing sterile dressing changes. She stated, I did not know any of this. She stated that the resident has had the nephrostomy since she was admitted . She stated that the facility did have supplies for sterile dressing changes. In an interview on 06/19/2025 at 02:05PM, the ADON stated that she had worked at the facility for 30 days. She stated that she had not done any dressing changes for Resident #21. She stated that her role was to oversee education and some audits, including urinary catheters. She stated that the nurses are responsible for direct care to the residents. She stated that Resident #21 is the only resident in the facility with nephrostomy tubes. She stated that she was not aware of the facility policy on nephrostomy tubes. She stated she had not received any training on any special care considerations for the insertion sites or on how to perform the dressing changes for the insertion sites. She stated that if she had been aware of the policy regarding sterile dressing changes, she would audit for different criteria and categorize it differently than the audits for urinary catheter care. She stated that her responsibility is to ensure orders are transcribed and put in place, as well as to monitor progress of the residents. She stated that the facility did have supplies to perform the dressing changes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the RN on 06/19/2025 at 02:44PM, she stated that she has worked at the facility since October of last year. She stated that she does not perform the dressing change to Resident #21's nephrostomy site with sterile gloves, supplies, and technique per the policy. She stated that she was unaware that the policy indicated that dressing change was sterile. She stated that based on the policy she should be doing sterile dressing changes for Resident #21. She stated that she did not recall any in-services regarding the nephrostomy policy. She stated that the impact to the resident of not performing dressing changes per the policy could lead to increased risk of infection. She stated that the resident has chronic UTIs. She denies any hospitalizations with UTI to her recollection. In an interview on 06/19/2025 at 03:37PM with the DON, she stated that it was her expectation that staff used sterile technique for the dressing changes to Resident #21's nephrostomy sites. She demonstrated knowledge of the facility policy. She stated that when she did the skin assessment for the resident that morning, she noted that there was no dressing to the site. She stated that she told LVN M to dress the site, but stated she had not gone back to ensure that it was done. She stated that she had not done any recent in-services on the policy for nephrostomy tubes or the related care considerations. She stated that staff were not trained on hire to perform nephrostomy care or dressing changes. She stated that she, the ADON, and the RN were responsible to ensure that the dressing changes were done for Resident #21. She stated that the potential risk to the resident was increased risk of infection. She stated that the resident has had a recent UTI but was not hospitalized . She stated that if the resident was removing the dressing herself that the nurses should be documenting it. She stated that the staff should not be signing off that they performed the care when they did not. In an interview on 06/19/2025 at 04:23PM, LVN J stated that she changed the dressing for Resident #21 every day that she works with her. She could not recall the ordered dressing change. She could not clearly indicate if she used sterile or clean gloves and supplies for dressing changes to Resident #21. She stated that she used sterile gloves for all dressing changes. In an interview with the MD at 05:52PM on 06/19/2025, she stated that if the policy stated that dressing should be changed with sterile technique, then it should be done with sterile technique. She stated that the site is already contaminated and not a sterile site. She stated that the resident has chronic UTIs. She stated that if the nephrostomy care is not performed per the policy that it would lead to an increased risk of infection. She stated that she was not aware that there was no dressing to the site and that it was her expectation that the site have a dressing. In an interview on 06/19/2025 at 06:30PM the ADM stated that he expected that dressing changes be performed per the physician orders and per policy. He stated that the potential impact to the resident of not doing wound care per the orders and policy standards could lead to worsening of the wound or ostomy site. Review of facility in-services for the last six months reflected there were no in-services regarding the nephrostomy care policy for the facility. Review of facility policy dated October 2010 for Nephrostomy Tube, Care of reflected, General Guidelines . 8. Change dressings every 1-3 days, or as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. Use sterile technique during dressing changes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents with pressure ulcers receive necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection for one (Resident #7) of two residents reviewed for pressure ulcers. 1. The facility failed to ensure that dressing changes were completed for Resident #7's pressure ulcer on 06/11/2025, 06/13/2025, and 06/16/2025. This failure could place residents with pressure ulcers at risk for infection, pain, and worsening of the wound. Findings included: Review of Resident #7's Face sheet reflected a [AGE] year-old, female admitted to the facility on [DATE]. Diagnoses included: Schizoaffective Disorder, bipolar type (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), Vascular Dementia with anxiety (dementia related to blood flow to the brain that includes feelings of intense and excessive worry and fear), Pain, and Functional quadriplegia (inability to move all four limbs). Review of Resident #7's MDS dated [DATE] reflected that the resident had a BIMS score of 14 (no cognitive impairment). Section M for Skin Condition reflected a 0 for M0210 (Unhealed Pressure Ulcers/Injuries), indicating that she did not have any unhealed pressure ulcers/injuries. The assessment was signed by RCMDS Q. Review of Resident #7's Care Plan reflected a Problem Area stating, Problem Start Date: 01/15/2025 Category: Pressure Ulcer/Injury Resident #7 has a pressure ulcer to sacrum (area of skin above the triangular bone at the base of the spine). Edited: 06/16/2025. There was a related Approach intervention stating, Provide treatment as ordered. Review of Resident #7's orders reflected an order for Wound Treatment Order: Location: mid-back/sacral area-Clean with Normal Saline/Wound Cleanser Apply: Collagen powder and cover with Primary Dressing: Border Gauze Secure with Tape Once a Day: Mon, Wed, Fri 06:00AM-06:00PM started on 06/18/2025.There was an order for, Wound Treatment Order: Location: mid back/sacral area Clean with Normal Saline/Wound Cleanser Apply: Collagen powder and hydrocolloid sheet Cover with Primary Dressing: Bordered gauze Secure with tape Once a day on Mon, Wed, Fri. with a start date of 04/02/2025 and a discontinue date of 06/18/2025. Review of Resident #7's Wound Evaluation and Management Summary dated 05/15/2025 reflected a stage 3 pressure wound to the resident's sacrum with a Duration as greater than 164 days. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #7's TAR reflected there was no treatment recorded for Monday, 06/09/2025; the treatment recorded for Wednesday, 06/11/2025 was signed off on by LVN K; the treatment recorded for Friday, 06/13/2025 was signed off on by LVN M; and no treatment was recorded for Monday, 06/16/2025. The TAR reflected a Wound Treatment, Pain Evaluation to be done, Mon, Wed, Fri; Set Frequency to match Treatment Administration Order. The sign offs reflected the same dates and persons indicated for the 06/09/2025, 06/11/2025, and 06/13/2025 treatments. There was a sign off on Monday, 06/16/2025, from LVN K, indicating she assessed pain during wound care that day. Observation of wound care with LVN M, CNA G, and CNA O for Resident #7 on 06/18/2025 at 10:30 AM revealed that the resident had a pressure wound to her sacrum with a diameter of approximately 0.2 cm and a depth of approximately 0.1 cm. The dressing removed from the patient revealed the date, 06/09/25 with the initials for LVN M. In an interview on 06/18/2025 at 03:00PM with LVN M, she stated that she did a full skin assessment on Resident #7 that on the morning of 06/18/2025 she and had not noticed the dressing from Resident #7's sacral wound during the assessment or during wound care performed on 06/18/2025 was dated 06/09/25 with her initials. She stated that she always records the dressing changes on the TAR. She stated that she did sign off on the wound care for Resident #7 on 06/13/25. She stated, I thought I did the wound care that day, but I must not have done it. She stated that she should not have documented that the treatment was done if it was not done. She stated that not doing a dressing change as ordered could place Resident #7 at risk for infection and worsening of the wound. In an interview on 06/19/2025 at 03:37PM with DON, she stated that it is her expectation that if staff document wound care that, it should be done. She stated that wound care should be performed per the orders. She stated that if staff are unable to finish a scheduled task on their shift that it should be passed on to the next shift, to herself, or the ADON, so that it can be completed. She stated that refusals of care should be documented after several attempts to the MD, herself, and the RP in addition to documenting the refusal. She stated the impact to the resident of not receiving care that was ordered could contribute to the worsening of the wound. Attempted an interview with LVN K on 06/19/2025 at 04:53PM. No call was returned prior to exit. In an interview with the ADM on 06/19/2025 at 06:30PM, he stated that he expected that dressing changes be performed per the physician orders and per policy. He stated that the potential impact to the resident of not doing wound care per the orders and policy standards could lead to worsening of the wound or ostomy site. Review of the facility's policy dated April 2024 for Pressure Injury/Skin Breakdown-Clinical Protocol failed to include guidance for facility expectations regarding following wound care orders.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs for 4 (ADON, RN, LVN M, and LVN J) of 5 staff reviewed for nephrostomy care for Resident #21. The staff were not aware that the nephrostomy policy for the facility indicated that Resident #21 should have sterile dressing changes per the facility policy. This failure could potentially affect the residents by placing them at risk for infection and deterioration of the stoma site due to staff who lack the appropriate skills and competencies to minimize infections. Findings: Review of Resident #21's Face sheet revealed a [AGE] year-old, female admitted on [DATE]. Diagnoses included: Hydronephrosis (swelling of the kidneys from blockage of the flow of urine), Urinary Tract Infection, Chronic Kidney Disease, and Type 2 Diabetes (chronic disorder of abnormal blood sugar levels). Review of Resident #21's Quarterly MDS dated [DATE] reflected a BIMS score of 15 (no cognitive impairment). For Section H-Bowel and Bladder it reflected a 9 for Urinary Continence, indicating Not Rated, resident had a catheter (indwelling or condom), urinary ostomy, or no urine output for the entire 7 days. For Section M-Skin Conditions it was indicated that the Resident has a Surgical Wound with Surgical Wound Care. Review of Resident #21's Care Plan reflected a Problem Area indicating, Problem Start Date: 05/23/2023 Category: Indwelling Catheter has nephrostomy tube [a catheter placed into the kidney through an incision in the back to drain urine] in place d/t Chronic cystitis [inflammation of the bladder wall], Hydronephrosis [swelling of the kidneys from blockage of the flow of urine], CKD [chronic kidney disease], and obstructive uropathy [blockage of the urinary tract]. There was an Approach intervention reflecting, Care for tubes/drains: nephrostomy site care per order Created: 05/23/2023. Review of Resident #21's Orders reflected an order to, Clean nephrostomy site with NS and pat dry. Apply split bandage and secure with tape. Twice A Day Morning 07:00AM -10:00AM, Bedtime: 07:00PM-10:00PM with a start date of 04/09/2025. Review of Physician Progress Note for Resident #21 dated 06/16/2025 reflected a note stating, Resident is currently being treated for a UTI (urinary tract infection)-gentamycin 80 mg inj. Other chronic conditions stable at this time. Review of Resident #21's TAR reflected an order for, Clean nephrostomy site with NS and pat dry. Apply split bandage and secure with tape. Twice a Day. There were sign offs on the dressing changes for LVN M for 06/18/2025 and 06/19/2025 indicating that the dressing change was done. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/17/2025 at 10:45AM, Resident #21 stated that she had nephrostomy tubes to both kidneys. She stated that the staff monitored and cared for the tubing. She denied any concerns. Observation on 06/18/2025 at 10:10AM of Resident #21 revealed that there was no dressing to either nephrostomy site. They were open to air. No redness or drainage was noted to the insertion sites for the nephrostomy tubes. In an interview with Resident #21 on 06/18/2025 at 10:10AM, she stated that the staff check the site every day, but they do not change a dressing to the site. She stated, they just put cream on my back. Observation on 06/19/2025 at 01:15PM revealed that there was no dressing to either nephrostomy site. They were open to air. No redness or drainage was noted to the insertion sites for the nephrostomy tubes. In an interview with Resident #21 on 06/19/2025 at 01:15PM, she stated all they have done is put some lotion on her back. She denied having any dressing added or changed to the nephrostomy sites. In an interview with LVN M on 06/19/2025 at 01:58PM, she was knowledgeable of the ordered dressing change but stated that she did not know that the dressing change should be done with sterile technique per the facility policy. She stated that she does not use sterile equipment or sterile technique for dressing changes for the resident. She stated that she had been doing regular dressing changes for the resident prior to the last two days when she worked. She stated after reading the policy that she should be doing sterile dressing changes. She stated, I did not know any of this. She stated that the resident has had the nephrostomy since she was admitted . She stated that the facility did have supplies for sterile dressing changes. In an interview on 06/19/2025 at 02:05PM, the ADON stated that she had worked at the facility for 30 days. She stated that she had not done any dressing changes for Resident #21. She stated that her role was to oversee education and some audits, including urinary catheters. She stated that the nurses are responsible for direct care to the residents. She stated that Resident #21 is the only resident in the facility with nephrostomy tubes. She stated that she was not aware of the facility policy on nephrostomy tubes. She stated she had not received any training on any special care considerations for the insertion sites or on how to perform the dressing changes for the insertion sites. She stated that if she had been aware of the policy regarding sterile dressing changes, she would audit for different criteria and categorize it differently than the audits for urinary catheter care. She stated that her responsibility is to ensure orders are transcribed and put in place, as well as to monitor progress of the residents. She stated that the facility did have supplies to perform the dressing changes. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the RN on 06/19/2025 at 02:44PM, she stated that she has worked at the facility since October of last year. She stated that she does not perform the dressing change to Resident #21's nephrostomy site with sterile gloves, supplies, and technique per the policy. She stated that she was unaware that the policy indicated that dressing change was sterile. She stated that based on the policy she should be doing sterile dressing changes for Resident #21. She stated that she did not recall any in-services regarding the nephrostomy policy. She stated that the impact to the resident of not performing dressing changes per the policy could lead to increased risk of infection. She stated that the resident has chronic UTIs. She denies any hospitalizations with UTI to her recollection. In an interview on 06/19/2025 at 03:37PM with the DON, she stated that it was her expectation that staff used sterile technique for the dressing changes to Resident #21's nephrostomy sites. She demonstrated knowledge of the facility policy. She stated that when she did the skin assessment for the resident that morning, she noted that there was no dressing to the site. She stated that she told LVN M to dress the site, but stated she had not gone back to ensure that it was done. She stated that she had not done any recent in-services on the policy for nephrostomy tubes or the related care considerations. She stated that staff were not trained on hire to perform nephrostomy care or dressing changes. She stated that she, the ADON, and the RN were responsible to ensure that the dressing changes were done for Resident #21. She stated that the potential risk to the resident was increased risk of infection. She stated that the resident has had a recent UTI but was not hospitalized . She stated that if the resident was removing the dressing herself that the nurses should be documenting it. She stated that the staff should not be signing off that they performed the care when they did not. In an interview on 06/19/2025 at 04:23PM, LVN J stated that she changed the dressing for Resident #21 every day that she works with her. She could not recall the ordered dressing change. She could not clearly indicate if she used sterile or clean gloves and supplies for dressing changes to Resident #21. She stated that she used sterile gloves for all dressing changes. In an interview with the MD at 05:52PM on 06/19/2025, she stated that if the policy stated that dressing should be changed with sterile technique, then it should be done with sterile technique. She stated that the site is already contaminated and not a sterile site. She stated that the resident has chronic UTIs. She stated that if the nephrostomy care is not performed per the policy that it would lead to an increased risk of infection. She stated that she was not aware that there was no dressing to the site and that it was her expectation that the site have a dressing. In an interview on 06/19/2025 at 06:30PM the ADM stated that he expected that dressing changes be performed per the physician orders and per policy. He stated that the potential impact to the resident of not doing wound care per the orders and policy standards could lead to worsening of the wound or ostomy site. Review of facility in-services for the last six months reflected there were no in-services regarding the nephrostomy care policy for the facility. Review of facility policy dated October 2010 for Nephrostomy Tube, Care of reflected, General Guidelines . 8. Change dressings every 1-3 days, or as ordered. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Use sterile technique during dressing changes.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 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 biologicals, to meet the needs of each resident for 2 of 4 medication carts (MA B's Medication Cart #1 and Medication Cart #2) and 4 of 6 residents (Resident #5, Resident #7, Resident #10, and Resident #19) reviewed for pharmacy services. 1. The facility failed to ensure MA B accurately reconciled Resident #5's narcotic medication log for Medication Cart #1 when she administered Resident #5's tramadol (controlled medication used for pain) 1 tablet two doses and Codeine/Acetaminophen (controlled medication used for pain) 1 tablets two doses on 6/18/25. 2. The facility failed to ensure MA B accurately reconciled Resident #7's narcotic medication log for Medication Cart #1 when she administered Resident #7's oxycodone (controlled medication used for pain) 1.5 tablets and lorazepam (controlled medication used to treat anxiety) 1 tablet on 6/18/25. 3. The facility failed to ensure MA B accurately reconciled Resident #19's narcotic medication log for Medication Cart #1 when she administered Resident #19's methylphenidate (controlled medication used to treat bipolar disorder) 1 tablet and Hydrocodone-Acetaminophen (controlled medication for pain) 1 tablets two doses on 6/18/25. 4. The facility failed to ensure MA B accurately reconciled and recorded Resident #10's narcotic medication log Medication Cart for Clonazepam 2 mg (Controlled medication used to treat anxiety) tablets. These failures could place residents at risk for loss of prescribed medications, potential for not receiving their prescribed medications, and risk of drug diversion. Findings included: 1. Record review of Resident #5's face sheet, indicated Resident #5, was a [AGE] year-old female, who was admitted to the facility on [DATE] with diagnoses which included acute pain due to trauma, cerebral infarction (stroke, condition when blood flow to parts of the brain is blocked), unspecified intellectual disabilities, hemiplegia (paralysis or weakness) affecting left nondominant side, cellulitis (bacterial skin infection) of left toe, pain in left lower leg, chronic combined systolic (congestive) and diastolic (congestive) heart failure (chronic condition of the heart that affects heart's ability to pump blood well). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's quarterly MDS assessment dated [DATE], indicated Resident #5 was able to make herself understood and usually understood others. The MDS assessment indicated Resident #5 had a BIMS score of 10, indicating her cognition was moderately impaired. The MDS assessment indicated Resident #5 received scheduled pain medication and had received an opioid (narcotic) medication within the 5-day look back period with pain intensity of 4/10 on numeric pain scale. Record review of Resident #5's comprehensive care plan revised on 05/08/25, indicated Resident #5 had the potential for pain related to impaired mobility, right shoulder pain with history of left femur fracture. The care plan interventions were to anticipate the resident's need for pain relief and respond immediately to any complaints of pain to make her as comfortable as possible through repositioning and administration of pain medications as ordered. Record review of Resident #5's order summary report indicated she had an order for acetaminophen-codeine-Schedule III tablet, 300-30mg give one tablet by mouth three times a day for pain with an order start date of 07/30/2021 and an order for tramadol -schedule IV tablets, 50mg give one tablet by mouth three times a day for pain with an order start date of 9/18/2023. Record review of Resident #5's medication administration record for 06/01/25-06/30/25, indicated Resident #5 received acetaminophen-codeine tablets, 300-30mg three times a day and tramadol one-tab 50mg three times a day including 6/18/25. Review of Resident #5's narcotic log records reflected the count for tramadol 50 mg tablets was 12 tablets and the count for acetaminophen/codeine 300mg/30mg tablets was 77 tablets. Review of the medication cards for Resident #5 reflected the Tramadol 50 mg had 10 tablets and the acetaminophen/codeine 300/30mg tablets had 75 tablets. During the medication cart reconciliation and interview on 06/18/25 at 05:45pm, MA B stated she administered two doses of tramadol and two doses of acetaminophen-codeine on 06/18/2025 to Resident #5 but failed to document the medications at the time of the administration of two acetaminophen-codeine 300/30mg tablets and two tramadol 50mg tablets on Resident #5's narcotic record. During an interview on 06/18/25 at 05:45 PM, MA B said she was responsible for documenting on the resident's narcotic record when a narcotic medication was administered but had not since she was very busy all day. MA B said not documenting the narcotic medication was administered could cause a discrepancy or a medication error, since someone will not know the resident had already received the narcotic medication. 2. Record review of Resident #7's face sheet dated 6/19/25, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included left acute respiratory failure with hypoxia (low levels of oxygen in body tissue), chronic obstructive pulmonary disease (lung condition caused by damage to the airways), schizoaffective disorder (mental disorder with unstable mood affecting behavior), bipolar type, Non-Alzheimer's vascular dementia (group of symptoms affecting memory and thinking), mild with anxiety, quadriplegia (symptom of paralysis that affects all limbs and body from neck down), seizure disorder, hypothyroidism (condition where the thyroid gland does not produce enough hormones), pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's quarterly MDS assessment dated [DATE] indicated Resident #7 was able to make herself understood and understood others. The MDS assessment indicated Resident #7 had a BIMS score of 14, which indicated her cognition was intact. The MDS assessment indicated Resident #7 was not present with behavioral symptoms and received scheduled pain medication. Record review of Resident #7's comprehensive care plan dated from 5/22/2025 indicated Resident #7 had chronic pain related to disc herniation and contractures. The care plan interventions included to anticipate the residents need for pain relief and respond immediately to any complaint of pain through administration routine and PRN pain medication. Record review of Resident #7's comprehensive care plan dated from 5/22/2025 indicated Resident #7 had a diagnosis of bipolar disorder and can have mood swings from euphoria to depression. The care plan interventions included to encourage activities of choice and administer medication per MD order. Record review of Resident #7's order summary report indicated Resident #7 had an order for lorazepam 1mg give one tablet by mouth two times a day for anxiety with a start date of 04/01/2025 and oxycodone 7.5mg four times a day for pain with a start date of 03/06/2025. Record review of Resident #7's medication administration record dated 06/01/25-06/30/25, indicated Resident #7 received lorazepam 1mg in the morning of 6/18/25 and oxycodone 7.5mg at midnight, morning, and mid-day of 6/18/2025. Review of Resident #7's narcotic log records for lorazepam 1 mg tablets reflected that the count for the medication was 30 pills. Review of the medication card for lorazepam 1 mg for Resident revealed there were 29 tablets. Review of Resident #7's narcotic log records for oxycodone 5 mg tablets revealed the count was 40 prefilled cells of prepared tablets. One card had whole tablets of 5 mg and the second card had pre-cut half tablets of oxycodone 2.5mg. The instructions indicated to give one of each card per dose. Review of the medication cards reflected there were 38 prefilled cells of prepared tablets. During the medication cart reconciliation and interview on 06/18/25 at 5:45pm, MA B stated she administered one dose of lorazepam 1 mg and one dose of oxycodone 7.5 mg on 06/18/2025 to Resident #7 but failed to document the administration of one tablet of lorazepam 1mg and 1.5 tablets of oxycodone to achieve a dose of 7.5mg on Resident #7's narcotic record. 3. Record review of Resident #19's face sheet dated from 06/19/2025 indicated a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses which included transient cerebral ischemic attack (stroke, condition when blood flow to parts of the brain is blocked), non-pressure chronic ulcer of other part of left lower leg with fat layer exposed, chronic pain, bipolar disorder, Type 2 diabetes, obstructive sleep apnea, and depression. Record review of Resident #19's quarterly MDS assessment dated [DATE], indicated Resident #19 was able to make herself understood and usually understood others. The MDS assessment reflected Resident #19 had a BIMS score of 14, indicating her cognition was intact. The MDS assessment indicated Resident #19 received scheduled pain medication during the 5-day look back period. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #19's comprehensive care plan dated 02/06/25, indicated Resident #19's need for accessing service to promote adjustment to new living environment. The care plan interventions indicated to evaluate the pain routinely to address pain management needs. Pain medications will be administered per physician orders. Pain medication effectiveness will be documented and reported as needed. Record review of Resident #19's nursing medication administrator record for 06/01/25-06/30/25, indicated Resident #19 received hydrocodone-APAP 10-325mg tablets in the morning and mid-day of 6/18/25 and methylphenidate 10mg on 06/18/2025. Record review of Resident #19's order summary report indicated Resident #19 had an order had an order for hydrocodone-APAP 10-325mg tablets give one tablet three times a day for pain with a start date of 06/07/25 and methylphenidate 10mg one tablet once every morning for symptoms of bipolar with a start date of 01/04/2025. Review of Resident #19's narcotic log records reflected there was 27 tablets of methylphenidate 10mg and 81 tablets of Hydrocodone-APAP 10mg-325mg. Review of the medication cards for Resident #19 reflected the methylphenidate 10 mg card had 26 tablets present and the Hydrocodone-APAP 10mg-325mg card had 79 tablets present. During the medication cart reconciliation and interview on 06/18/25 at 5:45pm, MA B stated she administered two doses of Hydrocodone-APAP 10mg-325mg tablets and one dose of methylphenidate 10mg tablets to Resident #19 but failed to document the administration of two tablets of hydrocodone-APAP 10-325mg and one tablet of methylphenidate 10mg on Resident #19's narcotic record. 4. Review of Resident #10's Face sheet reflected a [AGE] year-old, female admitted on [DATE]. Diagnoses included: Dementia, with agitation (loss of thinking, memory, or reasoning), Paranoid Schizophrenia (serious mental illness involving hallucinations, delusion, and disorganized thinking), Cognitive Communication Deficit (problem with communication caused by cognition rather than a language or speech deficit), and Generalized Anxiety disorder (intense and excessive worry and fear). Review of Resident #10's Quarterly MDS dated [DATE] reflected a BIMS score of 2 (severe cognitive impairment). It reflected that she was able to sometimes understand others and was usually able to make her needs known. The MDS reflected that the resident had received antianxiety medications for the look back period for that assessment. Review of Resident #10's Care Plan reflected a Problem stating, Problem Start Date: 03/08/2024 Category: Psychosocial Well-Being [Resident #10] is at risk for increased behavioral symptoms and changes in mood related to schizophrenia, bipolar disorder, MDD, and anxiety. Edited: 04/18/2025 and an approach intervention stating, Approach Start Date: 03/08/2024 Administer medications as ordered. Monitor and record effectiveness. Monitor and report any adverse side effects. Review of Resident #10's orders reflected, clonazepam - Schedule IV tablet; 2 mg; amt: 1 tablet; oral Special Instructions: Give Two 1mg tablets PO four times a day. Four Times A Day Morning 07:00 AM - 10:00 AM, Mid-Day 11:00 AM - 02:00 PM, Late Afternoon 03:00 PM - 06:00 PM, Bedtime 07:00 PM - 10:00 PM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 06/18/25 at 05:45 PM, MA B's Medication Cart #2 reflected the clonazepam 2 mg count for Resident #10 was logged as 96 pills. There were 95 tablets present for the count. There was one card of 6 pills, two cards with 30 pills, and one card with 29 pills. MA B stated that she had counted the carts at shift change with no discrepancies noted. She stated that she did not see the one pill removed from the middle of a full card of medication for Resident #10. MA B stated that when a medication discrepancy is found, the DON should be notified immediately. Observation and interview on 06/18/2025 at 05:50 PM revealed the DON was notified of narcotic count discrepancies with MA B. The DON and MA B walked directly to the medication carts to start an audit. In an interview with DON on 06/19/2025 at 08:20 AM, she stated that the narcotic administration logs for Resident #5, Resident #7, and Resident #19 reflected the same amount of medication administration records for the residents for the time periods that MA B was responsible for the medication carts that day. She stated that MA B stated that she gave the medications but failed to log them in the narcotic log records. She stated that she expected those who were administering narcotics to log each administration of narcotic medications. She stated that all staff were drug tested on [DATE]. She stated all drug tests came back negative. She stated that Resident #5, Resident #7, Resident #10, and Resident #19 stated they had received their medications on 06/18/2025. She stated that she concluded that the medication discrepancies related to Resident #5, Resident #7, and Resident #10 were documentation errors. She stated that the facility had not had any narcotic discrepancies to her knowledge. In an interview with Resident #7 on 06/19/2025 at 09:02 AM, she denied any concerns with receiving her medications on 06/18/2025. She stated she does not recall how many doses of pain or anxiety medications she received. In an interview with LVN L on 06/19/25 at 06:03PM she stated that she counted the cart with LVN M and all medications counts were correct and all cards were counted. She denied any discrepancies in narcotics in the building to her recollection. She stated that she had no concerns for any suspicious staff behaviors or reports from residents or other staff regarding such. In an interview with LVN M on 06/19/25 at 06:07pm she stated that she counted the cart off to MA B. She denied any discrepancies in narcotics in the building to her recollection. She stated that she had no concerns for any suspicious staff behaviors or reports from residents or other staff regarding such. In an interview with CNA D on 06/19/25 at 06:08PM she stated that she did count the cart off to MA B the morning of 06/18/2025. She stated all medications counts were correct and all cards were counted. She denied any discrepancies in narcotics in the building to her recollection. She stated that she had no concerns for any suspicious staff behaviors or reports from residents or other staff regarding such. She stated that she thought it could have been an accidental dislodgement from the card when the cards are being manipulated. She denied observing any loose pills in the medication drawer. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/19/25 at 06:30PM with the ADM and DON, the DON stated that regarding the narcotic discrepancies that were found on 06/18/2025 and submitted to the state for intake. She stated that she concluded that there was no diversion. She stated that interviews with the residents stated that they all received their medications. She stated that she interviewed all staff on shift and those who worked with the cart on 06/17/2025. She stated that she inspected the card with the one pill removed from the middle that could not be explained by the MA. She stated that the plastic covering was not compressed and appeared to have been an accidental snag. She stated that all employees were drug tested and were negative. She denied any history of suspicious behavior from staff regarding medications or any history of narcotic discrepancies. She stated that she removed everything from the drawer with the one pill in the middle removed, and stated that she found a small, round, white pill. She stated that she did not check the lettering on the pill. She stated that she immediately destroyed the pill with the drug buster solution. She stated that it was found under the front of the drawer before the medication cards. The ADM stated he deferred to the DON for the investigation findings and impact. The DON stated there was no harm or impact to the residents regarding the incorrect counts. Review of Drug Test results for all staff on shift on 06/18/2025 reflected that all staff tested negative on a ten-panel drug test. Record review of the facility's policy Controlled Substances indicated . Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift 10. Upon administration a. the nurse administering the medication is responsible for recording: 1. Name of the resident receiving the medication; 2. Name, strength, and dose of medication; 3. Time of administration; 4. Method administration; 5. Quantity of the medication remaining; and 6. Signature of nurse administering medication .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record reviews the facility failed to prepare, distribute, and serve food in accordance with professional standards for food service safety. 1.The facility failed to maintain proper kitchen sanitation when the [NAME] did not follow proper hand hygiene protocols. 2.The facility failed to ensure residents were safe from potentially contaminated food when staff did not sanitize their hands between giving residents food. The deficient practice could place residents who were served from the kitchen at risk for health complications and foodborne illnesses. Findings Include: 1. Observation on 6/18/2025, at 9:30 AM, revealed that the Cook, after donning sanitized gloves, continued to prepare pureed noodles. While still wearing the same pair of gloves, she used three different kitchen utensils, a spatula, a serving spoon, and a whisk. She also touched the puree menu book, made notations using a pen, and opened the top of the puree machine to add liquid to the noodles, all without changing her gloves or sanitizing her hands. Furthermore, the [NAME] was observed washing her hands while still wearing the gloves and continued to prepare the puree without replacing them. In an interview on 6/19/2025, at 1:05 PM, DM, stated that the facility ensured staff washed their hands before serving food to residents through in-service training. Dietary aides actively monitored compliance to reinforce proper hand hygiene practices. The DM emphasized that all staff members must sanitize or wash their hands immediately after touching personal items, such as hair or their face, to uphold hygiene standards. Additionally, the DM stated that staff were aware of the critical role hand hygiene played in preventing foodborne illnesses. The facility has set up a designated handwashing station in the kitchen for staff to use before returning to food preparation. On 6/19/2025, at 1:54 PM, an attempt was made to conduct a telephone interview with the Cook, but there was no response. A voicemail was left requesting a return call. In an interview on 06/19/2025, at 2:20 PM, DW I stated that the facility regularly receives in-service training regarding hand hygiene. Regarding hand hygiene policy, she noted that staff must wash their hands and change gloves between tasks and after handling trash. She emphasized that not using proper hand hygiene could result in cross-contamination, potentially causing residents to become sick. On 6/19/2025, at 2:25 PM, an interview was conducted with DW H. She revealed that she does not recall receiving in-service training on hand hygiene however, she understands the importance of hand washing. DW H acknowledged not washing your hands could result in residents becoming ill. 2. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 6/16/2025 at 12:13 PM during lunch service revealed that lunch trays were handed out to Resident #9 and Resident #69, and staff did not sanitize their hands. Staff began sanitizing their hands after passing Resident #9 and Resident #69's rooms. In an interview on 6/19/2025 at 1:53 p.m., MA A stated that she gets the food off the cart. Then she takes the food and sets it up in their room. If the residents need to be fed or if they need assistance, the resident . She is required to wash her hands or sanitize them before serving food. If she touches a non-clean surface, then she must clean her hands. She said that gloves are not required to serve food to residents. She gets in-service on hand hygiene. If hands are contaminated, the resident could get contaminated food. If she sees a staff member not cleaning their hands, she reminds them to do it. In an interview on 6/19/2025 at 2:03 p.m., MA B stated she is supposed to wash her hands before handling residents' food trays. She said if her hands are not cleaned, a resident could get sick from touching a contaminated item. She mentioned her last hand hygiene in-service was a month ago. She said if she sees someone not cleaning their hands, she will remind them to do so. In an interview on 6/19/2025 at 2:10 p.m., CNA F stated that when passing food to residents, she will sanitize her hands before getting the residents' trays. She said this is done for infection control. She said that if she sees a staff member not clean their hands, she will tell them to do it. She said she has been trained on hand hygiene and infection control. In an interview on 6/19/2025 at 3:18 p.m., the ADM stated that staff are required to sanitize their hands before handling residents' food trays. The ADM said that he has not seen any staff not doing that correctly. The ADM stated that if he sees any staff not cleaning their hands, then he will remind them to do it, and then he will talk with them later about hand hygiene. The ADM said he will then do in service on hand hygiene with all staff. The ADM said that when this is not done, residents are at risk of getting sick. In an interview on 6/19/2025 at 4:18 p.m., the DON stated that when staff are passing out food to residents, either in the hall or the dining room, they are required to sanitize their hands. The DON said she has not seen any staff not sanitizing their hands before grabbing food trays. She said if she sees that happening, she will remind them to clean their hands, and she will do an in-service on hand hygiene. She stated if proper hand hygiene is not taken , that puts residents at risk . Record Review of Facility Policy, Resident Personal Food Policy, REV 9-11-2023, reflected: Always wash your food, hands, counters, and cooking tools. Wash hands in warm soapy water for at least 20 seconds before and after touching food. Wash your cutting boards, dishes, forks, spoons, knives, and counter tops with hot soapy water. Do this after working with each food item. Rinse fruits and veggies. Do not wash meat, poultry, fish, or eggs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If water splashes from the sink in washing, it can spread bacteria. Clean the lids on canned goods before opening.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the resident medical records for two of six residents reviewed for wound care documentation (Resident #7 and Resident #21) were complete and accurately documented. 1. The facility failed to ensure that documentation of dressing changes provided to Resident #7 was accurate and completed on 06/09/2025, 06/11/2025, 06/13/2025, and 06/16/2025. 2. The facility failed to ensure that documentation of dressing changes provided to Resident #21 was accurate and completed on 06/18/2025 and 06/19/2025. This deficient practice could put the resident at risk of having inaccurate medical records and not receiving the ordered treatments and care. Findings: Review of Resident #7's Face sheet reflected a [AGE] year-old, female admitted to the facility on [DATE]. Diagnoses included: Schizoaffective Disorder, bipolar type (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), Vascular Dementia with anxiety (dementia related to blood flow to the brain that includes feelings of intense and excessive worry and fear), Pain, and Functional quadriplegia (inability to move all four limbs). Review of Resident #7's Significant Change MDS dated [DATE] reflected that the resident had a BIMS score of 14 (no cognitive impairment). Section M for Skin Condition reflected a 0 for M0210 (Unhealed Pressure Ulcers/Injuries), indicating that she did not have any unhealed pressure ulcers/injuries. The assessment was signed by RCMDS Q. Review of Resident #7's Care Plan reflected a Problem Area stating, Problem Start Date: 01/15/2025 Category: Pressure Ulcer/Injury [Resident#7] has a pressure ulcer to sacrum [skin above the triangular bone at the base of the spine]. Edited: 06/16/2025. There was a related Approach intervention stating, Provide treatment as ordered. Review of Resident #7's orders reflected an order for Wound Treatment Order: Location: mid-back/sacral area-Clean with Normal Saline/Wound Cleanser Apply: Collagen powder and cover with Primary Dressing: Border Gauze Secure with Tape Once a Day: Mon, Wed, Fri 06:00AM-06:00PM started on 06/18/2025. There was an order for, Wound Treatment Order: Location: mid back/sacral area Clean with Normal Saline/Wound Cleanser Apply: Collagen powder and hydrocolloid sheet Cover with Primary Dressing: Bordered gauze Secure with tape Once a day on Mon, Wed, Fri. with a start date of 04/02/2025 and a discontinue date of 06/18/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #7's Wound Evaluation and Management Summary dated 05/15/2025 reflected a stage 3 pressure wound to the resident's sacrum with a Duration as greater than 164 days. Review of Resident #7's TAR reflected there was no treatment recorded for Monday, 06/09/2025; the treatment recorded for Wednesday, 06/11/2025 was signed off on by LVN K; the treatment recorded for Friday, 06/13/2025 was signed off on by LVN M; and no treatment was recorded for Monday, 06/16/2025. The TAR reflected a Wound Treatment, Pain Evaluation to be done, Mon, Wed, Fri; Set Frequency to match Treatment Administration Order. The sign offs reflected the same dates and persons indicated for the 06/09/2025, 06/11/2025, and 06/13/2025 treatments. There was a sign off on Monday, 06/16/2025, from LVN K, indicating she assessed pain during wound care that day. In an interview on 06/17/2025 at 08:57AM with Resident #7, she stated that she was receiving dressing changes to a wound on her tailbone. She stated that the dressing was being changed by nurses. She denied any concerns. Observation of wound care with LVN M, CNA G, and CNA O for Resident #7 on 06/18/2025 at 10:30 AM revealed that the resident had a pressure wound to her sacrum with a diameter of approximately 0.2 cm and a depth of approximately 0.1 cm. The dressing removed from the patient revealed the date, 06/09/25 with the initials for LVN M. In an interview on 06/18/2025 at 03:00PM with LVN M, she stated that she did a full skin assessment on Resident #7 on 06/18/2025 and had not noticed the date on the dressing from Resident #7's sacral wound during the assessment or during wound care on 06/18/2025 was dated 06/09/25 with her initials. She stated that she always records the dressing changes on the TAR. She stated that she did sign off on the wound care for Resident #7 on 06/13/25. She stated, I thought I did the wound care that day, but I must not have done it. She stated that she should not have documented that the treatment was done if it was not done. She stated that not doing a dressing change as ordered could place the Resident #7 at risk for infection and worsening of the wound. Review of Resident #21's Face sheet revealed a [AGE] year-old, female admitted on [DATE]. Diagnoses included: Hydronephrosis (swelling of the kidneys from blockage of the flow of urine), Urinary Tract Infection, Chronic Kidney Disease, and Type 2 Diabetes (chronic disorder of abnormal blood sugar levels). Review of Resident #21's Quarterly MDS dated [DATE] reflected a BIMS score of 15 (no cognitive impairment). For Section H-Bowel and Bladder it reflected a 9 for Urinary Continence, indicating Not Rated, resident had a catheter (indwelling or condom), urinary ostomy, or no urine output for the entire 7 days. For Section M-Skin Conditions it was indicated that the Resident has a Surgical Wound with Surgical Wound Care. Review of Resident #21's Care Plan reflected a Problem Area indicating, Problem Start Date: 05/23/2023 Category: Indwelling Catheter has nephrostomy tube [a catheter placed into the kidney through an incision in the back to drain urine] in place d/t Chronic cystitis [inflammation of the bladder wall], Hydronephrosis [swelling of the kidneys from blockage of the flow of urine], CKD [chronic kidney disease], and obstructive uropathy [blockage of the urinary tract]. There was an Approach intervention reflecting, Care for tubes/drains: nephrostomy site care per order Created: 05/23/2023. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #21's Orders reflected an order to, Clean nephrostomy site with NS and pat dry. Apply split bandage and secure with tape. Twice A Day Morning 07:00AM -10:00AM, Bedtime: 07:00PM-10:00PM with a start date of 04/09/2025. Review of Physician Progress Note for Resident #21 dated 06/16/2025 reflected a note stating, Resident is currently being treated for a UTI (urinary tract infection)-gentamycin 80 mg inj. Other chronic conditions stable at this time. Review of Resident #21's TAR reflected an order for, Clean nephrostomy site with NS and pat dry. Apply split bandage and secure with tape. Twice a Day. There were sign offs on the dressing changes for LVN M for 06/18/2025 and 06/19/2025 indicating that the dressing change was done. In an interview on 06/17/2025 at 10:45AM, Resident #21 stated that she had nephrostomy tubes to both kidneys. She stated that the staff monitored and cared for the tubing. She denied any concerns. In an interview on 06/18/2025 at 09:40 AM with LVN M, she stated that she had not done a dressing change on Resident #21 on 06/18/2025. Observation on 06/18/2025 at 10:10AM of Resident #21 revealed that there was no dressing to either nephrostomy site. They were open to air. No redness or drainage was noted to the insertion sites for the nephrostomy tubes. In an interview with Resident #21 on 06/18/2025 at 10:10AM, she stated that the staff check the site every day, but they do not change a dressing to the site. She stated, they just put cream on my back. Observation on 06/19/2025 at 01:15PM revealed that there was no dressing to either nephrostomy site. They were open to air. No redness or drainage was noted to the insertion sites for the nephrostomy tubes. In an interview with Resident #21 on 06/19/2025 at 01:15PM, she stated all they have done is put some lotion on her back. She denied having any dressing added or changed to the nephrostomy sites. In an interview on 06/19/2025 at 11:53AM, the DON stated that she did a skin assessment on Resident #21 that morning prior to surveyor arrival at 08:00AM. She stated that she noted that there was not a dressing to the nephrostomy sites and she instructed the LVN M to do the do the dressing change and ensure there was a dressing to the nephrostomy sites for Resident #21. In an interview with LVN M on 06/19/2025 at 01:58PM, she stated that the initials charted for 06/18/2025 and 06/19/2025 for the dressing change to the nephrostomy sites for Resident #21 were hers. She stated that she intended to do the dressing change on 06/19/2025, but had not had time to do it yet. She stated that she should not have documented that the dressing changes were done if they were not yet done. She stated that the resident has had the nephrostomy since she was admitted . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/19/2025 at 03:37PM with the DON, she stated that it is her expectation that if staff document something, that it should be done. She stated that if staff are unable to finish a scheduled task on their shift that it should be passed on to the next shift, to herself, or the ADON, so that it can be completed. She stated the impact to the resident of not documenting care accurately is that the resident may not have received the care that was ordered and could contribute to the worsening of the wound. Attempted an interview with LVN K on 06/19/2025 at 04:53PM. No call was returned prior to exit. In an interview with the ADM on 06/19/2025 at 06:30PM, he stated that he expected that dressing changes be performed per the physician orders and per policy and that documentation should be accurate in the medical record. Review of facility policy dated April 2024 for Pressure Injury/Skin Breakdown Clinical Protocol reflected, Assessment and Recognition The licensed nurse or MD/NP/PA will assess and document an individual's significant risk factors for developing pressure injuries; for example, immobility, recent weight loss, and a history of pressure injury(s). 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure injury including location, stage, length, width and depth, presence of exudates [drainage from a wound or other lesion] or necrotic tissue [dead or dying cells and tissue]; b. Pain assessment; c. Resident's mobility status; d. Current treatments, including support surfaces; and e. All active diagnoses which may contribute to pressure injury/skin break down. Review of facility policy dated October 2010 for Nephrostomy Tube- Care of reflected, Documentation (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The following information should be recorded in the resident's medical record. 1. The date and time the procedure was performed. 2. Name and title of the person(s) who performed the procedure. 3. The resident's response to the procedure.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents for 1 of 1 facility reviewed for pests. 1.The facility failed to ensure the facility was free of gnats, and 2 roaches throughout the facility including resident rooms and resident restrooms 2. The facility failed to ensure the facility was free of bedbugs for Resident # 9. These deficient practices placed residents at risk of exposure to pests, diseases, infections, and diminished quality of life. The findings included: Record review of Resident # 9's admission face sheet dated 6/18/25 reflected a [AGE] year old female admitted on [DATE] and readmitted on [DATE] with diagnoses of unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), anxiety (intense, excessive, and persistent worry and fear about everyday situations), abnormalities of gait and mobility, low back pain, depression (a group of conditions associated with the lowering of a person's mood), restless leg syndrome (a condition characterized by a nearly irresistible urge to move the legs), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), fibromyalgia (a long term condition that involves widespread body pain and tiredness), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), insomnia (difficulty falling and staying asleep), and hypotension (low blood pressure). Review of Resident # 9's Quarterly MDS dated [DATE] reflected a BIMS score of 11 indicating moderate cognitive impairment. Resident # 9 required set up or clean up assistance with eating, oral hygiene, personal hygiene, transfers, and toileting. Resident # 9 required supervision or touching assistance for dressing and bathing. Review of Resident # 9's care plan dated 5/10/25 reflected behavioral symptoms of hoarding items which makes it difficult to maintain a safe and tidy living space with interventions of monitor items collected and brought into facility from community outings. Redirect and educate on putting clothing items away into their proper spaces. To perform room rounding interventions and notification of appropriate department to maintain safe tidy living spaces. Review of Resident # 9's Nursing progress note dated 6/17/25 at 10:46 PM reflected observation of resident bible at nurse station counter with bed bugs crawling out of bible. Nurse and CNA inspected Resident # 9 room for more bed bugs. Additional bed bugs discovered in Resident # 9 purse and bed linens. All linen, clothing, and cloth items were bagged up to be washed in hot water. Skin assessment completed for Resident # 9 with small red area to shoulders and bilateral upper extremity. Appears to have been scratched hydrocortisone cream applied. Staff educated on managing and preventing infestation. Attempt made 3x to notify resident family member and educate on prevention/managing infestations as well. Pest control called to come exterminate. MD and DON notified. Hydrocortisone cream applied to bug bites for itching if needed. Also, complete skin assessment every shift X 3 day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675587	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Manor Healthcare Center	3011 W Adams Ave Temple, TX 76504

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 6/17/25 at 10:46 AM revealed a half-eaten sandwich unwrapped sitting on the overbed table in room [ROOM NUMBER]A. Further observation at 11:29 AM revealed a half-eaten sandwich still sitting unwrapped on the overbed table in room [ROOM NUMBER]A now with 2 gnats on it and circling around it. Skin observation on 6/17/25 at 11:45 AM of Resident # 9 by nurse surveyor in presence of CNA D who assisted resident in undressing. The clusters of red raised bumps were observed on the left shoulder and middle back and left leg with some skin break down due to skin itching and resident scratching those areas. Per CNA D the resident received a shower last night and the resident was moved to another room. Observation on 6/18/25 at 12:05 PM revealed 2 different roaches crawling across the floor of room [ROOM NUMBER]A in the secure unit. Observation on 6/19/25 at 3:47 PM revealed gnats on resident's bed linen in the secure unit room [ROOM NUMBER]A. In an interview on 6/18/25 at 10:26 AM the ADM stated he was aware of Resident # 9's room being found to have bed bugs. The ADM stated all of Resident # 9's belongings were bagged and taken to housekeeping for cleaning. The ADM stated the exterminator was called to come out and that the MS had completed the bed bug pre-treatment protocol and that the DON had been notified. In an interview on 6/18/25 at 10:33 AM the DON stated she had been made aware of Resident # 9's room having bed bugs. The DON stated the following steps occurred: all the resident belongings were bagged and sent to laundry, skin assessment was completed on the resident, the resident was showered and given new clothes, the resident was moved rooms, pest control was called, the room was fumigated and sealed for 48 hours, the resident's family member was notified and educated, staff education was started and is still ongoing. The DON stated the facility followed their policy and she did not feel anything different could have been done. In an interview on 6/18/25 at 10:42 AM the MS stated he was notified about the bed bugs on 6/17/25 late in the evening. The MS stated the next morning he came and prepared the room for the exterminator to come. The MS stated he inspected the common areas and surrounding rooms and did not find any bed bugs in these areas. The MS stated pest control was contacted around 8:00 am on 6/18/25 and came to the facility at 9:00 am and treated the room. The MS stated he would be monitoring the affected room and the surrounding areas. In an interview on 6/19/25 at 2:28 PM LVN M stated she had observed pests around the building. LVN M stated she has documented these sightings in the pest control log and communicated her concerns to the ADM to ensure appropriate action was taken. In an interview on 6/19/25 at 2:30 PM the MS stated pest control services are conducted once a month at the facility by the pest control company the facility is contracted with. The MS emphasized the importance of proper pest control management, noting that inadequate handling could potentially lead to infections within the facility. The MS confirmed that he had received training related to pest control and understood the protocols necessary for maintaining a safe environment. The MS stated he would schedule follow up training sessions to reinforce protocols related to both pest management and safety reporting. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pre-treatment d. Treatment of resident symptoms e. Treatment of infestation f. Evaluation of treatment effectiveness and continued monitoring Record review of pest control log reflected roaches had been documented being seen 20 times throughout the facility since January of 2025, nonspecific bugs had been sighted 2 times in April 2025, bug bites had been sighted on resident in room [ROOM NUMBER] in June 2025, flies and gnats had been sighted 2 times once in February 2025 and once in March 2025. Further review reflected pest control company documented regular monthly service calls on 1/2/25, 2/7/25, 3/6/25, 4/3/25, 5/2/25, and 6/18/25. Follow up service completed 6/12/25 no further follow up services documented from any of the insect sightings. Record review of pest control service contract reflected services performed were to be perform monthly pest control service including coordinating with client's staff to implement an integrated pest management plan, monitor and track pest issues inside and outside of facility, addressing site issues both reported and observed, recording actions taken and observations to staff to be kept on record. Pest control each month consists of inspecting and treating exterior pest issues including all exits, potential entry points, and grounds. Inspecting and treating interior pest issues including kitchen, laundry, exits, and closets. Monitoring and maintain any equipment used to bait and or eliminate pests inside and outside. When requested treat specific areas that are experiencing a particular problem, which may include the removal of persons in affected area for varying time periods. Providing suggestions and advice to the staff that would help alleviate any existing pest issues and prevent future issues. Pest included in the agreement are roaches, bed bugs, spiders, scorpions, crickets, silverfish, beetles, rodents, flies, gnats, fruit flies, wasps, bees, ants, and termites.