STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675624	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitehall Rehab & Nursing	1116 E Loop 304 Crockett, TX 75835

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 - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436 Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy for 3 of 12 (Residents #18, #25, and #59) residents observed for care. CNA C and CNA D failed to provide Resident #25 with full privacy while providing incontinent care on 11/11/24. RN A and LVN B failed to sit while feeding Resident's #18 and #59 on 11/11/24. These failures could place residents at risk of not being treated with dignity and respect. Findings: 1. Record review of a facility face sheet dated 11/13/24 indicated Resident #25 was a [AGE] year-old female that was admitted to the facility on [DATE]. She was admitted with diagnosis of dementia. Record review of a comprehensive care plan dated 6/24/24 indicated Resident #25 was incontinent of bowel and bladder and to check and change as needed. Record review of a Significant Change MDS assessment dated [DATE] indicated Resident #25 had a BIMS score of 15 which indicated intact cognition and was dependent of staff for toileting hygiene. During an observation on 11/11/24 at 10:36 AM Resident # 25 was provided incontinent care by CNA C. CNA C did not pull the privacy curtain between the room or at the door and Resident # 25's roommate was present in the room. At 10:44 am CNA D knocked on Resident # 25's door and walked in room while resident was receiving care exposing her to the hallway. Both CNA's proceeded to dress Resident # 25 with no privacy curtain pulled. During an interview on 11/11/24 at 10:59 AM Resident # 25 said the staff often don't pull her privacy curtain and she felt exposed and embarrassed. Said she would like it if the curtain was pulled so everyone would not see her getting care if her door opened. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Whitehall Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1116 E Loop 304 Crockett, TX 75835	

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/11/24 at 10:54 AM CNA D said she had been at the facility since August and was a newly certified nurse aide. She said she had been trained on resident privacy and dignity. She said she should have knocked louder and waited to enter. She said the privacy curtain should have been pulled to keep resident from being exposed to the hallway. She said the resident could be upset being exposed and privacy not maintained. During an interview on 11/11/24 at 10:57 AM CNA C said she had worked at the facility for 6 years. She said she should have pulled the privacy curtain before starting resident care and she had been trained on privacy. She said residents could be embarrassed if they were exposed. 2. Record review of a facility face sheet dated 11/13/24 indicated Resident #18 was [AGE] year old female that admitted on [DATE] for diagnosis of dementia. Record review of a comprehensive care plan dated 7/11/24 indicated Resident #18 was at risk for nutrition and hydration deficit related to progressing dementia; she required frequent cuing and monitoring to complete her meals and drink fluids; she was fed by staff at times to assist with meal intake. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #18 had a BIMS score of 02 indicating severe cognitive impairment and required supervision with eating. Record review of a facility face sheet dated 11/13/24 indicated Resident #59 was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis of metabolic encephalopathy (change in how your brain works). Record review of a comprehensive care plan dated 8/19/24 indicated Resident #59 had an ADL (activity of daily living) deficit and required supervision and setup with meals. Record review of a Quarterly MDS assessment dated [DATE] indicated Resident #59 had a BIMS score of 07 indicating moderately impaired cognition and required supervision with eating. During an observation on 11/11/24 at 12:45 PM RN A and LVN B were both observed standing while feeding residents in the dining room. RN A was standing over Resident # 18 and LVN B was standing over Resident # 59. During an interview on 11/11/24 at 12:50 PM LVN B said that she had worked at the facility for 4 years and Resident #59 needed assistance with meals. She said the staff should be seated when assisting with meals. She said she did not sit because there was not a chair and by standing it could make the resident feel intimidated or rushed. During an interview on 11/11/24 at 4:17 PM RN A said she had worked at the facility 2 years and Resident #18 could sometimes feed herself but does need some assistance at times. She said when assisting residents staff should be seated. She said she should have gotten a chair and sat to assist Resident #18. She said by standing over a resident it could be presumed as being authoritative and make them uncomfortable. Attempted interview on 11/11/24 at 12:55 PM with Resident's #18 and #59 and neither could answer questions. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/13/24 at 10:53 AM the DON said she had been at the facility 3 years and was responsible for oversight of all nursing staff and education on resident rights. She said all staff should pull the privacy curtain during care and sit when assisting with meals. She said by not doing so it could make a resident feel exposed, embarrassed, or rushed. She said she expected all staff to maintain resident rights and dignity. During an interview on 11/13/24 at 3:16 PM the Administrator said all employees were responsible for following resident rights and ensuring resident privacy and dignity were maintained. She said the situations were not ideal and would not speak on the risk to the residents. She said she expected all staff to always respect resident privacy and dignity. Record review of training transcript for RN A indicated she completed resident rights training 6/24/24. Record review of training transcript for LVN B indicated she completed resident rights training 7/28/24. Record review of training transcript for CNA C indicated she completed resident rights training 6/04/24. Record review of training transcript for CNA D indicated she completed resident rights training 8/24/24. Record review of a facility policy dated 2/20/2021 titled Resident Rights indicated, .the facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment that did not result in bodily injury within 24 were reported within 24 hours for 1 of 6 residents (Resident #42) reviewed for abuse and neglect. The Administrator failed to report an allegation of neglect on 4/14/24 when Resident #42 eloped from the facility and was found in the emergency room parking lot next door to the facility. This failure could place residents at risk for harm and injury. Findings included: Record review of a facility face sheet dated 11/11/24 for Resident #42 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke), dementia, and hyperlipidemia (high cholesterol). Record review of a comprehensive MDS assessment dated [DATE] for Resident #42 indicated that she had a BIMS score of 9, which indicated that she had moderately impaired cognition. She had hallucinations and delusions. Wandering behavior was not present during 7-day lookback period. She was independent with most all ADLs and was able to independently ambulate at least 150 feet. She was always continent to bowel and bladder. She had a wander/elopement alarm device. Record review of a comprehensive care plan initiated on 9/1/22 and most recently revised on 10/18/24 for Resident #42 indicated that she was a high risk for elopement related to progressing dementia and signs of sundowning with interventions that read: .check for placement of wanderguard Q shift . and .Use audible monitoring system to alert staff of exit seeking behaviors as appropriate . Care plan also indicated that she exhibited wandering/exit seeking and read: .[Resident #42] wanders through the facility at times and is at risk for elopement and injury . She had an intervention that read: .Check for proper functioning of the audible alarm system every shift and PRN as ordered . Record review of a physician's order summary report dated 11/11/24 for Resident #42 indicated that she had the following order dated 10/13/24: .Check function of wanderguard every shift for wandering .; and the following order dated 4/14/24: .Wanderguard - check placement every shift for safety . Record review of a facility incident report dated 4/14/24 at 3:10 pm for Resident #42 indicated that resident had eloped from the facility and was found in the emergency room parking lot next door. Report read .heard 100 hall alarm sound when in assisting another resident. Went to check at door and outside for elopement. No one immediately outside. Went to search for [Resident #42], she was not in her room, facility searched, resident not in building, sent staff outside, found resident within 10 minutes in the ER (emergency room) parking lot at hospital next door . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of TULIP (Texas Unified Licensing Information Portal) website accessed on 11/12/24 indicated that elopement incident on 4/14/24 was not reported to HHSC (Health and Human Services Commission). During an observation and interview on 11/11/24 at 4:20 pm Resident #42 was observed at nurse's station. She ambulated without difficulty and without assistive devices. She was unable to recall incident or appropriately answer questions. She had impaired cognition and verbalized that she worked at facility doing shorthand. Wanderguard was observed in place to right wrist. During an interview on 11/13/24 at 10:05 am the Maintenance man said he checked each door alarm weekly. He said if a resident eloped, they could be at risk of all kinds of injuries and they could be hit by a car. During an interview on 11/13/24 at 10:40 am the DON said Administrator was responsible for reporting incidents. She said she did not consider this incident an elopement because she thought staff had had Resident #42 within their sight at all times. She said staff should respond to alarms immediately. During an interview on 11/13/24 at 10:20 am the Administrator said she was responsible for reporting incidents and said that staff never actually lost Resident #42. She said a staff member had gone outside and saw Resident #42. She said she believed staff had eyes on Resident #42 the entire time. She said she was the abuse coordinator and she used HHSC guidance to determine reporting criteria. She said she would have reported it if she thought the incident had been a reportable incident, but since she thought staff had eyes on her the entire time, she did not report it. She said if incidents were not reported then possibly a thorough enough investigation might not occur and residents could be harmed. She said after this incident, they put an order in place to ensure wanderguard was in place on the medication administration record. Record review of a facility policy titled Missing Resident Policy dated 10/24/22 and revised on 8/15/23 read . Appropriate reporting requirements to the State Survey agency shall be conducted . Record review of a facility policy titled Abuse/Neglect Policy and Procedure dated 1/8/24 read .Definitions: . Neglect: failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness . and .Reporting: Administrator or designee will then notify the appropriate State agency(s) when required, after identification of alleged incident. Initiate process according to State- specific regulations . Record review of a Long-Term Care Regulatory Provider Letter titled Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility (NF) Must Report to the Health and Human Services Commission (HHSC) dated August 29, 2024 read: .2.1 Incident that a NF Must Report to HHSC. A NF must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: a missing resident . and .An incident that does not result in serious bodily injury and involves: a missing resident-Immediately, but not later than 24 hours after the incident occurs or is suspected .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50818 Based on observation, interview and record review, the facility failed to ensure that a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new pressure ulcers from developing for 1 of 2 residents (Resident #21) reviewed for pressure ulcers. The facility failed to provide wound care for pressure ulcer for Resident #21 on Left Heel for 3 of 27 days and failed to provide wound care for pressure ulcer on Right Buttocks for 4 of 27 days in October 2024 which could have caused pressure ulcers to deteriorate. This failure could place residents with pressure ulcers at risk for wound deterioration and decline in existing pressure ulcers. Findings included: Record review of an Admission Record dated 10/04/24 indicated Resident #21 was admitted on [DATE], was [AGE] years old, and was diagnosed with senile degeneration of brain, fracture of left femur, unstageable pressure ulcer of left heel, and stage 3 pressure ulcer of right buttock. Record review of an MDS dated [DATE] indicated Resident #21 had severe cognitive impairment, required substantial to total assistance for all ADLs, was at risk for developing pressure ulcers, had one stage 3 and one unstageable pressure ulcer at the time of admission. Record review of a VOHRA Wound Physicians Evaluation and Management summary dated 10/18/24 specified Resident #21 had a pressure injury to her buttocks and to her left heel. Physician treatment plan reflected the following orders: STAGE 3 PRESSURE WOUND OF THE RIGHT BUTTOCK FULL THICKNESS DRESSING TREATMENT PLAN Primary Dressing(s) Alginate rope apply once daily for 21 days Secondary Dressing(s) Gauze island w/ bdr apply once daily for 21 days UNSTAGEABLE (DUE TO NECROSIS) OF THE LEFT HEEL FULL THICKNESS DRESSING TREATMENT PLAN Primary Dressing(s) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Betadine apply three times per week for 21 days; Alginate calcium w/silver apply three times per week for 30 days Secondary Dressing(s) Gauze island w/ bdr apply three times per week for 30 days Record review of a treatment record for October 2024 for Resident #21 reflected that wound care for pressure ulcer of left heel had not been documented 3 of 27 days, and wound care for pressure ulcer of buttocks was not documented for 4 of 27 days. During an interview with an employee at the facility who wished to remain anonymous said that wound care was not always done for Resident #21 when the treatment nurse was off work. Employee said it was the responsibility of the RN on the floor to perform wound care as ordered when the treatment nurse was off work. During an interview on 11/12/24 at 10:38AM the Treatment Nurse said she performs wound care for Resident #21 on weekdays. She said on weekends or any other day when she is off, an RN working performs wound care. During an interview on 11/13/24 at 2:20 PM the DON said the treatment nurse was responsible for wound care when she was at the facility, and the charge RN or RN supervisor was responsible for performing wound care when the treatment nurse was not working. She said the expectation of staff was to always perform wound care as it was ordered. She said going forward she would more closely monitor treatment reports to ensure orders were being followed. She said risks to residents if physician wound care orders were not followed would be worsening wounds. Record review of a wound care policy dated 3/11/2024 reflected that .Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 1 of 6 residents (Resident #42) reviewed for accidents. The facility failed to provide adequate supervision to prevent Resident #42 from eloping from the facility and being located in an empty lot with multiple fall and environment hazards approximately 550 feet behind facility and approximately 300 feet from highway on 10/13/24 at 1:30 am. The facility failed to keep Resident #42 in a safe environment to prevent an elopement on 10/13/24 at 1:30 am. The noncompliance was identified as PNC (past non-compliance). The IJ (immediate jeopardy) began on 10/13/24 and ended 10/14/24. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk for serious injury, accidents, and death. Findings included: Record review of a facility face sheet dated 11/11/24 for Resident #42 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke), dementia, and hyperlipidemia (high cholesterol). Record review of a comprehensive MDS assessment dated [DATE] for Resident #42 indicated that she had a BIMS score of 9, which indicated that she had moderately impaired cognition. She had hallucinations and delusions. Wandering behavior was not present during 7-day lookback period. She was independent with most all ADLs and was able to independently ambulate at least 150 feet. She was always continent to bowel and bladder. She had a wander/elopement alarm device. Record review of a comprehensive care plan initiated on 9/1/22 and most recently revised on 10/18/24 for Resident #42 indicated that she was a high risk for elopement related to progressing dementia and signs of sundowning with interventions that read: .check for placement of wanderguard Q shift . dated 4/15/24 and . Use audible monitoring system to alert staff of exit seeking behaviors as appropriate . dated 9/22/23. Care plan also indicated that she exhibited wandering/exit seeking and had an intervention that read: .Check for proper functioning of the audible alarm system every shift and PRN as ordered . dated 9/21/22. Interventions added after incident included: .Monitor resident for tailgating when visitors are in the building or on the unit . dated 10/13/24 and .Electronic monitoring as needed with family consent . dated 10/18/24. Record review of a physician's order summary report dated 11/11/24 for Resident #42 indicated that she had the following order dated 10/13/24: .Check function of wanderguard every shift for wandering .; and the following order dated 4/14/24: .Wanderguard - check placement every shift for safety . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a facility form titled AHS - Elopement/Wandering Risk assessment dated [DATE] for Resident #42 indicated that she was at risk for elopement or unsafe wandering. Record review of a facility form titled AHS - Elopement/Wandering Risk assessment dated [DATE] for Resident #42 indicated that she was at risk for elopement or unsafe wandering. Record review of a facility incident report dated 10/13/24 for Resident #42 indicated that she eloped from the facility and was located outside the facility and redirected back to building without issues. Administrator, DON, physician, and responsible party all appropriately notified. Record review of a witness statement dated 10/13/24 and completed by RN H read .I heard alarm sounding on 100 hall - station 1. I went outside the door and looked at area around exit door area not seeing anyone I went back inside and checked resident [Resident #42] room to ensure that she was in there. She had just stated that she was going to bed per her norm. Not seeing resident in bed or [bathroom] in her room, I went back outside and looked around exit area and toward road. I then went to notify the other staff members. As I was walking down to unit 2 I approached [LVN F] and [CNA E] and informed them of [Resident #42] was not in her room and asked if they had seen her. The stated they had not. The other aides from unit 2 were also coming up the hall. I went outside the therapy room exit door and walked toward [facility name] to circle the back side of the building. The other staff members went outside the short hall door and [LVN F] remained in the building. When I rounded the side of the building where aides were searching, I heard [CNA G] ask if that was a person over there. I looked and saw her too. [CNA E] and myself [CNA E] ran toward her and were able to redirect resident back inside building without incident. Resident stated that she was looking at the stars. Resident showed no signs of distress or injury . Record review of a witness statement dated 10/13/24 and completed by LVN F read .I heard an alarm going off and discovered it was the exit door in short hallway next to DON office. Nurse proceeded to door and looked outside door and did not see any one. Sent [CNA M], Aide to inform [RN H]. As she walked down hall toward front, [RN H] was coming towards us. He asked if we had seen [Resident #42] because she was not in her room. [CNA G] and [CNA E] the at door with us. The 4 staff members then went outside building, going in different directions searching for resident. I stayed inside building monitoring doors and other facility residents. Shortly after, resident was found outside and safely returned . Record review of a witness statement dated 10/13/24 and completed by CNA G read .I heard alarm going off and it was the door by DON office in that short hall. [RN H] let us know that he could not find [Resident #42]. He said they had just seen her but she is not in her room and they can't find her. We went outside to look for her. [LVN F] the nurse stayed inside. We saw someone moving ahead of us and [RN H] and [CNA E] took off towards her. I went back in and went to unit one to monitor. [CNA M] monitored station 2 with [LVN F] until they got her and came back inside . Record review of a witness statement dated 10/13/24 and completed by CNA M read .I heard an alarm going off. I went down to the door that was alarming - the door on hall next to DON office. I was with [CNA G]. We did not see a resident near by the door or in hall. [LVN F] said go get [RN H] but I turned and he was walking toward me and asked us if we had seen [Resident #42]. We had not seen her so then we went outside and all walked toward the smoke shack. We looked in different directions for her. It was almost right away that we saw her walking toward the Texas Burger. [CNA E] and [RN H] ran after her. Me and [CNA G] went back in the building to check on the other residents . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a witness statement dated 10/13/24 and completed by CNA E read .I was in the break room eating and heard alarm going off at smoking door exit. Went to door - no residents around and looked out window and didn't see anyone there. I went to look for [RN H] to tell him. Walking down 200 hall I seen the nurse from station 2 walking down hall. She said the door was alarming on the short hall by DON office. [RN H] come around from 100 hall asking if we seen [Resident #42]. He told us she wasn't in her room. I had just seen [Resident #42] because she was up front she turned back around to go towards her room. We all went toward the short hall door. Me, [CNA G], and [CNA M] immediately go outside to look for her. [RN H] went out the therapy exit door. [CNA M], [CNA G], and I looked in all different directions. Just as [CNA M] said is that a person over there [RN H] was coming back around the building and met us there and said yes it is so we take off. I run and [RN H] was running/speed walking and we caught up to her towards the [business name]. We came back to the facility and went back inside . During an interview and observation on 11/11/24 at 12:40 pm the DON said Resident #42 was found in an empty lot between facility and [business name]. The empty lot where Resident #42 was located was observed to be approximately 550 feet behind facility and approximately 300 feet from highway. Multiple hazards were observed in the empty lot such as fall/trip hazards, ant beds, holes, rusty pipes, broken glass, and uneven ground. During a telephone interview on 11/11/24 at 2:25 pm CNA G said that the door on unit 1 alarmed first. She said she immediately headed to respond to the alarm, and that is when she saw RN H coming down the hall and he told her that Resident #42 was not in her room. She said they then went outside the door on the short hall. She said she was standing next to the smoke shack when she was outside looking for her and saw Resident #42's figure moving in the distance. She said she was unsure how long Resident #42 was outside but thought that it was about 3 to 4 minutes from the first alarm going off until they found her. During an observation on 11/11/24 at 2:38 pm, the exit door on 100-hall that Resident #42 eloped from was set off with wanderguard by this surveyor. Nursing staff immediately responded to the alarm. The exit door on the short hall by the DON's office was also set off from the outside with the same wanderguard. The exit door to the smoking area was also set off with wanderguard from outside. Each door was observed to alarm separately. During an interview on 11/11/24 at 3:25 pm the Administrator said she felt like the resident took the shorter path around the back of the building instead of going completely around because it would have taken her longer. She said she felt like the staff did a good job of retrieving Resident #42 and bringing her back inside the facility. She said Resident #42 now has a sitter at night and staff check on her every 15 minutes throughout the day. During an observation and interview on 11/11/24 at 4:20 pm Resident #42 was observed at the nurse's station. She ambulated without difficulty and without assistive devices. She was unable to recall incident or appropriately answer questions. She had impaired cognition and verbalized that she worked at facility doing shorthand. Wanderguard was observed in place to right wrist. During a telephone interview on 11/12/24 at 9:28 pm LVN F said she stayed inside the facility with other residents while the rest of the staff went outside to look for Resident #42. She was able to verbalize training regarding elopements and appropriate actions to take in the event of an elopement. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Whitehall Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1116 E Loop 304 Crockett, TX 75835	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 11/12/24 at 9:35 pm CNA E said she had been at the nurse's station and Resident #42 had been walking around at the nurse's station and then Resident #42 turned and walked back towards her room. She said RN H was rounding, checking on the residents and was in a resident's room. She said she then walked to the break room to eat lunch. She said she heard the door alarm going out to the smoking area start going off while she was eating lunch, so she got up and went to check it. She said she looked around outside and did not see anyone. She said she was not sure if it was a malfunction or what it was, she had never dealt with an elopement before. She said that she put the code in to turn the alarm off and immediately went to look for RN H. She said she couldn't find him, so she headed to the unit 2 nurses' station and the alarm for the door on the short hall next to the DON office was going off and the nurse did not know the code. She said they then saw RN H coming up the hallway saying that Resident #42 was not in her room, and he could not find her. They immediately went outside to look for her while LVN F stayed inside the facility. She said RN H had already made a perimeter around the building and when he was coming back around from the side, CNA G said is that a person over there? and that was when they saw her walking towards [Texas Burger]. She said she started running towards Resident and RN H was right behind her walking really fast. She said they got up to her almost to [Texas Burger] in the empty lot. They were able to bring her back inside and RN H took over after that. She was able to appropriately answer questions related to elopement training. During an interview on 11/13/24 at 10:05 am the Maintenance man said that he used a wanderguard to set off each door weekly to ensure they functioned correctly. He said residents that eloped could be at risk for all kinds of injuries such as being hit by a car and killed. During an interview on 11/13/24 at 10:20 am the Administrator said if residents eloped, they could be harmed, a lot of things could happen, they could fall, or maybe get lost. She said Resident #42 now has a sitter at night and was more closely supervised during the day, that staff were documenting her location every 15 minutes. She said they have placed checking of the wanderguard on the MAR, checked all residents in facility for elopement risk, tightened up on the door codes to prevent resident's from using codes to exit. During an interview on 11/13/24 at 10:40 am the DON said if a resident eloped, they could be at risk for falls, getting in the road, being ran over, getting injured, hunger, thirst, and low blood sugar. She said she expects her staff to immediately respond to door alarms to help prevent elopements. During a telephone interview on 11/13/24 at 10:30 am RN H said he checked on residents every hour and a half or so, and that Resident #42 must have just slipped by him. He said she did wander the facility and wore a wanderguard. He said she could have been seriously injured or harmed or she could have run out into the street. He said he was in a resident's room when he initially heard the door alarm going off, he said staff should immediately respond to the alarms, but he was tied up with a resident and it took him a minute or so to respond. Record review of a facility policy titled Missing Resident Policy dated 10/24/22 and revised 8/15/23 read: . This facility ensures that resident who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility took the following action to correct the non-compliance on 10/14/24: Record review of Elopement/Wandering Risk assessment history indicated all residents were reassessed for elopement risk by 10/13/24. The facility identified seven residents to be at risk and to require additional supervision. Record review of 15-minute check documentation forms dated 10/13/24 through 11/11/24 indicated that staff document Resident #42's location every 15 minutes throughout the day. Record review of invoices from [business name], a private sitting company indicate that facility paid for a private sitter for Resident #42 from the night of 10/14/24 through 11/11/24. Record review of facility form for elopement drill indicated that facility held elopement drills on 10/13/24 for day shift attended by 8 staff members; 10/13/24 for night shift attended by 5 staff members; 10/14/24 day shift attended by 10 staff members; and 10/14/24 night shift attended by 7 staff members. Record review of facility log sheets dated 10/13/24 through 10/19/24 indicated that documentation of daily door checks were done for front door, dining room door, 100-hall exit door, exit door by DON office, therapy exit door, 400-hall exit door and 500-hall exit door. Record review of Resident #42's physician orders indicated that a new order was put into place to check function of wanderguard every shift for wandering dated 10/13/24. During interviews on 11/12/24 between 1:10 pm and 1:40 pm LVN B, MA L, Medical Records, LVN K, CNA C, and CNA G were able to verbalize training regarding elopements and appropriate actions to take in the event of an elopement. The noncompliance was identified as PNC. The IJ began on 10/13/24 and ended 10/14/24. The facility had corrected the noncompliance before the survey began.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49017 Based on observations, interviews and record reviews, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice and their care plans for 1 of 4 residents (Resident #19) observed for respiratory care and services. The facility failed to ensure Resident #19's nebulizer mask, humidifier bottle and tubing for the oxygen concentrator were changed per the physician's orders. These failures could place residents who require respiratory care at risk for respiratory infections, breathing in dust and allergens, decreased effectiveness of oxygen concentrators, and exacerbation of respiratory distress. Findings included: Record review of a facility face sheet dated 11/13/2024 for Resident #19 indicated that she was a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (a condition that limits airflow into and out of the lungs), generalized anxiety disorder (fear characterized by behavioral disturbances), Type 2 diabetes mellitus (a problem in the way the body regulates and uses sugar as a fuel), and Chronic Kidney Disease, Stage 2 (involves a gradual loss of kidney function). Record review of a quarterly MDS dated [DATE] for Resident #19 indicated that she had a BIMS score of 15, which indicated that she was cognitively intact. Section O indicated that she had received nebulizer treatments for at least 15 minutes for 2 of the previous 7 days of the assessment reference date (9/6/2024). Record review of medication administration records for Resident #19 for November 2024 indicated that she received nebulizer medication three times daily and oxygen at 4 liters via nasal cannula continuous daily. Record review of a consolidated physician's order list for Resident #19 indicated an order date of 7/11/24 to change oxygen set up and nebulizer tubing every Sunday. Record review of comprehensive care plan with a revision date of 6/15/2024 indicated the Resident #19 used oxygen therapy routinely related to chronic obstructive pulmonary disease. During an observation and interview on 11/11/24 at 10:36 am, Resident # 19 was observed lying in bed. Resident #19 had oxygen on 4 liters via nasal cannula. The humidified water bottle attached to the oxygen concentrator was dated 10/27/24 and had a small amount of water at the bottom of the bottle. A nebulizer mask was observed on her bedside table in a bag which was dated 11/27/24. Resident #19 stated that she wore her oxygen all the time and that she received nebulizer treatments daily. She said that the nurse changed the oxygen tubing and the nebulizer mask but that she could not recall the last time it was changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation 11/11/24 at 3:05 PM the humidifier bottle had a small amount of water and dated 10/27/24. The nebulizer mask on the bedside table was in a bag and dated 11/27/2024. During an observation on 11/12/24 at 8:30 AM the humidifier bottle was full of water and bubbling. The bottle was dated 11/12/2024. The nebulizer mask was in a bag on the bedside table and dated 11/12/2024. During an interview on 11/13/24 at 11:00 AM with the DON, she stated that the charge nurses on night shift were responsible to replacing the oxygen set up every Sunday and that it was on the resident's medication administration record. She said that the nurse was responsible for putting the correct date on the oxygen set up. She said that she expected the charge nurse to change the oxygen set up as ordered and as needed if the oxygen mask or tubing was visibly soiled and if the water on the concentrator was low or empty. She said that not changing the oxygen set up can lead to possible infection control risk due to soiled mask. She said that the water was necessary to humidify the oxygen for the resident's comfort and to avoid drying out the resident's nasal passages. During an interview on 11/13/24 at 01:36 PM with the Administrator, she stated that the director of nurses would be following up with the night shift nurses to ensure that orders were being followed and that anything that needed to be dated would be dated correctly. Record review of a facility policy titled Following Physician Orders implemented 9/28/2021 read .the nurse will . carry out and implement physician's orders. Record review of a facility policy titled Oxygen Administration reviewed on 1/5/2020 read Change disposable parts once a week and label with date.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 49017 Based observation and interview, the facility failed to ensure no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span for residents eating meals in their rooms. The facility failed to ensure that no more than 14 hours lapsed between a substantial evening meal and breakfast the following day and provide a nourishing snack for residents that ate in their rooms. This failure placed residents at risk of their nutritional needs, preferences, and requests being met. Findings include: During an observation on 11/11/2024 at 9:30 AM breakfast trays were being served by staff to rooms on hall 100. During observation on 11/12/2024 between 9:00 am and 9:30 AM breakfast trays were being served by to staff to residents on Hall 100. During an interview on 11/12/2024 at 2:00 PM with 10 members of the facility resident council , the residents stated that the facility served breakfast late and that for the residents that had their meals in their rooms it was often after 9:00 am before they were served breakfast. The residents stated supper was served around 6:00 PM. Residents stated snacks were available at the nurse's station in the evening and that the snacks consisted of crackers or cookies. Residents said they had to go to the nurse's station if they wanted a snack, that staff did not bring them to their rooms. There were 3 residents present in the meeting that were diabetic and they stated that they did not receive snacks at night. The residents said if they wanted a sandwich in the evening that they had to tell the kitchen before supper. The residents said the mealtime between supper and breakfast was long, and that the supper menu was a lighter meal. Posted mealtimes in the dining room are breakfast 7:30 AM; lunch 12:00 PM; Supper 5:30PM. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/13/24 at 10:15 AM with the Dietary Manager she said breakfast was served in the dining room at 7:30 AM and that the last trays for the hall were out for serving by 8:50 AM every morning. She said supper was served at 5:30 PM and that the hall trays were out by 5:45 PM every day. She said the nursing staff were responsible for getting the hall trays from the kitchen and passing them out on the hall. She stated snack times were 10:00 AM, 2:00 PM and 8:00PM. She said the evening kitchen staff were responsible for stocking and preparing the snacks. She said the snacks were prepared and taken to the nurse's station for the nursing staff to pass out. She said all residents with diabetes had a label printed out and those residents get sandwiches every evening. She said she had complaints in the past that sandwiches were not being made and left for the evening snacks, she could not recall when the complaint was. She said she had a meeting with the evening shift staff, and they were instructed to make sandwiches for the evening snacks. She said she has not had any other complaints about snacks, so she did not know that it was a problem. The Dietary Manager stated she did not have a policy on frequency of meals and snacks. She stated she knew that the time limit was 14 hours between supper and breakfast. During an interview on 11/13/24 at 11:25 AM with the DON, she stated she was aware that there were inconsistencies in mealtimes. She stated dietary normally brings the trays to station 1 and then they announce that trays were ready for station 2 and the dietary staff meets that nursing staff halfway with the trays. She said she was not aware that the sandwiches were not being passed out to residents during the evening. She said her expectations are that dietary staff were consistent with mealtimes and that nursing staff serves trays promptly to the residents. She said possible effects of extended or inconsistent mealtimes would be that residents that need to take medications with meals or receive insulin before meals could have unwanted side effects related to taking medication prior to meals and meals were late. During an interview on 11/13/24 at 01:20 PM with Dietary Aide N, he said he worked at the facility for 3 months. He stated that he was responsible for preparing evening snacks for the facility. He stated tthe snacks were prepared and sent to the nurse's station with supper trays. He stated snack cakes and crackers were placed on the cart. He stated that he prepares 10 sandwiches and cuts them in half to send them to each nurse's stations. He stated that he does not put the residents name/label on the sandwiches, but he does put a label with the date on it. He said he does not know how the snacks were passed out once they were at the nurse's station. During an interview on 11/13/24 at 01:30 PM with [NAME] P he said he has worked at the facility for 5 months. He said he helps with preparing the snacks for the evening shift. He said snack cakes, cookies and chips were placed on the snack cart. He said that half sandwiches were made every night. He said he would make sandwiches for all the residents that have evening snacks ordered. He said extra sandwiches were made for residents that request the sandwiches. He stated the snacks were sent with the evening meal trays. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/13/24 at 01:41 PM with the Administrator she stated she has worked in the facility for 2 years. She stated she was made aware of the residents complaining about breakfast being served late. She said she did not believe that the residents on the hall received their meals after 9:00 AM. She then stated there has been some staffing challenges in the dietary department and that they have had some challenges in that department. She stated they did back up the serving time and that breakfast was out timely this morning. She said she has been working with the dietary manager on solutions to make meal service more consistent. She said she has received complaints from residents in the past on how late the breakfast trays were being served. She stated by not providing a consistent mealtime and following the time frame allowed between meals that residents could get hungry, and that consistency was needed to assist in maintaining weights. She said she would work with the director of nurses on ensuring that snacks were being given to the residents. During an interview on 11/13/2024 at 10:15 AM with the Dietary Manager she said the facility did not have a policy regarding mealtimes and snacks.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50818 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in the facility's only kitchen. The facility failed to discard molded food including tomatoes, honeydew melons, and a bag of shredded mozzarella cheese. The facility failed to store food safely including cookie dough, sliced cheese, french fries, whipped topping, and prepared pudding. These failures could place residents at risk for food-borne illnesses. Findings included: During an observation on [DATE] at 9:04 AM in the kitchen, the walk-in refrigerator contained the following items: a cardboard box containing molded tomatoes a cardboard box containing molded honeydew melons a bag of molded shredded mozzarella cheese a cardboard box containing sealed bags of whipped topping that had a brown and sticky liquid on approximately half of the top of the box and several of the bags inside the box a container of prepared pudding that was uncovered, and two cardboard boxes of unsealed raw cookie dough. During an observation on [DATE] at 9:09 AM in the kitchen, the refrigerator contained the following items: a bag of unsealed sliced cheese that was unlabeled and undated. a bag of unsealed french fries that was unlabeled and undated. During an interview on [DATE] at 9:10 AM, [NAME] Q said all kitchen staff were responsible for checking the freezers and refrigerators daily to ensure that moldy or expired food were discarded and not served to residents. She said the risks to residents if they consume expired food would be food-borne illness and residents could get sick. During an interview on [DATE] at 9:15 AM, Dietary Aide R said that he does not check food in the freezers or refrigerators. He said the cooks and dietary manager were responsible for making sure expired or molded food is discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 9:30 AM, the DM said she regularly checks for expired food in the morning when she gets to work, but she had an emergency today and was late to work. She said the cooks were responsible for checking for expired food if she was not at the facility. She said the risks to residents if they were served expired food was food poisoning. During an interview on [DATE] at 2:16 PM, the Administrator said she and the DM were responsible for making sure all kitchen staff received appropriate training. She said the expectation was that kitchen staff were checking food quality daily and cleaning the kitchen as scheduled. She said that she does not like to answer questions about the risks to residents, but that it wouldn't be good to serve them expired food. Record review of a facility policy revised [DATE], titled Frozen and Refrigerated Foods Storage indicated, . Packaged frozen items that are opened and not used in their entirety must be properly sealed, labeled and dated for continued storage . and .All refrigerated and frozen items in storage will contain a minimum label of common name of product and dated .