STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675638	A. Building B. Wing	04/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Pines Nursing and Rehabilitation	3301 E. Mockingbird Lane Victoria, TX 77904

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview and record review the facility failed to ensure each resident was treated with respect, dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 3 residents (Resident #5) reviewed for dignity, in that: The facility failed to ensure Resident #5 was not left exposed during wound care on 4/24/24. This failure could place residents at risk of poor self-esteem and decreased self-worth and quality of life. Findings include: Record review of Resident #5's Admission Record, dated 4/20/24, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning), Hemiplegia (paralysis of one side of the body) of right side, Parkinsonism (a motor syndrome that manifests as rigidity and/or tremors), Cognitive Communication Deficit, and Depression. Record review of Resident #5's quarterly MDS assessment, dated 2/26/24, revealed the resident had a BIMS score of 00, which indicated severe cognitive impairment. Record review of Resident #5's Care Plan, revised 4/20/24, revealed: The resident has a pressure ulcer or potential for pressure ulcer development . Administer wound care as ordered . Record review of Resident #5's Order Summary Report, dated 4/26/24, revealed an order for wound care as follows: Cleanse stage IV sacral wound with vashe (Wound Cleanser). Apply collagen and calcium alginate with silver to wound bed. Paint peri-wound with skin prep. Secure with silicone dressing QD and PRN every day shift for wound care. Observation of wound care to the sacrum for Resident #5 on 4/24/24 at 7:12 AM revealed LVN C approached Resident #5 and explained the procedure. Further observation revealed after removing the resident's dressing, LVN C walked away from Resident #15, leaving the resident's buttocks and sacral wound exposed, to retrieve the trash can. LVN C returned with the trash can and continued with the treatment. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an attempted interview on 4/27/24 at 12:53 PM, Resident #5 did not respond to investigator's questions. During an interview on 4/27/24 at 1:45 PM, LVN D stated Resident #5 was not supposed to be left exposed during wound care. LVN D further stated the resident should have been covered and given privacy during care. During an interview on 4/27/24 at 6:32 PM, the DON stated she expected nurses to provide privacy during wound care to preserve the resident's privacy and dignity. Record review of the facility's policy, titled, Resident Rights, revised 11/28/16, reflected: The resident has a right to a dignified existence . A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life . The facility must protect and promote the rights of the resident . Respect and dignity -The resident has a right to be treated with respect and dignity .Privacy and confidentiality -The resident has a right to personal privacy .1. Personal privacy includes accommodations, medical treatment . personal care

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interviews, and record review, the facility failed to ensure residents' right to reside and receive services in the facility with reasonable accommodations of residents needs for 2 of 2 residents (Resident #5 and Resident #15) reviewed for accommodations of needs, in that. The facility failed to ensure Resident #5, and Resident #15 were able to press the call light when assistance was needed. This deficient practice could place residents at risk of not receiving care or attention when needed. Findings included: Record review of Resident #5's Admission Record, dated 4/20/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Dementia (group of thinking and social symptoms that interferes with daily functioning), Hemiplegia (paralysis of one side of the body) of right side, Parkinsonism (a motor syndrome that manifests as rigidity and/or tremors), Cognitive Communication Deficit, Muscle Weakness, Abnormal Posture, Muscle Wasting and Atrophy (decrease in size or wasting away of a body part or tissue), Pain, and Depression. Record review of Resident #5's MDS assessment, dated 2/26/24, revealed the resident had a BIMS score of 00, suggesting severe cognitive impairment. Further review of this assessment revealed Resident #15 functional limitation in range of motion to bilateral upper and lower extremities, was dependent (Helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) for all self-care and dependent for mobility. Record review of Resident #5's Care Plan, dated 1/24/23, revealed the following focus area last revised on 6/21/23: The resident is at risk for falls .Interventions .Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed .The resident needs a safe environment with .a working and reachable call light . Further review of this document revealed the following focus area last revised on 11/4/23: Resident has a communication problem r/t to cog/comm deficit, such as expressing words, emotions, spontaneous speech and needs time to communicate basic needs .Goal: Resident will be able to make basic needs known by allowing time for her to express herself and emotions on a daily basis . Interventions .Ensure/provide a safe environment: Call light in reach .Monitor effectiveness of communication strategies and assistive devices . During observation and interview on 4/20/24 at 6:23 pm, Resident #5 was seen lying in bed with family at bedside. Resident #5 was awake, alert, and her upper limbs were contracted across her chest. Interview with resident was attempted but answers were unintelligible. Resident #5 slightly moved left hand but was unable to press call light when asked by the investigator to press the button. Resident #5's family member said she was unable to press the call light herself and believed the facility staff were aware of this. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/24 at 11:28 am, LVN D said Resident #5 was not able to press the call light. During an interview on 4/22/24 at 12:10 pm, CNA D said Resident #5 was not able to press the call light button. CNA D further stated that Resident #5 was checked on and repositioned every two hours. During an interview on 4/27/24 at 12:47 pm, LVN A said she did not believe Resident #5, cognitively and physically, was able to press the call light. Record review of Resident #15's Admission Record dated 4/23/24 revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: Alzheimer's Disease (disease affecting memory and other important mental functions), Dementia (group of thinking and social symptoms that interferes with daily functioning) , Type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), COPD (lung diseases that block airflow and make it difficult to breathe) , Cognitive Communication Deficit, Dysphagia (difficulty swallowing) , Functional Quadriplegia (complete inability to move due to severe disability or frailty caused by another medical condition) , Pressure ulcer of sacral region Stage 4, Depression and Anxiety. Record review of Resident #15's MDS assessment dated [DATE] revealed a BIMS score of 5, suggesting severe cognitive impairment. Further review of this assessment revealed Resident #15 functional limitation in range of motion to bilateral upper and lower extremities; was dependent (Helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) for all self-care and Dependent for mobility. Record review of Resident #15's Care Plan, dated 3/8/23, revealed the following focus area last revised on 9/27/23: The resident is at risk for falls r/t recent admit to hospital and now with increased weakness and decreased mobility skills .Interventions .Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Further review of this document revealed the following focus area last revised on 4/11/23: The resident has a communication problem r/t she is hared [sic] of hearing and speaker must adjust tone to be heard .Goal: The resident will be able to make basic needs known by on a daily basis .Interventions .Ensure/provide a safe environment: Call light in reach .Monitor effectiveness of communication strategies and assistive devices . Observation and atteBased on observation, interview and record review the facility failed to ensure residents' had the right to reside and receive services in the facility with reasonable accommodation of residents needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 2 of 11 residents (Resident #5 and Resident #15) reviewed for accommodations of needs. The facility failed to ensure Resident #5 and Resident #15 were able to press the call light when assistance was needed. This deficient practice could place residents at risk of not receiving care or attention when needed. Findings include: (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Record review of Resident #5's Admission Record, dated 4/20/24, reflected the resident was admitted to the facility on [DATE]. Resident #5 had diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning), Hemiplegia (paralysis of one side of the body) of right side, Parkinsonism (a motor syndrome that manifests as rigidity and/or tremors), Cognitive Communication Deficit, Muscle Weakness, Abnormal Posture, Muscle Wasting and Atrophy (decrease in size or wasting away of a body part or tissue), Pain, and Depression. Record review of Resident #5's quarterly MDS assessment, dated 2/26/24, reflected the resident had a BIMS score of 00, which indicated severe cognitive impairment. Resident #5 functional limitation in range of motion to bilateral upper and lower extremities, was dependent (Helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) for all self-care and dependent for mobility. Record review of Resident #5's Care Plan, dated 1/24/23, reflected the following focus area last revised on 6/21/23: The resident is at risk for falls .Interventions .Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed .The resident needs a safe environment with .a working and reachable call light . Further review of this document revealed the following focus area last revised on 11/4/23: Resident has a communication problem r/t to cog/comm deficit, such as expressing words, emotions, spontaneous speech and needs time to communicate basic needs .Goal: Resident will be able to make basic needs known by allowing time for her to express herself and emotions on a daily basis . Interventions .Ensure/provide a safe environment: Call light in reach .Monitor effectiveness of communication strategies and assistive devices During observation and interview on 4/20/24 at 6:23 PM, Resident #5 was seen lying in bed with family at the bedside. Resident #5 was awake, alert and her upper limbs were contracted across her chest. Interview with the resident was attempted but answers were unintelligible. Resident #5 slightly moved their left hand but was unable to press the call light when asked by the State Surveyor to press the button. Resident #5's family member said she was unable to press the push button call light herself and believed the facility staff were aware of this. Resident #5's family member further stated it would have been better for the resident to have a flat call light. During an interview on 4/22/24 at 11:28 AM, LVN D said Resident #5 was not able to press the push button call light. LVN D further stated a soft call light would have been better for Resident #5 was but did the facility did not have any. During an interview on 4/22/24 at 12:10 PM, CNA D said Resident #5 was not able to press the call light button. CNA D further stated Resident #5 was checked on and repositioned every two hours. During an interview on 4/27/24 at 12:47 PM, LVN A said she did not believe Resident #5, cognitively and physically, was able to press the call light. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #15's Admission Record, dated 4/23/24, reflected the resident was readmitted to the facility on [DATE]. Resident #15 had diagnoses which included: Alzheimer's Disease (disease affecting memory and other important mental functions), Dementia (group of thinking and social symptoms that interferes with daily functioning) , Type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), COPD (lung diseases that block airflow and make it difficult to breathe) , Cognitive Communication Deficit, Dysphagia (difficulty swallowing) , Functional Quadriplegia (complete inability to move due to severe disability or frailty caused by another medical condition) , Pressure ulcer of sacral region Stage 4, Depression and Anxiety. Record review of Resident #15's quarterly MDS assessment, dated 3/15/24, reflected a BIMS score of 5, which indicated severe cognitive impairment. Resident #15's functional limitation in range of motion to bilateral upper and lower extremities; was dependent (Helper does all the effort. Resident does none of the effort to complete the activity, or the assistance of 2 or more helpers was required for the resident to complete the activity) for all self-care and dependent for mobility. Record review of Resident #15's Care Plan, dated 3/8/23, reflected the following focus area last revised on 9/27/23, reflected: The resident is at risk for falls r/t recent admit to hospital and now with increased weakness and decreased mobility skills .Interventions .Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Further review of this document revealed the following focus area last revised on 4/11/23: The resident has a communication problem r/t she is hared [sic] of hearing and speaker must adjust tone to be heard .Goal: The resident will be able to make basic needs known by on a daily basis .Interventions .Ensure/provide a safe environment: Call light in reach .Monitor effectiveness of communication strategies and assistive devices Observation and attempted interview on 4/25/24 at 5:24 PM revealed Resident #15 was seen lying in bed. She was awake, alert, and her arms were crossed across her chest, right arm appeared contracted across her chest and left hand was observed with severe edema (swelling) and appeared to have limited range of motion. Interview with the resident was attempted but Resident #15 did not respond to questions. Resident #15 was unable to press the call light when asked. During an interview on 4/27/24 at 12:47 PM, LVN A said all staff should have been checking for residents' ability to press the call light button. LVN A further stated if a resident was unable to press the push button call light button, they were given a soft call light (a special device used for residents with limited ROM) they could press when assistance was needed. During an interview on 4/27/24 at 6:32 PM, the DON said interventions for Resident #5 and Resident #15 included: rounding every 2 hours, turning every 2 hours and CNAs were sent to check on the residents more often because they had a higher acuity and needed more assistance than others. The DON said Resident #5 and Resident #15 were able to press the call light button but refused to do so. Record review of the facility's policy, titled Resident Rights, revised 11/28/16, reflected: . Respect and dignity - 3. The right to reside and receive services in the facility with reasonable accommodation of resident needs . mpted interview on 4/25/24 at 5:24 pm revealed Resident #15 was seen lying in bed. She was awake, alert, and her arms were crossed across her chest, right arm appeared contracted across her chest and left hand was observed with severe edema and appeared to have limited range of motion. Interview with resident was attempted but Resident #15 did not respond to questions. Resident #15 was unable to press the call light when asked. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/27/24 at 12:47 pm, LVN A said all staff should have been checking for residents' ability to press the call light button. LVN A further stated that if a resident was unable to press the call light button, they were given a soft call light (a special device used for residents with limited ROM). During an interview on 4/27/24 at 6:32 pm, the DON said she had not evaluated Resident #5's and Resident #15's ability to press the call light button. She added that interventions for Resident #5 and Resident #15 included: rounding every 2 hours, turning every 2 hours and CNAs were sent to check on the residents more often because they have a higher acuity and need more assistance than others. Record review of the facility's policy, titled, Resident Rights, revised 11/28/16, revealed: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility . A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality . The facility must provide equal access to quality care regardless of diagnosis, severity of condition . Planning and implementing care - d. The right to receive the services and/or items included in the plan of care .3. The planning process must-- b. Include an assessment of the resident's strengths and needs . Respect and dignity - 3. The right to reside and receive services in the facility with reasonable accommodation of resident needs .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview and record review the facility failed to ensure the a comprehensive care plan was developed within seven days of the comprehensive assessment and review and revise the care plan after each assessment for 1 of 12 residents (Resident #15) reviewed for care plans. The facility failed to ensure Resident #15's care plan was revised to reflect edema to left hand with elevation. These failures could place residents at risk of current needs not being met. Findings included: Record review of Resident #15's Admission Record, dated 4/23/24, reflected the resident was readmitted to the facility on [DATE]. Resident #15 had diagnoses which included: Alzheimer's Disease (disease affecting memory and other important mental functions), Dementia (group of thinking and social symptoms that interferes with daily functioning) , Type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), COPD (lung diseases that block airflow and make it difficult to breathe) , Cognitive Communication Deficit, Dysphagia (difficulty swallowing) , Functional Quadriplegia (complete inability to move due to severe disability or frailty caused by another medical condition) , Pressure ulcer of sacral region Stage 4, Depression and Anxiety. Record review of Resident #15's quarterly MDS assessment, dated 3/15/24, reflected a BIMS score of 5, which indicated severe cognitive impairment. Resident #15's functional limitation in range of motion to bilateral upper and lower extremities; was dependent (Helper does all the effort. Resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) for all self-care and Dependent for mobility. Record review of Resident #15's Progress Notes reflected: Effective Date: 03/11/2024 20:08 [8:08 pm] .Note Text: resident has 3+ edema to left arm no warmth or redness noted VS within normal limits informed NP .orders to elevate arm .Author: [LVN H] Effective Date: 03/13/2024 16:03 [4:03 pm] .Note Text: New order per [NP] Xray to left hand .due to swelling .Author: [ADON A] Effective Date: 03/14/2024 12:52 [12:52 pm] .Note Text .New orders received to start keflex 500 mg po bid x 10 days for cellulitis, keep left hand elevated on pillows .Author: [LVN C] Effective Date: 04/09/2024 09:20 [9:20 am] .Note Text: Left hand swollen .Author: [LVN E] Record review of Resident #15's Care Plan last reviewed 3/29/24, did not address edema and elevation of left arm. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #15's Order Summary Report, dated 4/26/24, reflected: elevate left arm, dated 3/11/24. During an interview on 4/27/24 at 12:47 PM, LVN A stated care plans were completed and updated by herself and RN A (MDS Coordinators). LVN A further stated care plans were completed quarterly when the MDS assessment was completed and PRN if there were changes in condition, services and/or needs. LVN A stated care plans were updated as soon as possible. LVN A further stated the facility had morning meetings and if changes were reported, she tried to update the appropriate care plans during the meeting. LVN A stated the facility also had daily nursing meetings with the DON, ADONs, Administrator and an the MDS nurse and standard of care meetings. LVN A stated she knew Resident #15's hand was swollen and when she saw it top of her stomach, she assumed it was elevated. LVN A further stated she was not aware Resident #15 had an order for her left arm to be elevated. LVN A stated she was not going to say whether or not Resident #15's left arm edema should have been care planned because the facility's care plans were liberalized/generalized. LVN A further stated yes, it should have been care planned. LVN A stated the left arm edema and elevation for Resident #15 was not care planned, she further stated she did not know why it had not been care planned. During interview on 4/27/24 at 2:17 PM, RN A stated the nurses on working on the floor were responsible for updating care plans with acute changes to the resident's conditions. RN A further stated the facility had a morning meeting every day and changes to the resident condition/orders were shared at this meeting. RN A stated she and LVN A were mainly responsible for admissions assessments, quarterly assessments and care plans. RN A further stated the MDS Coordinators (LVN A and RN A) updated care plans, but care plans were updated for acute changes in condition by the floor nurses. RN A stated updates were done when changes happened, and added there was not a timeframe, but the goal was to update the care plans immediately. RN A further stated she was not aware Resident #15's edema to left arm and that her care plan had not been updated to reflect the edema and elevation to her left arm, stating the floor nurse should have updated Resident #15's care plan. RN A stated this change should have been shared in the morning meeting, and she did not remember the edema/elevation to Resident #15's left arm being discussed in the morning meetings. During an interview on 4/27/24 at 6:32 PM, the DON stated she expected care plans to be updated the day the change occurred. The DON stated the MDS, and charge nurses were responsible for updating care plans quarterly and when there were changes to orders. Record review of the facility's, undated, policy, titled Comprehensive Care Planning, read: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .The facility will establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life .The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented .revised based on changing goals, preferences and needs of the resident and in response to current interventions

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by an interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 1 of 12 residents (Resident #12) reviewed for care plans. The facility failed to ensure Resident #12's care plan was revised to reflect prescribed diet and weight loss. These failures could place residents at risk of current needs not being met. Findings included: Record review of Resident #12's Admission Record, dated 4/22/24, reflected the resident was admitted to the facility on [DATE]. Resident #12 had diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning) , Malnutrition, Dysphagia (difficulty swallowing) , Cognitive Communication Deficit, Depression and GERD (digestive disease in which stomach acid or bile irritates the food pipe lining) . Record review of Resident #12's quarterly MDS assessment, dated 1/3/24, reflected the resident had a BIMS score of 99, which indicated the resident was unable to complete the interview. Resident #12 weighed 147 pounds, a weight loss of 5% or more, was not on physician-prescribed weight-loss regimen and was on a mechanically altered and therapeutic diet. Record review of Resident #12's Care Plan, dated 12/20/17, reflected the following focus area last revised on 6/3/23: Potential for weight loss due to impaired cognition with Dementia, Depression, edentulous status without the use of his dentures currently. DX: GERD and Malnutrition .Goal: Resident will maintain stable weight and adequate nutrition by consuming 75-100% of meals X 3 per day with diet and liquids at most lenient texture and with compliance to diet as ordered x90 days .Target date:4/9/24 Record review of Resident #12's Order Summary, dated 4/20/24, reflected: Regular diet Mechanical Soft texture, Nectar consistency, Red Glass Program, Pureed meats with gravy, no straw. Magic cup with lunch for Per MBS study 2/13/23 related to Unspecified Protein-Calorie Malnutrition, start date 7/6/23; Readycare 2. 0 four times a day for Weight Loss give 90CC, start date 2/27/24; Super Cereal in the morning for with breakfast, start date 10/25/23. Record review of the facility's Weight and Vitals Summary, dated, 4/20/24, reflected Resident #12 weighed 145.6 lbs on 1/5/24 a 14.8% weight loss compared to 7/10/23 (170.8 lbs), 148.4 lbs on 1/12/24 a 13.1% weight loss compared to 7/10/23 (170.8 lbs), 143.4 lbs on 1/19/24 a 11.8% weight loss compared to 8/1/23 (162.2 lbs), 144.4 lbs on 2/2/24 a 10.3% weight loss compared to 8/11/23 (161 lbs), 144.4 lbs on 2/6/24 a 10. 3% weight loss compared to 8/11/23 (161 lbs), and 144.4 lbs on 2/9/24 a 10.3% weight loss compared to 8/11/23 (161 lbs). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #12's Progress Notes reflected: Effective Date: 01/10/2024 09:31 [9:31 am] Type: Dietary Note .Note Text: Wt's 147.2 lbs, 145.6 lbs - loss of 11.6 lbs/90 days (7.38%), 25.2 lbs/180 days (14.75%). On a Mech Soft Diet, Nectar Thick Liquids, Pureed Meats with gravy, no straw, Super Cereal in a.m. with breakfast, Magic Cup with lunch . Red Glass Program. Provided a House Shake after meals and at bedtime d/t weight loss .Current diet, nutritional supplements and p. o. intake areadequate [sic] as evidenced by fairly stable weekly weights past 4 weeks. Recommend continuing with same plan of care - goal is no significant weight changes next 30 days. Author .Dietitian Effective Date: 01/22/2024 18:28 [6:28 pm] Type: Nursing . Note Text: Contacted [NP] due to resident [sic] 5LBS wight [sic] loss in a week, did inform weight loss may have been due to resdient [sic] having a resp infection, will continue to monitor and weigh resdient [sic] weekly Author: [ADON A] Assistant Director of Nursing Effective Date: 02/26/2024 10:16 [10:16 am] Type: Dietary Note .Note Text: Wt's 145.6 lbs, 144.4 lbs - loss of 17.8 lbs/180 days (10.97%). On a Mech Soft Diet, Nectar Thick Liquids, Super Cereal in a.m., pureed meats with gravy, no straw . Magic Cup with lunch. Red glass Program. Provided a House Shake after meals and at bedtime .Review of chart indicates p. o. intake is good for most meals, however, continued weight loss trend noted. Recommend the following: .House Shake after meals and at bedtime. Provide 90ml ReadyCare 2.0 or Med Pass 2.0 QID with med pass. Goal is no further weight loss. Author .Dietitian Effective Date: 03/30/2024 07:18 [7:18 am] Type: Dietary Note . Note Text: Wt's 144.4 lbs, 142 lbs - loss of 17.4 lbs/180 days (10.92%). On a Mech Soft Diet, Nectar Thick Liquids, Pureed Meats with gravy, no straw, Magic Cup with lunch .Red Glass Program. Provided 90ml ReadyCare 2.0 QID . Review of chart indicates 2. 24 RD recommendations are in place and weight has stabilized as evidenced by most recent weekly weight of 142 lbs. Recommend continuing with same plan of care . Author .Dietitian Effective Date: 04/18/2024 11 :08 [11:08 am] Type: Dietary Note . Note Text: Wt's 142 lbs, 141 lbs - loss of 16.2 lbs/180 days (10.31 %). On a Mech Soft Diet, Nectar Thick Liquids, Super Cereal with breakfast, Pureed Meats with gravy, no straw, Magic Cup with lunch . Red Glass Program. Provided 90ml ReadyCare 2. 0 QID .Current diet, nutritional supplements and p. o. intake are adequate as evidenced by fairly stable weight past 90 days. Recommend continuing with same plan of care . Author .Dietitian During an interview on 4/27/24 at 12:47 PM, LVN A stated care plans were completed and updated by herself and RN A (MDS Coordinators). LVN A further stated care plans were completed quarterly when the MDS assessment was completed and PRN if there were changes in condition, services and/or needs. LVN A stated care plans were updated as soon as possible. LVN A further stated the facility had morning meetings and if changes were reported, she tried to update the appropriate care plans during the meeting. LVN A stated the facility also had daily nursing meetings with the DON, ADONs, Administrator and an the MDS nurse and standard of care meetings. LVN A stated care plans were supposed to reflect diet as ordered and stated Resident #12's diet was not included in the resident's care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/27/24 at 2:17 PM, RN A stated the nurses on working on the floor were responsible for updating care plans with acute changes to the resident's conditions. RN A further stated the facility had a morning meeting every day and changes to the resident condition/orders were shared at this meeting. RN A stated she and LVN A were mainly responsible for admissions assessments, quarterly assessments and care plans. RN A further stated the MDS Coordinators (LVN A and RN A) updated care plans, but care plans were updated for acute changes in condition by the floor nurses. RN A stated updates were done when changes happened, and added there was not a timeframe, but the goal was to update the care plans immediately. RN A stated she not aware Resident #12's care plan had not been updated to reflect his weight loss and diet orders. During an interview on 4/27/24 at 6:32 PM, the DON stated diet orders were to be care planned. The DON further stated she expected care plans to be updated the day the change occurred. The DON stated the MDS, and charge nurses were responsible for updating care plans quarterly and when there were changes to orders. Record review of the facility's, undated, policy, titled Comprehensive Care Planning, read: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .The facility will establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life .The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented .revised based on changing goals, preferences and needs of the resident and in response to current interventions Record review of the facility's policy, titled Red Glass and Fortified Food Program, dated 2012, revealed: . The red glass program uses the presence of a red glass on the resident's meal tray to alert facility staff to which residents may have had a weight loss and/or need additional monitoring and encouragement to complete meals and fluids. Dietary will provide the red glass .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview and record review the facility failed to ensure pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 2 residents (Resident #15) reviewed for pain management. The facility failed to adequately assess and treat Resident #15's pain. This failure could place residents at risk for unnecessary pain, discomfort and decreased quality of life. Findings include: Record review of Resident #15's Admission Record, dated 4/23/24, reflected the resident was readmitted to the facility on [DATE]. Resident #15 had diagnoses which included: Alzheimer's Disease (disease affecting memory and other important mental functions), Dementia (group of thinking and social symptoms that interferes with daily functioning), Type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), cognitive communication deficit, Pressure ulcer of sacral region Stage 4 and Anxiety. Record review of Resident #15's quarterly MDS assessment, dated 2/13/24, reflected a BIMS score of 99, which indicated the resident was unable to complete the interview. Resident #15 had an unhealed Stage 4 pressure ulcer present upon admission/entry or re-entry and was taking an Opioid. Record review of Resident #15's quarterly MDS assessment, dated 3/15/24, reflected a BIMS score of 5, which indicated severe cognitive impairment. Resident #15 received PRN medications or was offered and declined and had an unhealed Stage 4 pressure ulcer present upon admission/entry or re-entry. Record review of Resident #15's Care Plan, reviewed 3/29/24, reflected: The resident has a pressure ulcer . 1. Stage IV left gluteal wound- present on admission. 2. Excoriation to peri-rectal area and inner thighs with treatment in place .Observe for s/s of c/o pain and medicate with pain medication as ordered Record review of Resident #15's Weekly Ulcer Assessment, dated 4/23/24, for the resident's left gluteal fold stage IV pressure ulcer reflected there was no pain associated with this wound. Record review of Resident #15's Order Summary Report, dated 4/26/24, reflected an order for wound care as follows: Cleanse stage IV left gluteal wound with hibiclens, rinse with normal saline Pat dry with 4X4 gauze. Apply collagen/silver then hydrofera blue to wound bed. Skin prep peri-wound and Cover with silicone dressing QOD and PRN. one time a day every Tue, Thu, Sat for Wound healing. Further review reflected an order, dated 3/7/23, HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for PAIN .Give 2 Tablets to Equal 10-650MG, the date discontinued was not listed. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #15's Progress Notes reflected an entry, dated 3/8/24, which read: Note Text .NP here on rounds and orders were obtained to DC Norco d/t no use in last 60 days. Record review of Resident #15's Order Summary, dated 4/26/24, revealed Resident #15 did not have an order for pain medication. Record review of Resident #15's orders reflected an order, dated 4/27/24 at 9:06 AM, for Tylenol Oral Tablet 325 MG, Give 2 tablet by mouth every 6 hours as needed for pain. Observation of wound care for Resident #15 on 4/26/24 at 9:59 AM revealed LVN C approached the resident and informed her she would be providing wound care to the resident's left gluteal area. Further observation revealed LVN C did not assess the resident's pain prior to the start of the wound care procedure. During the procedure, while cleaning Resident #15's left gluteal area wound, the resident yelled, [NAME], [NAME], [NAME], and, hurry up. LVN C continued to provide wound care to Resident #15's left gluteal area and did not ask the resident if she had pain. LVN C did not complete a pain assessment during any part of the procedure. During an observation of wound care for Resident #15 on 4/27/24 at 9:38 AM revealed RN B approached the resident and informed the resident she would be providing wound care to the resident's left gluteal area. Further observation revealed RN B did not assess the resident's pain prior to the wound care procedure. During the procedure, while cleaning Resident #15's left gluteal area wound, the resident yelled, ou, ou, it hurts. RN B continued to provide wound care to the resident's left gluteal area and did not ask the resident if she had pain, but said she was almost done. RN B did not complete a pain assessment during any part of the procedure. During an interview with LVN C on 4/24/24 at 9:20 AM, LVN C stated she provided wound care for the facility and the floor nurses provided wound care in her absence. LVN C stated she was responsible for weekly ulcer assessments, and further stated she documented wound details on the residents' weekly ulcer assessments every Monday. LVN C stated she started the wound care position about nine months ago, and further stated she had not received training or skills check-off while at the facility. During an interview with LVN C on 4/26/24 at 10:14 AM, LVN C stated Resident #15 did not have any medications ordered for pain. During an interview with RN B on 4/27/24 at 10:14 AM, RN B stated Resident #15 had Acetaminophen 325 mg X2 ordered for pain, which was administered at 9:15 AM. During an interview with LVN C on 4/27/24 at 2:09 PM, LVN C stated Resident #15 was usually asked about pain prior to wound care and if the resident had pain, Tylenol was administered. LVN C stated she thought Resident #15 had an order for Tylenol PRN but did not have an order for pain medication during wound care. During an interview with the DON on 4/27/24 at 6:32 PM, the DON stated she was unsure if Resident #15 was assessed for pain management, and further stated all residents with pressure ulcers usually had something ordered for pain. The DON stated she expected nurses to follow wound care orders, infection control practices and provide privacy. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's, undated, policy, titled Dressing Change Checklist, reflected, Verifies Treatment: . Determines need to pre-medicate for pain. If necessary, verify pain medication order and allow appropriate time for medication to be effective Record review of the facility's policy, titled, Pain Management, Assessment Scale, revised 05/25/2016, reflected .Complaints of pain will be assessed accordingly by the nurse and effectively managed through prescribed medications, and comfort measures, and all available resources of the facility . Procedure 1. Assess resident's physical symptoms of pain, physical complaints .14. The care plan team will routinely assess the effectiveness of pain management interventions. Appropriate care plans will be maintained for the management of the resident's pain

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 39251 Based on observation, interview and record review the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for 6 out of 23 days (4/3/24, 4/4/24, 4/8/24, 4/9/24, 4/14/24, and 4/18/24) reviewed for sufficient nursing staff. The facility failed to have sufficient staff available to provide resident care on from 6:00 PM - 6:00 AM on 4/3/24, 4/4/24, 4/8/24, 4/9/24, 4/14/24 and 4/18/24. This failure could put residents at risk of not receiving necessary care to maintain their highest practicable physical, mental and psychosocial wellbeing. Findings include: Record review of the facility's Direct Care Reports reflected the number of CNAs scheduled for the 6:00 PM - 6:00 AM shift was: 4/3/24 - 4 CNAs 4/4/24 - 2 CNAs 4/8/24 - 1 CNA (6:00 PM - 10:00 PM) and 3 (6:00 PM - 6:00 AM) 4/9/24 - 1 CNA (6:00 PM - 10:00 PM) and 3 (6:00 PM - 6:00 AM) 4/14/24 - 4 CNAs 4/18/24 - 4 CNAs Further review of the Direct Care Reports reflected the census was: 4/3/24 - 108 residents 4/4/24 - 108 residents 4/8/24 - 110 residents 4/9/24 - 110 residents 4/14/24 - 108 residents (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/18/24 - 107 residents Record review of facility's staff time punches reflected on: 4/3/24 o 1 CNA 8:36 PM - 4:48 AM o 1 CNA 6:04 PM - 6:05 AM o 1 CNA 5:34 PM - 6:06 AM 4/4/24 o 1 CNA 6:23 PM - 5:49 AM o 1 CNA 5:46 PM - 5:57 AM o 1 CNA 6:04 PM - 6:05 AM o 1 CNA 6:00 PM - 10:00 PM o 1 CNA 5:27 PM - 6:19 AM 4/8/24 o 1 CNA 6:31 PM - 6:12 AM o 1 CNA 5:47 PM - 5:57 AM o 1 CNA 5:49 PM - 6:00 AM 4/9/24 o 1 CNA 1:02 PM - 9:51 PM o 1 CNA 6:24 PM - 6:01 AM o 1 CNA 5:51 PM - 5:55 AM o 1 CNA 6:46 PM - 10:11 PM o 1 CNA 5:54 PM - 6:01 AM 4/14/24 o 1 CNA 9:40 PM - 4:53 AM (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o 1 CNA 5:54 PM - 5:53 AM o 1 CNA 6:08 PM - 5:54 AM o 1 CNA 6:00 PM - 6:05 AM o 1 CNA 4:40 PM - 6:23 AM 4/18/24 o 1 CNA 6:22 PM - 5:54 AM o 1 CNA 10:11 PM - 6:03 AM o 1 CNA 6:18 PM - 10:06 PM o 1 CNA 6:01 PM - 6:01 AM Record review of Resident Grievances reflected: 2/22/24 - .Resident states his call light is not answered timely especially at night. 2/22/24 - .Pressed the call light and after 15 minutes of waiting family member went to hall for assistance . She is concerned that the facility is understaffed. 3/5/24 - Resident's daughter said her Mother voices that is taking a long time for her call light to be answered . Record review of Resident Council Grievances revealed: 2/27/24 - .Food cold .Meal trays are not being served timely - residents sit for a while before they get their food . 2/27/24 - .Call lights not answered timely . 3/26/24 - .Food cold .call lights not answered timely .trays not always delivered timely . Record review of Resident Advisory Council Minutes reflected: 2/26/24 - Food continues to be cold .Are the meal trays delivered timely? No sit for a while before we get our food .Are call lights being answered in a timely manner? Takes a while 30 minutes to hour .Are medications received timely? Not always . 3/25/24 - .Food continues to be cold .Are call lights answered in a timely manner? Takes a while 30 minutes to 1 hour. CNA states that they are doing two halls . During observation on 4/19/24 at 10:15 PM revealed there were three staff members outside in the parking lot smoking. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 4/19/24 at 10:23 PM revealed there was 1 CNA per wing and one nurse in. During observation on 4/19/24 at 10:36 PM revealed there was 1 LVN and 1 CNA for 37 residents in the. During an interview on 4/19/24 at 11:10 PM, CNA A said on 4/16/24 Resident #5's family member was upset because there were no staff on the wing and her mother needed to be changed. CNA A said the same family member was upset on 4/15/24 because the dinner trays were sitting in the C wing hallway for approximately 40 minutes. During observation and interview on 4/20/24 at 12:29 PM revealed Resident #4 lying in bed and the call light was on. Resident #4 said the light had been on for approximately 20 minutes because she needed to use the bathroom. Resident #4 said sometimes it took up to 1 and half hours for staff to respond at night, adding most of the time there was only one nurse and one CNA for 4 halls at night. Resident #4 said the food was always cold. During observation on 4/25/24 at 1:58 PM revealed the call light for room D2/3 was already on, further observation revealed there were two nurses and one MA sitting at the nurses' station and several staff walking around, which included two staff on D wing talking in the hallway. The call light on D wing was answered at 2:19 PM. During an interview on 4/20/24 at 5:52 PM the DON said the facility assessment was the closest thing the facility had to a staffing policy. During an interview on 4/21/24 at 6:23 PM, Resident #5's family member said the facility did not have enough help on the floor. She further stated meals were often late, sometimes over an hour the tray carts were left in the C wing hallway and the facility did not have enough staff to deliver trays or at times only had one staff that had to do it all. During interview on 4/22/24 at 11:28 AM, LVN D said some weekends were less staffed, so nurses were busier and were unable to complete their documentation. LVN D further stated when there were only two nurses on, they each took two wings and although they were able to complete all nursing tasks, it was hard to complete documentation. LVN D said there was not enough staff to feed residents before their food got cold. LVN D further stated for example she worked the 6 AM-6 PM shift and sometimes she was alone from 5 PM-6 PM and she had six residents to feed so sometimes some residents were not fed until 7-730 PM. LVN D said lunch was scheduled for 12 PM but sometimes the meals did not come out until after 1 PM. Observation and interview on 4/22/24 at 12:29 PM revealed Resident #4 was lying in bed, she said her call light was on because she needed to use the bathroom. Resident #4 further stated the call light had been on for approximately 20 minutes and there was only one CNA. Further observation revealed Resident #4's lunch tray was not delivered until 12:41 PM. Observation on 4/26/24 at 8:38 am revealed the breakfast trays on A wing were still on the cart in the hallway. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/34 at 2:07 PM, Resident #2 said sometimes the food was room temperature and the trays were not delivered on time. Resident #2 said he did not know if the facility had enough staff to get food delivered while it was still hot. Resident #2 said one time he pressed his call light at 2:30 AM and it was not answered until 6 AM but could not remember when this was. Resident #2 further stated the facility did not have enough staff in general, adding sometimes the night shift were busy and did not administer medications until 9 PM. During an interview on 4/23/24 at 2:32 PM, Resident #3 said the wound care nurse was not able to complete treatments when she was working on the floor. Resident #3 further stated the facility was very short staffed and only had 1 nurse and 1 CNA in the 100, 200, and 300 halls per 12-hour shift. Resident #3 said she did not think this was safe for residents if there was an emergency. Resident #3 said 1 CNA for 40 residents was a lot and if she needed assistance it took approximately 45 minutes sometimes for someone to respond. During an interview on 4/23/24 at 10:10 PM, LVN C said she worked 20 hours yesterday, 4/22/24, because there was no one else to cover. During interview on 4/24/24 at 9:20 AM, LVN C said she worked on the floor and was responsible for wound care. LVN C further stated she was responsible for approximately 35 residents, and 25 wound care treatments during her night shift. LVN C said she asked to stay late, come in early, or work overtime very often, probably about twice per week. LVN C said her schedule was supposed to be 8 am-5 pm Monday - Friday but had been working 6 pm-6 am for about a month because the facility needed more nurses at night. During an interview on 4/24/24 at 2:55 PM, CNA B said there was 1 LVN and 1 CNA in the and she was responsible for three hallways with approximately 37 residents. During an interview on 4/27/24 at 3:57 PM, the Administrator said the facility had a basic staffing pattern, adding the residents in the did not require as much assistance and residents on the side required more assistance, because they had a higher level of need. The Administrator further stated the residents on C and D wings seemed to require more assistance with care, so they tried to shift more assistance to that side. The Administrator said there was usually one nurse, 1 CNA and 1 MA on and 2-3 nurses, 2 CNAs on C and D wings, one on A wing, and one on E wing, which included weekends. The Administrator said the staffing numbers listed on the Direct Care Report were the minimum needed to provide care for the entire facility. The Administrator said the facility had an on-call nurse who helped cover shifts as need, she further stated at times staff were asked to stay over and asked others if they could come in early. The Administrator said nursing management covered as needed. The Administrator said she had concerns about staffing brought to her attention by staff, residents, and families. During interview on 4/27/24 at 6:13 AM, LVN F said she did not arrive to the facility until 6:30 PM on 4/23/24. LVN F further stated she tried to call in, but the facility did not have anyone to cover her shift. LVN F said the shift was pretty busy until approximately 10-11 PM, adding there were a lot of call lights going off, showers, and residents being put to bed. LVN F said that was why she administered medications late on 4/23/24. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/27/24 at 6:32 PM, the DON said residents had complained about call lights taking too long to be answered, food being served late and cold. The DON further stated she believed there was enough staff to serve food to resident before it got cold but sometimes the management team needed to assist. The DON said in there were 2 CNAs each wing, except D wing because it did not have as many residents, and three nurses during the day on side #1 and in side #2, there was one nurse, one CNA and there were 2 MAs, one on each side. The DON said at night staffing levels were the same for the CNAs with one nurse on each side. The DON said staffing needs were reassessed daily and they were always evaluating staffing and the acuity of each hall. The DON further stated staffing depended on the acuity of the residents and the goal was to always have 2 CNAs both shifts on A and E wings due to the high acuity of resident needs. The DON said the facility had an on-call nurse that reached out to management, nurses, and CNAs for help when there were call-ins/shortages. The DON further stated this did not happen often, but it did happen. The DON said she had concerns about staffing brought to her attention by staff, residents, and families. The DON said the facility did not have a policy regarding call lights, but her expectation was they were answered in a timely manner. The DON stated 22 minutes was probably too long to respond to a call light. Record review of the facility assessment revealed it did not address staffing needs. Record review of Appropriate Nurse Staffing Levels for U.S. Nursing Homes (06/29/2020), www.ncbi.nlm.nih.gov/pmc/srticles/PMC7328494 was assessed on 07/12/2023 indicated US nursing homes are required to have sufficient nursing staff with the appropriate competencies to assure resident safety and attain or maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident . nursing homes must take into account the resident acuity to assure they have adequate staff levels to meet the needs of residents

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 39251 Based on observation and interview the facility failed to post the current nurse staffing information for 1 of 1 facility reviewed for postings. The facility failed to ensure the nurse staffing information was posted upon entrance on 4/19/24 and 4/20/24. This deficient practice could place residents at risk by not providing adequate staffing information to ensure resident care needs were met. Findings included: Observation on 4/19/24 at 10:23 PM, revealed a posting which detailed nurse staffing information for 4/19/24 was not available at the entrance #1. Further observation revealed a posting detailing nurse staffing information for 4/19/24 was not available at the entrance #2. Observation on 4/20/24 at 2:51 PM, revealed a posting detailing nurse staffing information for 4/20/24 was not available at the entrance #1. Further observation revealed a posting detailing nurse staffing information for 4/20/24 was not available at the entrance #2. Observation and interview on 4/20/24 at 3:15 PM, revealed the staffing pattern was not posted. The DON stated the staffing pattern was not posted and the staffing pattern was supposed to be posted on the entrance #1 bulletin board. The DON further stated ADON B was responsible for posting the staffing patterns. During an interview on 4/25/24 at 4:43 PM, ADON B stated the nurse staffing pattern postings within the facility were her responsibility. ADON B further stated she was off and did not know who was responsible for the postings in her absence. During an interview on 4/20/24 at 5:52 PM, the DON said the facility did not have a staffing policy.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview and record review the facility failed to ensure the medication error rate was not five percent or greater. The facility had a medication error rate of 16% based on 5 errors out of 30 opportunities, which involved 2 of 4 residents (Resident #17 and Resident #18) reviewed for medication errors. 1. LVN F failed to administer medications as ordered to Resident #17 by administering Trazadone (a treatment for Depression) and Nortriptyline (a treatment for Depression)1 hour and 54 minutes after the scheduled time and not administering Melatonin (a treatment for Insomnia). 2. LVN F failed to administer a medication as ordered to Resident #18 by administering Donepezil (a treatment for Dementia) 3 hours after the scheduled time and Trazadone (a treatment for Bipolar Disorder) 2 hours after the scheduled time. These failures could place residents at risk of not receiving the desired therapeutic effect of their medications. Findings include: 1. Record review of Resident #17's Admission Record, dated 4/24/24, reflected the resident admitted to the facility on [DATE]. Resident #17 had diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning), Schizoaffective Disorder (a combination of symptoms of schizophrenia and mood disorder), Major Depressive Disorder (mental health disorder characterized by persistently depressed mood) and Insomnia (common sleep disorder). Record review of Resident #17's Order Summary Report, dated 4/24/24, reflected: Melatonin Oral Tablet 10 MG (Melatonin) Give 1 tablet . by mouth in the evening for Insomnia; Nortriptyline HCl capsule 25 MG Give 1 capsule by mouth at bedtime related to Major Depressive Disorder; Trazodone HCl Tablet 50 MG Give 1 tablet by mouth at bedtime related to Major Depressive Disorder. Record review of Resident #17's Medication Audit Report, dated 4/25/24, reflected: Melatonin was scheduled for 7:00 PM and was administered on 4/23/24 at 9:59 PM; Trazadone was scheduled for 8:00 PM and was administered on 4/23/24 at 9:54 PM; Nortriptyline was scheduled for 8:00 PM and was administered on 4/23/24 at 9:54 PM. Observation on 4/23/24 beginning at 9:53 PM revealed, LVN F compared blister packs to Resident #17's MAR (medications were already in a medication cup prior to medication pass) and checking them off on the MAR. The MAR reflected red for Melatonin, Trazadone, and Nortriptyline which indicated late medication administrations on the EMR. Further observation revealed Melatonin was not administered. LVN F stated the red in the MAR indicated the medication administration was late. LVN F said she only had Melatonin 5 mg tablets and order called for 1 10 mg tablet so she would have to administer 2, 5 mg tablets. LVN F said she was not going to administer the melatonin because there were only 5 mg tablets available. LVN F administered the medications to Resident #17 at 9:58 PM. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #18's Admission Record, dated 4/24/24, reflected the resident admitted to the facility on [DATE]. Resident #18 had diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning) , Schizoaffective Disorder (a combination of symptoms of schizophrenia and mood disorder), Major Depressive Disorder (mental health disorder characterized by persistently depressed mood), and Bipolar Disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Record review of Resident #18's Order Summary Report, dated 4/24/24, reflected: Donepezil HCl Tablet 5 MG Give 1 tablet by mouth at bedtime related to Unspecified Dementia and Trazodone HCl Tablet 50 MG Give 1 tablet by mouth at bedtime for insomnia related to Bipolar Disorder. Record review of Resident #18's Medication Audit Report, dated 4/25/24, reflected: Donepezil was scheduled for 7:00 PM and was administered on 4/23/24 at 10:00 PM and Trazadone was scheduled for 8:00 PM and was administered on 4/23/24 at 10:00 PM. Observation on 4/23/24 beginning at 9:59 PM revealed, LVN F compared blister packs to Resident #18's MAR and checked them off on the MAR. MAR reflected red for Donepezil and Trazadone which indicated late medication administrations on the EMR. LVN F administered the medications to Resident #18 at 10:03 PM. During interview on 4/25/24 at 12:50 PM, the DON said the medication administration times for AM and PM was a 4-hour block from 6:30 AM to 10:30 AM and 6:30 PM to 10:30 PM. The DON further stated if a resident was ordered one 10 mg tablet of a medications and the medication was available in 5 mg tablets, she would have expected a nurse to administer two 5 mg tablets of the medication. During interview on 4/27/24 at 6:13 AM, LVN F said medications were late because the MA took the medication cart, and she did not arrive to the facility until 6:30 PM on 4/23/24. LVN F said the shift was pretty busy until approximately 10-11 PM, and there were a lot of call lights going off, showers, and residents being put to bed. LVN F said that was why she administered medications late on 4/23/24. LVN F further stated the medications were not administered late and were just documented later. LVN F said she was an LVN and knew she could have given two 5 mg tablets of Melatonin to Resident #17, but the order said to give one tablet. LVN F further stated if she did not administer a medication, she normally did not check it off on the MAR and entered a progress note which reflected the reason the medication was not administered. During interview on 4/27/24 at 6:32 PM, the DON said medications were documented after administration because staff needed to ensure the residents received medications/treatments before they were documented. The DON further stated administration should not be documented before medications/treatments were completed because residents could refuse. The DON said medications should be administered within one hour of the scheduled time, one hour before or one hour after, unless it was liberalized time. Record review of the facility's policy titled, Medication Administration Procedures revised 10/25/17, reflected the following: .administer the medication and immediately chart doses administered on the medication administration record. It is recommended that medication be charted immediately after administration .20. The 10 rights of medication should always be adhered to . 5. Right time . 7. Right documentation

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39251 Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 3 of 3 medication carts (Medication cart #1, Medication cart #2, and Medication cart#3) reviewed for medication storage. 1. The facility failed to ensure the Medication cart by the nurses' station did not have a medication cup with pills sitting on top of the cart. 2. LVN F failed to ensure the Medication cart on 100 hall was not left unlocked with a resident standing next to it, while the LVN went into resident room to administer medications . 3. The facility failed to ensure the Medication cart on 300 hall was not left unlocked. 4. The facility failed to ensure the Medication cart was not left unlocked. These deficient practices could place residents at risk of medication misuse and drug diversion. Findings include: 1. Observation on 4/23/24 at 9:28 PM revealed LVN F was sitting at the nurses' station with her back to the medication cart #1. The medication cart was unlocked, unattended and had a medication cup with pills in it on top of the medication cart. There were no staff members or residents in the area. During an interview on 4/23/24 at 9:34 PM, LVN F stated she usually went to each resident room with the medication cart and then pulled each resident's medications. LVN F further stated she was not told she could not prepare medications in advance, and she had done this in the past but usually locked the medication cups in the cart. LVN F stated medication carts were not supposed to be left unlocked when unattended. LVN F further stated medications should not have been left unattended on top of the cart because a resident could have taken medications. 2. During observation and interview on 4/23/24 at 10:05 PM, LVN F left the medication cart #1 unlocked with a resident standing next to the cart while she entered the resident's room to administer medications to another resident. LVN F stated the medication cart was left unlocked and medication carts were not to be left unlocked when unattended. LVN F further stated the resident standing in the hallway could have accessed the medication in the cart. 3. During observation and interview on 4/23/24 at 9:30 PM, the medication cart #2 on the 300 hall was unlocked and there were no staff in the hallway. MA A stated the medication cart should not have been unlocked. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During observation and interview on 4/24/24 at 7:04 AM, a medication cart #3 was unlocked and unattended. There were no staff at the nurses' station or in the hallway and a resident was sitting in his wheelchair next to the medication cart. MA B stated her medication cart #3 should not have been unlocked. During an interview on 4/27/24 at 6:32 PM, the DON stated medication carts should never be unlocked and medications should not be left on top of medication carts unattended. The DON further stated these expectations were relayed to the nursing staff several times. Record review of the facility's policy titled, Medication Administration Procedures revised 10/25/17, reflected the following: 3. Open the unit dose package only when you are administering medication directly to the resident. Removing the medication from its unit dose packaging in advance lessens the ability to positively identify the medication and increases the chance of drug administration errors and contamination. During the medication administration process, the unlocked side of the cart must always be in full view of the nurse .8. the medication cart must be completely locked, or otherwise secured

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview, and record review the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that meets met his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident for 3 of 10 residents (Resident #7, Resident #11,, and Resident #15) reviewed for dietary services.needs, in that: 1. The facility failed to ensure Resident #7 did not received a health shake, or a red glass as prescribed on 4/22/24. 2. The facility failed to ensure Resident #11 did not received the appropriate portion size of pureed spaghetti and meatballs and a red glass on 4/20/24. 3. The facility failed to ensure Resident #15 did not received a house shake on 4/25/24 or red glass on 4/25/24 and 4/26/24 . This These deficient practices could place residents at risk for poor food intake, weight loss, and not having their nutritional needs met. Findings includedd: 1. Record review of Resident #7's Admission Record, dated 4/25/24, revealed reflected the resident was admitted to the facility on [DATE]. Resident #7 had with diagnoses that which included: Dementia (group of thinking and social symptoms that interferes with daily functioning), Iron Deficiency Anemia (occurs when the body does not have enough iron), Anxiety, Major Depressive Disorder (mental health disorder characterized by persistently depressed mood), Muscle Wasting, and Weight Loss . Record review of Resident #7's quarterly MDS assessment, dated 3/25/24, revealed reflected the resident had a BIMS score of 10, suggesting which indicated moderate cognitive impairment. Record review of Resident #7's Progress Notes revealedreflected: Effective Date: 03/30/2024 08:02 [8:02 am] . Note Text .On a Mech Soft Diet, Red Glass Program . Provided a Health Shake with meals d/t weight loss .Review of chart indicates p. o. intake is fair to good - expect weight to stabilize with addition of a House Shake with all meals. Continue with same plan fo [sic] care . Author .Dietitian Record review of Resident #7's Order Summary, dated 4/20/24, revealedreflected: Regular diet Mechanical Soft texture, Regular consistency, Red Glass Program, start date 7/6/23 and Health Shake with meals, start date 3/15/24. Record review of Resident #7's meal ticket, dated 4/22/24, revealed reflected diet was Regular/Mechanical Soft .Health Shake . (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 4/22/24 at 12:42 PM, Resident #7 was sitting on the side of the bed eating lunch. Further observation revealed there was no Health Shake or red glass. Resident #7 confirmed stated he did not receive a Health Shake or red glass. 2. Record review of Resident #11's Admission Record, dated 4/22/24, revealed reflected the resident was a readmitted to the facility on [DATE]. Resident #11 had with diagnoses that which included: Type 2 diabetes - condition in which the body has trouble controlling blood sugar and using it for energy. Dysphagia (difficulty swallowing), Malnutrition, Anxiety, Muscle Wasting, and Cognitive Communication Deficit. Record review of Resident #11's quarterly MDS assessment, dated 2/26/24, revealed reflected the resident had a BIMS score of 7, suggesting which indicated severe cognitive impairment. Record review of Resident #11's Progress Notes revealedreflected: Effective Date: 02/26/2024 18:35 [6:35 pm] . Start Date: 2/26/2024 per .FNP resident to continue on Puree texture, resident does not tolerate mech soft Record review of Resident #11's Order Summary, dated 4/22/24, revealedreflected: Regular diet Pureed texture, Nectar consistency, for Dysphagia, start date 2/26/24. Record review of Resident #11's meal ticket, dated 4/20/24, revealed reflected diet was Regular/Puree . Entree 1 # 6 Sc P Spaghetti with Meatballs .Red Glass . During observation and interview on 4/20/24 at 5:06 PM revealed, Resident #11 was sitting in the annex dining room. Resident #11 was asked by investigator the State Surveyor if this portion was enough for him, but he did not respond. During interview on 4/20/24 at 5:19 PM, the DON said it was hard for her to say if Resident #11's entree portion seemed enough for him . Observation and interview on 4/20/22 at 5:23 PM revealed the puree entree was served with a blue scoop and the regular entree was served with a black scoop . [NAME] A said the regular entree was served with a 6 oz scoop and the puree entree was served with a 3 oz . During interview on 4/27/24 at 5:31 PM, [NAME] A said he used a blue scoop, 3 oz, to serve the spaghetti with meatballs entree on 4/20/24. [NAME] A further stated that was the scoop used for purees all of the time. [NAME] A said he was unable to say if the blue 3 oz scoop was a #6. He further stated he used a black scoop to serve the puree. Record review of the facility's Recipes to Scale, dated 4/21/24, revealedreflected: Saturday, April 20, 2024 - Supper .Spaghetti with Meatballs .Serve: #6 scoop Record review of the facility's, undated, Disher Scoop Sizes, Colors and Yields, undated, revealedreflected the #6 scoop was white and yielded 2/3 cup, the blue scoop was a #16 and yielded 1/4 cup. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #15's Admission Record, dated 4/23/24, revealed reflected the resident was readmitted to the facility on [DATE]. Resident #15 had with diagnoses that which included: Alzheimer's Disease (disease affecting memory and other important mental functions), Dementia (group of thinking and social symptoms that interferes with daily functioning) , Type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), cognitive communication deficit, Pressure ulcer of sacral region Stage 4, Anxiety. Record review of Resident #15's quarterly MDS assessment, dated 3/15/24, revealed reflected a BIMS score of 5, suggesting which indicated severe cognitive impairment. Record review of Resident #15's Progress Notes revealedreflected: Effective Date: 04/18/2024 . Note Text . On a Mech Soft Diet, Super Cereal with breakfast, House Shake with supper. HS snack Record review of Resident #15's meal ticket, dated 4/25/24 , revealed reflected diet was Regular/Mechanical Soft .Health Shake Record review of Resident #15's Order Summary Report, dated 4/26/24, revealedreflected: Regular diet Mechanical Soft texture, Regular consistency, start date 8/14/23 and House Shake in the evening .W /Supper. During observation and interview on 4/25/24 at 5:24 PM revealed, Resident #15 was lying in bed with a dinner tray at the bedside. Further observation revealed there was no Health Shake on the tray. CNA, I confirmed stated Resident #15 had not received a house shake with her dinner. During an interview on 4/27/24 at 2:49 pm, the DFN said did not remember what size scoop was used to serve the spaghetti with meatballs puree. The DFN further stated a #6 scoop was 5 oz and he was not sure why a 3 oz scoop was used to serve the puree. The DFN said the spaghetti with meatballs recipe was reviewed with [NAME] A. Attempted interview with the RD Call attempted by phone on 4/25/24 at 11:46 pm to RDwas unsuccessful. Record review of the facility's policy, titled Preparation of Foods, dated 2012, revealedreflected: .2. All food . will be attractively served at the proper temperature and in a form to meet the individual needs of the resident .5. Food will be cut, chopped, ground or pureed to meet individual needs of the resident Record review of the facility's policy, titled Red Glass and Fortified Food Program, dated 2012, revealed: . The red glass program uses the presence of a red glass on the resident's meal tray to alert facility staff to which residents may have had a weight loss and/or need additional monitoring and encouragement to complete meals and fluids. Dietary will provide the red glass .

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview, and record review the facility failed to ensure meals were prepared in a form designed to meet individual needs for 1 of 10 residents (Resident #6) reviewed for dietary services. The facility failed to ensure Resident #6 was served mechanical ground meat as prescribed. These deficient practices could place residents at risk for poor food intake, weight loss and not having their nutritional needs met. Findings included: Record review of Resident #6's Admission Record, dated 4/20/24, reflected the resident was admitted to the facility on [DATE]. Resident #6 had diagnoses which included: Hypokalemia (low potassium levels in the bloodstream), Malnutrition, Weakness, Muscle Wasting and Atrophy (decrease in size or wasting away of a body part or tissue), Dysphagia (difficulty swallowing), Cognitive Communication Deficit, Altered Mental Status, Tachycardia (elevated heart rate over 100 beats per minute), Hypertension (high blood pressure) and Anxiety. Record review of Resident #6's comprehensive MDS assessment, dated 1/31/24, reflected the resident had a BIMS score of 99, which indicated the resident was unable to complete the interview. Resident #6 required partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with eating, had complaints of difficulty or pain with swallowing, had obvious or likely cavity or broken natural teeth, and did not have a mechanically altered or therapeutic diet. Record review of Resident #6's Progress Notes reflected: Effective Date: 03/26/2024 14:10 [2:10 pm] . Note Text .RP called and made aware of diet changes d/t resident voicing having trouble chewing meats. Author: [LVN B] Record review of Resident #6's Order Summary, dated 4/25/24, reflected: Regular diet Regular with Mechanical Ground Meat texture, Regular consistency, start date 3/26/24. Record review of Resident #6's meal ticket, dated 4/22/24, reflected diet was Regular/Regular. During observation and interview on 4/22/24 at 12:20 PM revealed Resident #6 was sitting in the dining room, she was served a whole piece of chicken fried steak that had not been cut up or ground. Resident #6 said the meat was hard and was not cut up. Resident #6 further stated she had no teeth and it was hard for her to eat meat. Attempted interview with the RD attempted by phone on 4/25/24 at 11:46 pm was unsuccessful. (continued on next page)

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	675638	A. Building B. Wing	04/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Pines Nursing and Rehabilitation	3301 E. Mockingbird Lane Victoria, TX 77904

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/27/24 at 1:58 pm, LVN B said she remembered receiving the order for Resident #6's diet change. LVN B further stated she completed a dietary slip and submitted it to the dietary department to inform them of the change. During an interview on 4/27/24 at 2:49 pm, the DFN said mechanical ground was ground with sauce. The DFN said he was not aware Resident #6 was ordered a mechanical ground meat diet. During interview on 4/27/24 at 5:31 PM, [NAME] A said mechanical ground is a shredded meal, it should be ground or cut up, he added he choose to cut it up because it looked more appetizing. [NAME] A said he was not aware Resident #6 was ordered a mechanical ground meat diet. Record review of the facility's policy, titled Preparation of Foods, dated 2012, reflected: .2. All food . will be attractively served at the proper temperature and in a form to meet the individual needs of the resident .5. Food will be cut, chopped, ground or pureed to meet individual needs of the resident

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview and record review the facility failed to ensure each resident received and the facility provided food that accommodated resident allergies, intolerances, and preferences for 1 of 15 residents (Resident #16) reviewed for dietary services. The facility failed to ensure Resident #16's was not served he was allergic to and was served onions with the meal. This deficient practice could place residents at-risk by contributing to poor intake, weight loss and/or allergic reaction. Findings include: Record review of Resident #16's Admission Record, dated 4/24/24, reflected the resident was readmitted to the facility on 8/21/20. Resident #16 had diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning), Type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), Muscle Wasting and Hypertension (high blood pressure). Record review of Resident #16's quarterly MDS assessment, dated 2/15/24, reflected the resident had a BIMS score of 12, which indicated moderately impaired cognition. Record review of Resident #16's Order Summary, dated 4/24/24, reflected the resident had an allergy to onions. Record review of Resident #16's Care Plan, revised 12/1/21, reflected: Resident is allergic to .onion . Resident will not receive known allergens .Do NOT administer food/medications/materials known to be allergens Observation of Resident #16's dinner plate on 4/24/24 at 5:30 PM revealed the residents plate contained chicken salad on a lettuce leaf, a deviled egg, vegetables and peaches. During an interview on 4/25/24 at 1:55 PM, Resident #16 said she was served chicken salad for dinner but could not eat it because she saw onions in it. Resident #16 further stated she asked for an alternate meal but was not brought anything else, so she ate [NAME] and crackers. Resident #16 said when she ingested onions she broke out in hives. During an interview on 4/27/24 at 5:31 PM, [NAME] A said he believed he did use onions in the chicken salad. [NAME] A further stated he was not told there was a resident with an onion allergy and was not aware Resident #16 had an allergy to onions. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Recipes to Scale, dated 4/25/24, reflected: .Chicken salad on Lettuce Leaf . Onion Yellow Jumbo Record review of the facility's policy, titled Preparation of Foods, dated 2012, reflected: .2. All food . will be attractively served .in a form to meet the individual needs of the resident

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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** 39251 Based on observation, interview, and record review, the facility failed to ensure resident medical records are kept in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete and accurately documented for 2 of 2 residents (Residents #5 and #15) reviewed for accuracy of records, in that: 1. The facility failed to ensure Resident #5's wound care and treatments as ordered by the physician were documented. 2. The facility failed to ensure Resident #15's wound care and treatments as ordered by the physician were documented. These deficient practices could place residents at risk for improper care due to inaccurate records. The findings were: 1. Record review of Resident #5's Admission Record, dated 4/20/24, reflected the resident was admitted to the facility on [DATE] with diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning), Hemiplegia (paralysis of one side of the body) of right side, Parkinsonism (a motor syndrome that manifests as rigidity and/or tremors), Cognitive Communication Deficit, and Depression. Record review of Resident #5's quarterly MDS assessment, dated 2/26/24, reflected the resident had a BIMS score of 00, which indicated severe cognitive impairment. Further review revelaed the resident had an unhealed Stage 4 pressure ulcer present upon admission/entry or re-entry. Record review of Resident #5's Order Summary Report, dated 4/26/24, reflected an order for wound care as follows: Cleanse stage IV sacral wound with vashe. Apply collagen and calcium alginate with silver to wound bed. Paint peri-wound with skin prep. Secure with silicone dressing QD and PRN every day shift for wound care. Record review of Resident #5's April WAR reflected the resident did not receive wound care on the following days: 4/5/24, 4/6/24, 4/15/24, 4/17/24 and 4/21/24. 2. Record review of Resident #15's Admission Record, dated 4/23/24, reflected the resident was readmitted to the facility on [DATE]. Resident #15 had diagnoses which included: Alzheimer's Disease (disease affecting memory and other important mental functions), Dementia (group of thinking and social symptoms that interferes with daily functioning), Type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), cognitive communication deficit, Pressure ulcer of sacral region Stage 4, and Anxiety. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #15's quarterly MDS assessment, dated 3/15/24, reflected a BIMS score of 5, which indicated severe cognitive impairment Resident #15 had an unhealed Stage 4 pressure ulcer present upon admission/entry or re-entry. Record review of Resident #15's Care Plan, reviewed 3/29/24, reflected: The resident has a pressure ulcer . 1. Stage IV left gluteal wound- present on admission .Interventions .Administer treatments as ordered Record review of Resident #15's Order Summary Report, dated 4/26/24, reflected an order for wound care as follows: Cleanse stage IV left gluteal wound with hibiclens, rinse with normal saline Pat dry with 4X4 gauze. Apply COLLAGEN/SILVER THEN hydrofera blue to wound bed. Skin prep peri-wound and Cover with silicone dressing QOD and PRN. one time a day every Tue, Thu, Sat for Wound healing. Record review of Resident #15's March WAR reflected the resident did not receive wound care on the following days: 3/21/24 and 3/25/24. Record review of Resident #15's April WAR reflected the resident did not receive wound care on 4/6/24. Record review of Resident #15's Progress Note, dated 2/28/24, and authored by the NP, reflected: Multivitamin q day, Vitamin C 500 mg BID x30 days, Zinc 50 mg x14 days for wound healing. Observation on 4/26/24 at 9:59 AM revealed Resident #15 was in bed. Resident #15 had Stage IV pressure injury to the left upper gluteal area. During an interview on 4/26/24 at 3:15 PM, the DON said the ADONs audited the records daily and she tried to audit weekly. She added the facility held a stand-up meeting where the ADONs brought their audit sheets and were asked if they had any missed medications/treatments, and they answered no. The DON said she was not aware of Resident #15's missed treatments in March and April. During an interview on 4/24/24 at 9:20 AM, LVN C said she audited the Wound Care Administration Records when she was in the office but not when she was working on the floor. She added she thought the last time she audited them was last Friday, 4/19/24. LVN C said she was not aware of the missed treatments in April for Resident #5 and March and April for Resident #15 and did not remember if she worked on 3/21/24, 3/25/24, 4/5/24, 4/6/24, 4/15/24, 4/17/24 and 4/21/24. She added she was responsible for ensuring wound care was completed as ordered and the floor nurses were responsible for providing wound care in her absence. LVN C stated blanks in the WAR meant the treatment were either not completed or were not signed off after completion. During an interview on 4/27/24 at 6:32 PM, the DON stated herself and LVN C were responsible for ensuring wound care was completed. She further stated LVN C ran a missed treatment report daily and a 72-hour report on Mondays, she added this report was reviewed in the morning meetings. The DON said she was not aware of missed treatments for Resident #5 and Resident #15. The DON stated when LVN C was asked if there were any missed treatments during the morning meeting, LVN C answered no every time. The DON said blanks in the WAR meant the treatments were either not completed or not documented after completion. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's, undated, document titled Dressing Change Checklist reflected: Dressing Removal: Washes hands prior to applying gloves, when changing gloves and upon removal of gloves throughout dressing procedure . cleanses wound per orders and facility policy (working from center of wound to outside of wound) Record review of the facility's policy, titled Fundamentals of Infection Control Precautions, dated 2018, reflected: .Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene . Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice) . Before and after changing a dressing . Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections .Recommended techniques for washing hands with soap and water include .rubbing hands together vigorously for at least 20 seconds covering all surfaces of the hands and fingers .Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use, and hands can become contaminated during removal of gloves

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 2 residents (Residents #5 and #15) reviewed for infection control, in that: 1. LVN C failed to maintain infection control practices when performing wound care for Resident #5. 2. LVN C and RN B failed to maintain infection control practices when performing wound care for Resident #15. These deficient practices could place residents at risk for delayed wound healing and infection. The findings were: 1. Record review of Resident #5's Admission Record, dated 4/20/24, reflected the resident was admitted to the facility on [DATE] with diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning), Hemiplegia (paralysis of one side of the body) of right side, Parkinsonism (a motor syndrome that manifests as rigidity and/or tremors), Cognitive Communication Deficit, and Depression. Record review of Resident #5's quarterly MDS assessment, dated 2/26/24, reflected the resident had a BIMS score of 00, which indicated severe cognitive impairment. Further review revealed the resident had an unhealed Stage 4 pressure ulcer present upon admission/entry or re-entry. Record review of Resident #5's Order Summary Report, dated 4/26/24, reflected an order for wound care as follows: Cleanse stage IV sacral wound with vashe. Apply collagen and calcium alginate with silver to wound bed. Paint peri-wound with skin prep. Secure with silicone dressing QD and PRN every day shift for wound care. Observation of wound care for Resident #5 on 4/24/24 at 7:12 AM revealed LVN C started to gather treatment supplies, then left the treatment cart to retrieve the laptop computer, upon returning to the treatment cart LVN C did not wash or sanitize hands prior to preparing tray and supplies. Further observation revealed LVN C donned gloves after gathering all treatment supplies without washing or sanitizing her hands and proceeded to don gown. 2. Record review of Resident #15's Admission Record, dated 4/23/24, reflected the resident was readmitted to the facility on [DATE]. Resident #15 had diagnoses which included: Alzheimer's Disease (disease affecting memory and other important mental functions), Dementia (group of thinking and social symptoms that interferes with daily functioning), Type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), cognitive communication deficit, Pressure ulcer of sacral region Stage 4, and Anxiety. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #15's quarterly MDS assessment, dated 3/15/24, reflected a BIMS score of 5, which indicated severe cognitive impairment Resident #15 had an unhealed Stage 4 pressure ulcer present upon admission/entry or re-entry. Record review of Resident #15's Care Plan, reviewed 3/29/24, reflected: The resident has a pressure ulcer . 1. Stage IV left gluteal wound- present on admission .Interventions .Administer treatments as ordered Record review of Resident #15's Order Summary Report, dated 4/26/24, reflected an order for wound care as follows: Cleanse stage IV left gluteal wound with hibiclens, rinse with normal saline Pat dry with 4X4 gauze. Apply COLLAGEN/SILVER THEN hydrofera blue to wound bed. Skin prep peri-wound and Cover with silicone dressing QOD and PRN. one time a day every Tue, Thu, Sat for Wound healing. Record review of Resident #15's Progress Note, dated 2/28/24, and authored by the NP, reflected: Multivitamin q day, Vitamin C 500 mg BID x30 days, Zinc 50 mg x14 days for wound healing. Observation on 4/26/24 at 9:59 AM revealed Resident #15 was in bed. Resident #15 had Stage IV pressure injury to the left upper gluteal area. Observation of wound care to the left gluteal area for Resident #15, on 4/27/24 at 9:38 AM, revealed RN B approached Resident #15 and explained the procedure. Further observation revealed RN B entered the bathroom and washed her hands for 5 seconds and donned gloves. RN B proceeded to clean Resident #15's peri-wound area and then the inside of the wound. RN B removed gloves after applying silicone dressing and donned new gloves without washing or sanitizing her hands. During an interview on 4/27/24 at 10:14 AM, RN B stated she knew it was recommended to wash hands for a total of 20-30 seconds to prevent infections and she washed her hands for approximately 10 seconds. RN B further stated she had received wound care and infection control training approximately 2 years ago when she started working at the facility. During an interview on 4/27/24 at 6:32 PM, the DON stated she expected nurses provide wound care according to physician orders and maintain infection control to promote wound healing. Record review of the facility's, undated, document titled Dressing Change Checklist reflected: Dressing Removal: Washes hands prior to applying gloves, when changing gloves and upon removal of gloves throughout dressing procedure . cleanses wound per orders and facility policy (working from center of wound to outside of wound) Record review of the facility's policy titled, Fundamentals of Infection Control Precautions, dated 2018, reflected: .Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene . Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice) . Before and after changing a dressing . Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections .Recommended techniques for washing hands with soap and water include .rubbing hands together vigorously for at least 20 seconds covering all surfaces of the hands and fingers .Wearing gloves does not replace the need for hand washing because gloves may have small inapparent defects or be torn during use, and hands can become contaminated during removal of gloves