STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675651	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Marcos Rehabilitation and Healthcare Center	1600 N I H 35 San Marcos, TX 78666

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689 Based on observations, interviews, and record review, the facility failed to respect the residents' right to personal privacy of medical records for 3 of 8 Residents (Residents #95, #34, and #50) reviewed for privacy. The facility failed to ensure MA H protected confidential resident health care information of Residents #95, #34, and #50. This failure could place residents at risk of personal information being exposed to unauthorized persons. Findings included: Record review of the undated Face Sheet for Resident #95 reflected he was an [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of Essential (primary) Hypertension (high blood pressure). Record review of Physicians Orders for Resident #95 dated 07/01/2024 reflected Order Summary: Coreg Oral Tablet 12.5 mg Give one tablet by mouth two times a day for heart failure. Hold for SBP less than 110, HR less than 60. Record review of the undated Face Sheet for Resident #34 reflected he was an [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of Essential (primary) Hypertension (high blood pressure). Record review of Physicians Orders for Resident #34 dated 04/30/2024 reflected Order Summary: Carvedilol Oral tablet 25 mg, give one tablet by mouth two times a day for HTN, hold if SBP is below 110. Record review of the undated Face Sheet for Resident #50 reflected she was a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of Essential (primary) Hypertension (high blood pressure). Record review of Physicians Orders for Resident #50 dated 04/12/2024 reflected Order Summary: Cozaar tablet 50 mg. Give one tablet by mouth two times a day for HTN, Hold if SBP less than 110. (continued on next page)

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

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/14/2024 from 7:52 AM until 8:20 AM revealed MA H left a notepad with Resident's #95, #34, and #50 names and vital signs (blood pressure and pulse) open on top of her medication cart which was facing the hallway . In an interview on 08/14/2024 at 8:37 AM MA H stated she had been a medication aide for a total of seven years and had been at the facility for one year and six months. She stated she should have protected confidential resident information by turning over or covering the vital sign sheet . In an interview on 08/15/2024 at 11:15 AM ADON A stated confidential medical information should be kept in a drawer or covered up. She stated it was a breach of resident confidentiality and could expose their personal medical information. In an interview on 08/15/2024 at 12:44 PM ADON B stated they always told staff to cover their notepads with patient information on them because it was a breach of confidentiality to leave it where people can see it . In an interview on 08/15/2024 at 1:56 PM the RNC stated the facility expected staff to have confidential resident information covered. She further stated it was a violation of HIPAA privacy for medical information . In an interview on 08/15/2024 at 4:24 PM the ADM stated staff were specifically trained to protect the PHI of residents . Record review of a facility Access and Confidentiality Agreement dated June 2023 reflected Confidential patient care information includes individually identifiable information in the possession of a health care provider regarding a patient's medical history, mental or physical condition or treatment, Examples include, but are not limited to: Medical and psychiatric records including paper . This information is sensitive, valuable and is protected by law and our privacy and security policies.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review, the facility failed to ensure residents had a safe, clean, comfortable, and homelike environment for 2 of 14 residents (Residents #75 and 450) reviewed for environment. The facility failed to ensure the room for Residents #75 and #450 did not possess a strong, foul odor due to Resident #75's behavior of urinating in places other than his toilet. This failure placed residents at risk of infection and diminished quality of life. Findings included: Review of the undated face sheet for Resident #75 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included metabolic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition), difficulty in walking, cognitive communication deficit, lack of coordination, muscle weakness, history of falling, speech and language deficits following unspecified cerebrovascular disease (any condition that affects the blood vessels of the brain), depression, edema, dementia, insomnia, and hemiplegia and hemiparesis (paralysis on one side of the body) following cerebral infarction. Review of the admission MDS assessment for Resident #75 dated 01/25/24 reflected a BIMS score of 15, reflecting intact cognition. It reflected he answered the assessment for activity preferences himself, finding it very important to have books, newspapers, and magazines to read, keep up with the news, and go outside to get fresh air when the weather was good. It reflected that he required set-up or clean-up assistance with toileting hygiene. Review of the care plan for Resident #75 dated 04/04/24 reflected the following: Potential for a behavior problem: the resident resists using a urinal. Attempts to ambulate to use the toilet. When he is unable to ambulate quickly enough, he will proceed to use the restroom in inappropriate places, such as outdoors or on the floor of his room. Will have fewer episodes of behaviors by review date. Administer medications as ordered. Monitor/document for side effects and effectiveness. o Anticipate and meet needs. o Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. o Praise any indication of progress/improvement in behavior. o Referral to an appropriate psychiatric provider as needed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated face sheet for Resident #450 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included rheumatoid arthritis, weakness, muscle, wasting and atrophy, chronic, obstructive, pulmonary disease, limitation of activities due to disability, blindness of right eye, protein, calorie, malnutrition, gout, adult failure to thrive, diarrhea, cognitive, communication deficit, chronic pain, depression, and abdominal pain. Review of the annual MDS assessment for Resident #450 dated 07/28/24 reflected a BIMS score of 14, reflecting intact cognition. It reflected none of the offered activities in the assessment for activity preferences were important to him. Review of the care plan for Resident #450 dated 07/25/24 reflected the following: Potential for a psychosocial well-being problem r/t ineffective coping. Will demonstrate adjustment to nursing home placement by/through review date. Needs assistance/supervision/support to identify precipitating factors/stressors. Observation on 08/13/24 at 08:06 AM revealed Resident #75 sitting in his room and in his wheelchair and Resident #450 lying in his bed. A bedside men's urinal half-full of yellow liquid sat on Resident #75's bedside table. The room possessed a strong, foul urine odor. Observations on 08/13/24 at 01:06 PM, 08/14/24 at 09:41 AM, and 08/14/24 at 02:12 PM revealed Resident #75 and #450's room had a strong, foul urine odor. During an interview and observation on 08/15/24 at 09:03 AM, Resident #450 stated he preferred to stay in bed because he did not feel very well, but he had noticed the foul odor, and it was awful. When asked if he knew the source of the odor, he pointed across the room. He stated, just look over there; it's filthy. He stated it smelled like urine, and he hated it. The room had a very strong, foul odor. There was a urinal on Resident #75's bedside table that was two-third full of yellow liquid. There was no sign of wetness on the floor or on Resident #75's bed. During an interview on 08/15/24 at 09:12 AM, MA H stated she had often noticed the foul smell in Resident #75's and #450's room, and the odor was that of urine. She stated Resident #75 sometimes urinated on the floor of the room. She stated she was not aware of any interventions to prevent Resident #75 from urinating on the floor or to handle the foul odor. MA H stated the housekeeping staff came along and cleaned, but the odor did not leave the room entirely and came back full strength soon after the room was cleaned. She stated she was not aware of anything the medication aides, CNAs, or nurses were supposed to do to make the situation better. MA H stated resident #75 was independent so there was not very much they could do to control his behavior . During an interview on 08/15/24 at 09:18 AM, CNA J stated Resident #75 urinated on the floor and other places and refused to wear briefs. She stated the housekeeper would enter the room to clean and the next thing you knew, there was urine on the floor again. CNA J stated she was not aware of any particular intervention except to try to catch him before he urinated, but every time they tried, it was too late. CNA J stated Resident #450 had not complained to her, but she thought he probably hated the smell . (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/15/24 at 01:04 PM, RN E stated she was aware that Resident #75's and #450's room smelled terribly of urine. She stated Resident #75 was very challenging, and they could not get him to stop urinating or spilling his urine or something. She stated he must be spilling his urinal or urinating in the bed for it to smell so badly, and he often had his bedside urinal under the covers or placed between his legs. RN E stated there had not been any specific guidance from management about how to handle the odor or Resident #75's behavior of urinating in places other than the toilet. RN E stated they opened the window sometimes to let the smell out but then people forgot to shut it, and it became hot. RN E stated she had read the care plans and learned about the residents from them, but she had not participated in care planning strategies for Resident #75. RN E stated the negative impact of the room smelling so badly was the residents would not want to be in the facility and family members were turned off from visiting. During an interview on 08/15/24 at 03:53 PM, the ADM stated Resident #75 urinated where he wanted to urinate. He stated they had tried to encourage him to use the commode or to use the urinal and he did not always cooperate. The ADM stated he urinated in lots of places in the room, and they found where he went by having housekeeping clean morning and afternoon. The ADM stated ADON A might know more about interventions to prevent Resident #75 from urinating in inappropriate places. The ADM stated the foul-smelling room could have a negative impact on residents but did not elaborate how. He stated they had offered to move Resident #450 out of that room, but he had chosen not to due to not wanting to move into one of the only open beds in the facility, all of which were in 3- or 4-person bedrooms. During an interview on 08/15/24 at 04:25 PM, ADON A stated Resident #75 had a habit of keeping his urinal full and urinating anywhere. She stated he refused to wear briefs and refused to allow them to empty his urinal sometimes. ADON A stated he was trying very hard to maintain his independence and would not admit that he needed help toileting. ADON A stated their interventions were not to monitor in documentation but to physically direct and visually monitor him. She stated she did not think there were any interventions that had been devised that were not in the care plan . Review of facility policy dated 05/22 and titled Homelike Environment reflected the following: It is the policy of this facility to provide a homelike environment, and to encourage and provide opportunities for each resident to occupy an area, reflecting his/her interests .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 5 of 8 residents (Residents #10, 71, 75, 449, and 450) reviewed for care plans. The facility failed to ensure the care plans for Residents #10, 71, 75, 449, and 450 included person-centered goals and interventions for activities. This failure placed residents at risk of not having their recreational and social needs met. Findings included: Review of the undated face sheet for Resident #10 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, dementia, difficulty in walking, muscle weakness, abnormal weight loss, abnormalities of gait and mobility, reduced mobility, abnormal posture, repeated falls, cognitive communication deficit, need for assistance with personal care, and major depressive disorder. Review of the annual MDS assessment for Resident #10 dated 11/04/24 reflected a BIMS score of 00, reflecting severe cognitive impairment. It reflected the staff assessed her for activity preferences and she enjoyed: listening to music, being around animals such as pets, doing things with groups of people, and spending time outdoors. Review of the care plan for Resident #10 dated 12/14/23 reflected the following: Has little or no activity involvement r/t Anxiety, Depression, behaviors (screaming/disruptive) resident will self-isolate and refuse activities offered. Will express satisfaction with type of activities and level of activity involvement when asked through the review date. Establish and record prior level of activity involvement and interests by talking with resident, caregivers, and family on admission and as necessary. o Explain the importance of social interaction and leisure activity time. Encourage participation by next review. o Explain that may leave activities at any time and is not required to stay for entire activity. o Invite to scheduled activities. o Invite/encourage family members to attend activities with resident in order to support participation. o Modify daily schedule and/or treatment plan to accommodate activity participation. o Monitor/document for impact of medical problems on activity level. There was no care planning for the particular activities that Resident #10 enjoyed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/13/24 at 09:20 AM revealed Resident #10 sitting in a wheelchair in the common area in front of a large television. She was not watching television and did not respond to efforts to communicate with her. Review of the undated face sheet for Resident #71 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included pneumonia, chronic pain, muscle weakness, unsteadiness on feet, diverticulitis (inflammation of abnormal pouches in the bowel), difficulty in walking , muscle wasting and atrophy, protein -calorie malnutrition, depression, insomnia, repeated falls, suicidal ideation, dementia, weakness, and cognitive communication deficit. Review of the annual MDS assessment for Resident #71 dated 08/06/24 reflected a BIMS score of 12, reflecting moderately impaired cognition. It reflected he answered the assessment for activity preferences himself, finding it very important to be around animals such as pets, somewhat important to keep up with the news, and go outside for fresh air when the weather was good. Review of the care plan for Resident #71 dated 10/31/23 reflected the following: Has little or no activity involvement r/t Depression, Disinterest will observe activities but will be reluctant to join, will join if friends do. Will express satisfaction with type of activities and level of activity involvement when asked through the review date. Establish and record prior level of activity involvement and interests by talking with resident, caregivers, and family on admission and as necessary. o Explain the importance of social interaction and leisure activity time. Encourage participation by next review. o Explain that may leave activities at any time and is not required to stay for entire activity. o Invite to scheduled activities. o Preferred activities are watching tv and socializing with other residents independently. o Provide activities calendar monthly. There was no care planning for the particular activities that Resident #71 enjoyed. Observation and interview of Resident #71 on 08/13/24 at 09:45 AM revealed he was lying in bed in the dark, with no music playing and no television on. He stated he wanted to rest. He stated he never did anything and did not think there was anything he would like to do. He stated he was cold all the time. He stated he might warm up if he went outside, but he did not know if he wanted to go outside. He stated he did not know what he wanted to do. Review of the undated face sheet for Resident #75 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included metabolic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition), difficulty in walking, cognitive communication deficit, lack of coordination, muscle weakness, history of falling, speech and language deficits following unspecified cerebrovascular disease (any condition that affects you're the blood vessels of the brain), depression, edema, dementia, insomnia, and hemiplegia and hemiparesis (paralysis on one side of the body) following cerebral infarction. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission MDS assessment for Resident #75 dated 01/25/24 reflected a BIMS score of 15, reflecting intact cognition. It reflected he answered the assessment for activity preferences himself, finding it very important to have books, newspapers, and magazines to read, keep up with the news, and go outside to get fresh air when the weather was good. Review of the care plan for Resident #75 dated 04/04/24 reflected the following: Dependent on staff for activities, cognitive stimulation, social interaction r/t [sic]. Resident will participate in some activities he is interested in. Will attend/participate in activities of choice by next review date. o Invite to scheduled activities. o Provide with activities calendar. Notify resident of any changes to the calendar of activities. There was no care planning for the particular activities that Resident #75 enjoyed. Observation and interview on 08/13/24 at 08:06 AM revealed Resident #75 was dressed and sitting up in his wheelchair. He stated he wanted the bed made. He stated he spent most of his day sitting outside in the shade but had just finished his breakfast. Review of the undated face sheet for Resident #449 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included senile degeneration of brain (Mental deterioration associated with old age), depression, anxiety disorder, dementia, fracture of femur neck, and conversion disorder with seizures or convulsions (a mental health condition that causes physical symptoms). Review of the admission MDS assessment for Resident #449 dated 07/28/24 reflected a BIMS score of 04, reflecting severe cognitive impairment. It reflected she answered the assessment for activity preferences himself, finding it very important to have books, newspapers, and magazines to read, listen to music she liked, be around animals such as pets, go outside to get fresh air when the weather was good, and participate in religious services or practices. Review of the care plan for Resident #449 dated 08/12/24 reflected the following: Dependent on staff for activities, cognitive stimulation, social interaction r/t [sic]. Resident will participate in some activities he is interested in. Will attend/participate in activities of choice by next review date. o Invite to scheduled activities. o Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression, and responsibility. o Provide with activities calendar. Notify resident of any changes to the calendar of activities. There was no care planning for the particular activities that Resident #449 enjoyed. Observation and interview on 08/13/24 at 07:41 AM revealed Resident #449 lying in her bed with head of bed elevated. She stated she did not know what she was supposed to do or how to get anyone's attention in the facility. She stated she was brand new and had just arrived at the facility. She stated she did not know what she wanted to do and did not know what her options were. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated face sheet for Resident #450 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included rheumatoid arthritis, weakness muscle wasting and atrophy, chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs), limitation of activities due to disability, blindness of right eye, protein-calorie malnutrition, gout, adult failure to thrive, diarrhea, cognitive communication deficit, chronic pain, depression, and abdominal pain. Review of the annual MDS assessment for Resident #450 dated 07/28/24 reflected a BIMS score of 14, reflecting intact cognition. It reflected none of the activities listed as options in the assessment for activity preferences were important to him. Review of the care plan for Resident #450 dated 08/12/24 reflected the following: Has little or no activity involvement r/t Resident wishes not to participate. Will express satisfaction with type of activities and level of activity involvement when asked through the review date. o Explain the importance of social interaction and leisure activity time. Encourage participation by next review. o Explain that may leave activities at any time and is not required to stay for entire activity. o Invite to scheduled activities. o Provide activities calendar monthly. There was no care planning for the particular activities that Resident #450 enjoyed. Observation and interview on 08/13/24 at 08:26 PM revealed Resident #450 lying in bed but not asleep. He smiled and stated he liked to spend most of his time in bed. During an interview on 08/15/24 at 10:18 AM, MDSN C stated MDSN D was responsible for the care plans but had only been doing the job for a couple months. She had a lot to learn to ensure care plans were completed. She stated the department heads were responsible for their own disciplines. She stated MDSN C entered the item into the care plan and then the department heads had to go in to personalize the plans. She stated they discuss care planning in the morning meetings, and they have care plan meetings with families and residents, and the AD is in both of those meetings. She stated the AD came to her sometimes for guidance on care pans, but she had only recently looked at the specific care plans to see that they did not have personalized activities included in them. She stated they needed to better educate the AD on her role in the care planning process. During an interview on 08/15/24 at 10:25 AM, MDSN D stated she was still learning the MDS/care plan process, but she could say that care plans were important because they let people know what specifically each resident needed. MDSN D stated several people in the facility used care plans including nurses and CNAs. She stated if the AD had to quit or be on leave unexpectedly, they would need the care plans to know what activities residents enjoyed . She stated specific activities resident liked should have been added to the care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/15/24 at 02:59 PM, the AD stated she was responsible for completing her activity assessments and the activities portion of the MDS. She stated she met with residents, found out what they liked and did not like, and then she created her activity care plan. She stated she had not been creating the care plan items but had been using the drop-down menus to make choices for residents. She stated she only found out that morning that she could type specific things into the care plans and did not know that was an option . During an interview on 08/15/24 at 03:59 PM, the ADM stated he knew Resident #71 refused a lot of things, the staff tried to intervene and offer things, but he was not interested. The ADM stated they tried to reapproach Resident #71 and encourage him to make the right decision. He stated Resident #71 did not want to participate in any activities. The ADM stated he did not think they should give up on finding something Resident #71 wanted to do, but they needed to encourage, and it was hard to do so when they ran out of options and good ideas. The ADM stated it was possible that bringing in his direct caregivers might help generate new ideas, and he did not know if that had been done. He stated the purpose of the care plan meeting was to discuss possible interventions and give feedback on what has worked in the past. The ADM stated he was not familiar with Resident #449, as she was a newer admission, but it was very important for her and all residents to be invited to and reminded of activities. He stated it was good for their mental health and socialization. The ADM stated he would think the care plan team would care plan for specific activity preferences. He stated care plans should be person-centered, personalized, and specific. Review of facility policy dated 12/23 and titled Comprehensive Person-Centered Care Planning reflected the following: It is the policy of this facility that the interdisciplinary team shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives in time frames to meet a residence. Medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689 Based on observation, interview, and record review the facility failed to ensure residents unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 3 of 15 residents (Residents #49, #41, and #34) reviewed for ADLs. The facility failed to ensure Residents #49, #41, and #34 were provided nail care as documented in their plan of care and MDS. This failure could place residents at risk of scratches, infection, and poor self-esteem. Findings included: Record review of an undated Face Sheet for Resident #49 reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy. The pancreas (gland) does not make enough insulin to carry sugar into cells to fuel the body), need for assistance with personal care, and unspecified visual loss. Record review of an annual MDS dated [DATE], for Resident #49 reflected a BIMS score of 15 indicating intact cognitive status. Section GG -Functional Abilities and Goals reflected she was dependent for all personal hygiene. Record review of a Care Plan dated 07/26/2021 for Resident #49 reflected ADL self-care performance deficit r/t debility. Personal Hygiene needs total assistance X 1, nursing. Observation and interview on 08/13/2024 at 07:24 AM Resident #49's fingernails were jagged with brown debris under them. Resident #49 stated she would like to have her nails cut. In an interview on 08/15/2024 at 8:48 AM Resident #49 stated she still needed her nails trimmed as they were breaking, and she had almost scratched her eye on 8/14/2024 as they were so jagged. In an interview on 08/15/2024 at 9:20 AM LVN F stated Resident #49 needed her nails cleaned, trimmed, and filed down. She stated if she scratched herself there was a risk for infection . Record review of an undated Face Sheet for Resident #41 reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Type 2 Diabetes Mellitus without complications (a long-term condition in which the body has trouble controlling blood sugar and using it for energy. The pancreas (gland) does not make enough insulin to carry sugar into cells to fuel the body). Record review of an annual MDS dated [DATE], for Resident #41 reflected she had a BIMS score of 9 indicating moderate cognitive impairment. Section GG -Functional Abilities and Goals reflected she was dependent for all personal hygiene. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Marcos Rehabilitation and Healthcare Center	1600 N I H 35 San Marcos, TX 78666

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 08/13/2024 at 07:34 AM revealed Resident #41 had long, thick toenails on both feet. Resident #41 stated she would like to have her toenails trimmed. In an interview on 08/15/2024 at 9:24 AM LVN F stated referrals for diabetics to be seen by podiatry were given to the Social Worker. She stated Resident #41 would need to be seen by a Podiatrist for her toenails as she had a diagnosis of Diabetes. Record review of a facility podiatry list with next date of service 08/30/2024 at 9:00 AM reflected Resident #41's name was not on the list. Record review of an undated Face Sheet for Resident #34 reflected he was an [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy. The pancreas (gland) does not make enough insulin to carry sugar into cells to fuel the body). Record review of the Quarterly MDS for Resident #34 dated June 19, 2024, reflected he had a BIMS score of 9 indicating moderate cognitive impairment. Section GG -Functional Abilities and Goals reflected he was dependent on staff for all personal hygiene. Record review of a Care Plan dated 03/27/2023 for Resident #34 reflected he had an ADL self-care performance deficit, will maintain and or improve current level of function in personal hygiene through the review date. Personal hygiene, assist as needed X 1 staff, nursing. Observation on 08/13/2024 at 07:54 AM revealed Resident #34 had 1/2-inch long fingernails on both hands with brown debris under them. In an interview on 08/15/2024 at 9:24 AM LVN F stated residents with a diagnosis of Diabetes should have their fingernails trimmed and cleaned by nursing staff. She further stated there was a risk for contamination and infection if they ate with dirty fingernails. She stated nurses were responsible for ensuring the residents were on the podiatrist list. She stated she performed necessary nursing care but could not say she always looked at nails while doing rounds. In an interview on 8/15/2024 at 9:34 AM the SW stated she had some residents scheduled to see the podiatrist at the end of August on the 30th. She further stated the nurses would tell her which residents needed to be on the list. She printed a list of residents who had been seen by the podiatrist and those who were scheduled . In an interview on 08/15/2024 at 11:15 AM ADON A stated she had worked at the facility for 8 years and had been an ADON since 2022. She stated the nurses and CNAs knew to give the social worker a list of who needs to see podiatry, but the nurses can trim a diabetics fingernails. She stated if the resident was not a diabetic, the CNAs can file their fingernails with emery boards and use an orange stick to clean under them. She stated ADON B was the ADON in charge of making resident rounds on 200 and 300 halls. She stated the potential risk to the residents with long, jagged fingernails were they could get skin tears, scratch their skin, and cause infections. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/15/2024 at 12:44 PM ADON B stated residents with long nails could sustain an injury if their nails were too long. She stated unclean nails could be an infection control issue if they put their fingers in their mouth. She further stated she did not always look at nails during her daily rounds . In an interview on 08/15/2024 at 4:24 PM the ADM stated his expectation was for residents to be cared for appropriately including nail care. He stated the possible risk of having dirty nails could be an infection . Record review of a facility Policy and Procedure revised 05/2007 and titled Nursing Administration Subject: Nursing Services - ADLS reflected Nursing service staff cares for its residents in manner and in an environment that promotes maintenance or enhancement of each resident's quality of life and promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Residents receive assistance as needed to manage their physical needs which includes personal hygiene, grooming, dressing, toileting, transferring, ambulating, and eating.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observations, interviews, and record review, the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 2 of 12 residents (Residents #71 and #449) reviewed for activities. The facility failed to provide Resident #71 and #449 with activities from 08/13/24, 08/14/24, and 08/15/24. This failure placed residents at risk of not having their recreational and social needs met. Findings included: Review of the undated face sheet for Resident #71 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included pneumonia, chronic pain, muscle weakness, unsteadiness on feet, diverticulitis (inflammation of abnormal pouches in the bowel), difficulty in walking , muscle wasting and atrophy, protein -calorie malnutrition, depression, insomnia, repeated falls, suicidal ideation, dementia, weakness, and cognitive communication deficit. Review of the annual MDS assessment for Resident #71 dated 08/06/24 reflected a BIMS score of 12, reflecting moderately impaired cognition. It reflected he answered the assessment for activity preferences himself, finding it very important to be around animals such as pets, somewhat important to keep up with the news, and go outside for fresh air when the weather was good. Review of the care plan for Resident #71 dated 10/31/23 reflected the following: Has little or no activity involvement r/t depression, disinterest will observe activities but will be reluctant to join, will join if friends do. Will express satisfaction with type of activities and level of activity involvement when asked through the review date. Establish and record prior level of activity involvement and interests by talking with resident, caregivers, and family on admission and as necessary. o Explain the importance of social interaction and leisure activity time. Encourage participation by next review. o Explain that may leave activities at any time and is not required to stay for entire activity. o Invite to scheduled activities. o Preferred activities are watching tv and socializing with other residents independently o Provide activities calendar monthly. There was no care planning for the particular activities that Resident #71 enjoyed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of activity logs for Resident #71 from 08/02/24 to 08/15/24 reflected seven instances of Observing Surroundings and 12 instances of TV/Radio/Movies. Observation and interview of Resident #71 on 08/13/24 at 09:45 AM revealed he was lying in bed in the dark, with no music playing and no television on. He stated he wanted to rest. He stated he never did anything and did not think there was anything he would like to do. He stated he was cold all the time. He stated he might warm up if he went outside, but he did not know if he wanted to go outside. He stated he did not know what he wanted to do. Observation on 08/13/24 at 10:12 AM, 11:55 AM, 12:42 AM, 01:12 PM, and 02:04 PM, 08/14/24 at 08:07 AM, 09:14 AM, 10:20 AM, 11:58 AM, 12:43 AM, 02:13 PM, 03:10 PM, and 04:00 PM, and 08/15/24 at 08:02 AM, 09:00 AM, 10:06 AM, 12:15 PM, and 01:27 PM revealed Resident #71 was lying in bed in the dark, with no music playing and no television on. Review of the undated face sheet for Resident #449 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included senile degeneration of brain (mental deterioration associated with old age), depression, anxiety disorder, dementia, fracture of femur neck, and conversion disorder with seizures or convulsions (a mental health condition that causes physical symptoms). Review of the admission MDS assessment for Resident #449 dated 07/28/24 reflected a BIMS score of 04, reflecting severe cognitive impairment. It reflected she answered the assessment for activity preferences himself, finding it very important to have books, newspapers, and magazines to read, listen to music she liked, be around animals such as pets, go outside to get fresh air when the weather was good, and participate in religious services or practices. Review of the care plan for Resident #449 dated 08/12/24 reflected the following: Dependent on staff for activities, cognitive stimulation, social interaction r/t [sic]. Resident will participate in some activities he is interested in. Will attend/participate in activities of choice by next review date. o Invite to scheduled activities. o Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression, and responsibility. o Provide with activities calendar. Notify resident of any changes to the calendar of activities. There was no care planning for the particular activities that Resident #449 enjoyed. Review of activity logs for Resident #449 from 08/02/24 to 08/15/24 reflected four instances of Observing Surroundings, one instance of Walking/Wheeling and 13 instances of TV/Radio/Movies. Observation and interview on 08/13/24 at 07:41 AM revealed Resident #449 lying in her bed with head of bed elevated. She stated she did not know what she was supposed to do or how to get anyone's attention in the facility. She stated she was brand new and had just arrived at the facility. She stated she did not know what she wanted to do and did not know what her options were. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/13/24 at 10:10 AM, 11:53 AM, 12:40 AM, 01:10 PM, and 02:02 PM, 08/14/24 at 08:05 AM, 09:12 AM, 10:18 AM, 11:56 AM, 12:41 AM, 02:11 PM, 03:08 PM, and 03:58 PM, and 08/15/24 at 08:00 AM, 08:58 AM, 10:04 AM, 12:13 PM, and 01:25 PM revealed Resident #449 was lying in her bed and looking straight ahead of her with the television on. During an interview on 08/15/24 at 01:18 PM, RN E stated she was the charge nurse who worked with Residents #71 and #449 during the day. She stated Resident #71 had experienced a decline and began refusing a lot of things like dressing, medications, and possibly activities. She stated she was not aware of his activity involvement, but if he was lying in bed all day in the dark, that was not good for him. She stated she sometimes rubbed his arms with cream, and she visited with him at least once, but she could not say she had seen him receiving any activities. She stated Resident #71's roommate insisted on lying in bed all day in the dark even though he could get up and maybe Resident #71's room was too depressing for him. She stated she was not aware of any care planning or efforts of the IDT to find activities that Resident #71 would be willing to do. She stated she knew Resident #449 less well, as Resident #449 was new to the facility. She stated she thought maybe Resident #449 was not feeling well and that might be why she was not out of bed during the survey. She came back a few minutes after the initial interview to say she was correct, and that Resident #449 was not feeling well . During an interview on 08/15/24 at 03:05 PM, the AD stated she was responsible for ensuring activities were completed for each resident. did not have Resident #71 on her one-on-one list. She stated she was not aware of any care planning about activities or IDT meeting about how to get him engaged in any activity he might enjoy. She stated she was new as activity director and did not know when she took the position how important her role was. She stated she loved that it was important, but she was still learning just how important it was. The AD stated she had been trying to develop ways to get residents like Resident #71 to come out of their rooms such as coffee in the rotunda (common area). She stated she had been in the position since March 2024 and was still learning her residents. The AD stated the activity Observing Surroundings referred to residents who sat in the common area watching people go by or watching television. She stated it was not a suitable activity for residents who were not mobile and just sat in their beds. She stated she had documented it for Resident #71 not because she thought he was actually observing his surroundings as an activity, but because she was instructed to do so. She did not say who instructed her to do so. The AD stated she was not super familiar with Resident #449. The AD stated she looked at Resident #49's activity assessment and saw that she needed to be reminded of activities. The AD stated she had stopped at Resident #449's room to invite her, but she had not been feeling well. The AD stated she had been given no guidance about talking with the aides and the nurse about what specific residents might like to do. The AD stated a possible negative consequence of not receiving activities was residents would be upset because they did not get to do something they would want to do. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/15/24 at 03:59 PM, the ADM stated he knew Resident #71 refused a lot of things, and the staff tried to intervene and offer things, but he was not interested. The ADM stated they tried to reapproach Resident #71 and encourage him to make the right decision. He stated Resident #71 did not want to participate in any activities. The ADM stated he did not think they should give up on finding something Resident #71 wanted to do, but they needed to encourage him, and it was hard to do so when they ran out of options and good ideas. The ADM stated it was possible that bringing in his direct caregivers might help generate new ideas, and he did not know if that had been done. He stated the purpose of the care plan meeting was to discuss possible interventions and give feedback on what has worked in the past. The ADM stated he was not familiar with Resident #449, as she was a newer admission, but it was very important for her and all residents to be invited to and reminded of activities. He stated it was good for their mental health and socialization . Review of facility policy dated 12/23 and titled, Activities Programming reflected the following: It is the policy of this facility to ensure that activities are available to meet. Resident needs and interests that support the physical, mental, and psychosocial well-being of the resident. May be facilities, sponsored group or independent. End of life: spiritual support, touch, massage, music, reading to the resident, etc.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48917 Based on observations, interviews, and record review the facility failed to assist residents in obtaining routine dental services to meet the needs of 2 of 12 (Resident # 13 and Resident # 79) reviewed for dental services. The facility did not assist Resident # 13 with obtaining dental services when her bottom denture broke. The facility did not assist Resident # 79 with obtaining dental services when he reported his dentures had been left in Mexico. This deficient practice could affect residents by placing them at risk of not receiving necessary care and services to maintain the highest practicable physical, mental, and psychosocial well-being which could result in a decreased quality of life. Findings included: Record review of Resident # 13's face sheet dated 8/15/2024 with an admitted [DATE] reflected a [AGE] year-old female with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (a severe or complete loss of strength or paralysis that prevents you from moving the affected body parts), diabetes mellitus (a group of diseases that result in too much sugar in the blood), acute respiratory failure (respiratory failure from inadequate gas exchange by the respiratory system), protein-calorie malnutrition, muscle weakness, muscle wasting and atrophy, diabetic retinopathy with macular edema (damage to the blood vessels in the eyes due to complications from diabetes), contracture of left hand muscle, dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus), atherosclerotic heart disease (damage or disease in the hearts major blood vessels), anemia (Lack of red blood cells), abnormalities of gait and mobility, cognitive communication deficit, depression, hypertension (high blood pressure), myocardial infarction (a blockage of blood flow to the heart muscle), congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), chronic kidney disease (longstanding disease of the kidneys leading too renal failure), and transient visual loss. Record review of Resident # 13's quarterly MDS dated [DATE] reflected a BIMS score of 11 which indicated moderate cognitive impairment at the time of the assessment. Further review of functional abilities reflected Resident # 13 had no impairment for upper and lower extremity for functional limitations for range of motion and needed setup or clean-up assistance for eating and oral hygiene. Review also reflected Resident # 13 received a regular textured diet. MDS also reflected no weight loss of 5% in the last month or 10% or more in last 6 months under the swallowing/nutritional status section. MDS reflected under oral/dental status, no broken or loosely fitting full or partial denture and no mouth or facial pain, discomfort, or difficulty with chewing. Record review of Resident # 13's care plan dated initiated 4/21/2022 revised on 1/6/2024 reflected Resident # 13 had ADL self-care performance deficit related to debility with interventions of personal hygiene, needs extensive assistance with ADL's, and able to eat independently. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident # 13's SLUMS (St. Louis University Mental Status) examination dated 4/4/2024 reflected a score of 20 out of 30 which reflected a diagnosis of dementia. Record review of Resident # 13's oral health screening form dated 1/19/2023 reflected under notes need dentures repaired to eat, lower denture broken, minimal lower ridge. Record review of Resident # 79's face sheet dated 8/15/2024 with an admitted [DATE] reflected an [AGE] year old male with diagnoses of dementia (a group of thinking and social symptoms that interferes with daily functioning), hypertension (high blood pressure), muscle wasting and atrophy, muscle weakness, dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus), cognitive communication deficit, hypothyroidism (underactive thyroid), chronic pain, severe protein calorie malnutrition, atrial fibrillation (irregular heart rate), peptic ulcer, osteoarthritis (a type of arthritis that occurs when flexible tissue at the ends of bones wears down), benign prostatic hyperplasia (age-related prostate gland enlargement that can cause urination difficulty), GERD (a digestive disease in which stomach acid or bile irritates the food pipe lining), lack of coordination, and abnormal weight loss. Record review of Resident # 79's quarterly MDS dated [DATE] reflected a BIMS score of 7 which indicated severe cognitive impairment at the time of the assessment. Further review of functional abilities reflected Resident # 79 had no impairment for upper and lower extremity for functional limitations for range of motion and needed setup or clean-up assistance for eating and oral hygiene. Review also reflected Resident # 79 received a mechanically altered diet. MDS also reflected no weight loss of 5% in last month or 10% or more in last 6 months under the swallowing/nutritional status section. MDS reflected under oral /dental status, no broken or loosely fitting full or partial denture, and no mouth or facial pain, discomfort, or difficulty with chewing. Record review of Resident # 79's care plan dated initiated 11/30/2022 revised on 8/5/24 reflected Resident # 79 had a nutritional problem or potential nutritional problem related to new admission. Diet ordered mechanical soft no added salt lactose free thin liquids. Interventions of if resident eats less than 50% of meal offer meal replacement. RD to evaluate and make diet change recommendations PRN. Weekly weights times 4 weeks then monthly if stable. Order appetite stimulant. Resident # 79 has unplanned/unexpected weight loss initiated 5/14/2024 and revision on 8/5/2024. On date 6/13/2024 weight loss recording of 6% in 1 month and 10.2% in 6 months. Intervention of alert RD if consumption was poor for more than 48 hours, monitor and evaluate any weight loss, monitor, and record food intake at each meal, provide supplement as ordered of 2 Cal 120 cc TID. Resident # 79 has oral/dental health problems related to no natural teeth date initiated 12/9/2022 and revision on 12/9/2022. Interventions include coordinate arrangements for dental care, transportation as needed/as ordered, monitor/document/report to MD PRN signs and symptoms of dental problems needing attention pain, abscess, debris in mouth, lips cracked or bleeding, teeth missing, loose, broken, eroded, decayed, tongue inflammation, ulcers in mouth, lesions, and provide mouth care as per ADL personal hygiene. Record review of Resident # 79's SLUMS (St. Louis University Mental Status) examination dated 6/21/2024 reflected a score of 11 out of 30 which reflects a diagnosis of dementia. Record review of Resident # 79's oral health screening form dated 4/5/2023 reflected under notes wanted dentures, possibility to make a new set. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident # 79's dental hygienist report dated 5/2/2024 reflected the patient tolerated dental hygiene treatment well with no complaints. Oral tissues within normal limits. The patient explained once again his dentures were left in Mexico and will need a new set. An email was sent to inform the dentist. Oral hygiene was reviewed and stressed. Dental hygiene supplies were provided to the patient. Record review of Resident # 79's dental appointment progress report dated 5/16/2024 reflected six-month recall. Patient wants to finally replace teeth. Diagnosis soft tissue within normal limits. Next visit impressions. Record review of Resident # 79's dental hygienist report dated 6/3/2024 reflected the patient tolerated dental hygiene treatment well with no complaints. Oral tissues within normal limits. The patient explained once again his dentures were left in Mexico and will need a new set. An email was sent to inform the dentist. Oral hygiene was reviewed and stressed. Dental hygiene supplies were provided to the patient. Record review of Resident # 79's dental hygienist report dated 7/2/2024 reflected the patient stated he wants dentures and has not seen the dentist for new dentures. The patient tolerated dental hygiene treatment well with no complaints. Oral tissues within normal limits. The patient explained once again his dentures were left in Mexico and will need a new set. An email was sent to inform the dentist. Oral hygiene was reviewed and stressed. Dental hygiene supplies were provided to the patient. During observation and interview on 8/13/2024 at 8:47 AM Resident # 79 observed to be in his room in bed asking for his teeth and saying he needs his teeth to eat. Resident observed to have no teeth in his mouth. During an observation and interview on 8/14/2024 at 8:34 AM Resident # 13 observed to be in her room in bed eating breakfast. Resident # 13 apologized for being a mess and having dropped food particles on the front of her bed sheet covering her chest. Resident # 13 said it was hard for her to eat since she was partially paralyzed on one side, had tremors on the other side, and had no teeth. Resident # 13 said she had not been seen by a dentist that she could remember. Resident # 13 said the staff would cut up her meat to help make it easier for her to eat. During an interview on 8/15/2024 at 10:02 AM the Social Worker said Resident # 13 had her initial dental evaluation completed 1/19/2023. The SW could not answer as to why no other steps had been taken in a timely manner in securing Resident # 13 with new dentures. The SW said and was able to show the state surveyor their dry erase board which listed all active services residents were receiving which had Resident # 13 listed under dental services. The SW said Resident # 79 had his initial dental evaluation completed on 4/5/2023. The SW said the dentist had contacted her on 7/22/2024 and told her that Resident # 79 would need to be seen in the office to have dental impressions completed for dentures to be made. The SW said it was their fault that no note had been entered into Resident # 79's medical chart about this conversation with the dentist. The SW said they had been attempting to coordinate transportation to the dental office for Resident # 79 and one other resident because the SW wanted both residents to be seen on the same day. The SW said there had been some delays in getting family consent and travel arrangements made. The SW could not answer as to why no other steps had been taken in a timely manner in securing Resident # 79 with new dentures. The SW said and was able to show the state surveyor their dry erase board which listed all active services residents were receiving which did not have Resident # 79 listed under dental services. (continued on next page)

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	675651	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Marcos Rehabilitation and Healthcare Center	1600 N I H 35 San Marcos, TX 78666

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/2024 at 11:40 am the SW said the dentist was scheduled to be in the facility on 8/30/2024 to complete the initial screen and full assessment of Resident # 13. The SW said the dentist said they would be in the facility prior to the end of the month to obtain the impressions for Resident # 79 's dentures. The SW also stated they were familiar with the facility dental policy and could not provide an answer as to why the dental services had not been obtained for Resident # 13 and Resident # 79 per the facility policy procedures. The SW said a negative impact of residents not having their dental needs met could be improper meal intake and communication problems. During an interview on 8/15/2024 at 3:17 pm the SW said the dentist had called and set an appointment on 8/21/2024 to complete step 1 of a 5-step process in obtaining a new set of dentures for Resident # 13 and Resident # 79. The SW said the initial screen had been completed on Resident # 13, but they had never been enrolled in dental services. During an interview on 8/15/2024 at 3:53 pm the ADM said his expectation was for the facility to provide needed dental services in a timely manner. The ADM said a risk of not receiving timely dental services was it could affect the residents intake of their meals. ADM said it was the SW responsibility to ensure dental services were completed. Record review of the facility Dental Services policy dated 1/2018 and revised on 12/2023 reflected under heading Policy: It is the policy of this facility to ensure that its residents who require dental services on a routine or emergency basis have access to such services without barrier. It is likewise the policy of the facility to repair or replace dentures of a resident except in those situations where the loss or damage directly results from the action of an alert and oriented resident who is responsible for his/her own medical decisions. Under heading Definitions: Promptly means within 3 business days or less from the time the loss or damage to dentures is identified unless the facility can provide documentation of extenuating circumstances that resulted in the delay. Under heading Procedure: 1.In the event that a Facility resident experiences loss or damage to his/her dentures, the Facility will: o Gather the necessary facts and information in order to make a determination as to whether the loss/damage directly results from the action of an alert and oriented resident who is responsible for his/her own medical decisions. o If so, and absent some extenuating or unusual circumstance, the Facility will not be financially responsible for the repair or replacement. o If not, and absent some extenuating or unusual circumstance, the Facility will be financially responsible for the repair or replacement. o If it is determined that the Facility is responsible for the loss of or damage to the dentures, there will be no charge to the resident for the repair or replacement. Repair or replacement will be accomplished in a reasonable manner, with the goal of returning the resident to his/her dentition baseline pre-loss or damage. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. In the event that a Facility resident requires emergency dental services, for the repair or replacement of dentures or otherwise, the Facility will: o Promptly and, in any event, no later than three (3) business days from the date of loss/damage, refer the resident for dental services. o Assist the resident in making the necessary dental appointments, when necessary or requested. o Arrange for transportation to and from the dental services appointment/location, using the lowest cost or no cost option to minimize the financial burden on the resident. 3. If a referral for dental services does not occur within three (3) business days from the date of the loss/damage, the Facility will: o Document what actions were taken to ensure the resident could eat, drink and communicate (if applicable) adequately while awaiting dental services. o Document the nature of the extenuating circumstances which led to the delay.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48917 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in one of one kitchen reviewed for dietary services. The cook failed to wear gloves while touching ready to eat food such as tortillas while making breakfast tacos on the breakfast tray service line. A container of sugar in the dry storage room was not sealed with an approximate 2-centimeter gap opening of the sugar container lid allowing for possible pest contamination. A 50 lb. bag of rice in the dry storage room was not sealed. The opening of the top of the bag was completely open to possible pest contamination. The temperature/sanitizer log for the dish machine was not completed, filled out, and up to date. The temperature/sanitizer log for the 3-compartment sanitizing sink was not completed, filled out, and up to date. The food temperature log was not completed, filled out, and up to date. The juice dispenser nozzle had pinkish orange slimy buildup inside the juice dispenser nozzle. The lower-level stainless steel shelving, where the plate dome covers, were stored, had food debris and buildup on the shelving surface. The cook failed to wear gloves when preparing pureed and ground food items for meal service. The cook failed to wear gloves while taking lunch meal temperatures and picking up ready to eat chicken leg quarters. These failures could place residents at risk for food borne contamination and food borne illness. The findings included: During an observation on 8/13/2024 revealed the following: At 7:15 AM the cook to be serving breakfast tray line without wearing gloves while picking up tortillas to construct breakfast tacos. At 7:18 AM the juice dispenser nozzle to have pinkish orange slimy buildup inside the juice dispenser nozzle. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 7:20 AM a container of sugar in the dry storage room was not sealed with an approximate 2-centimeter gap opening of the sugar container lid allowing for possible pest contamination. At 7:21 AM a 50 lb. bag of rice in the dry storage room was not sealed. The opening of the top of the bag was completely open to possible pest contamination. At 7:37 AM the food temperature log was not completed, filled out, and up to date. At 7:39 AM observation of signage posted in kitchen stating wear gloves when handling food. Sign was signed by Dietary Manager. At 7:41 AM the lower-level stainless steel shelving, where the plate dome covers were stored, had food debris and buildup on the shelving surface. Record review on 08/13/24 reflected the temperature/sanitizer log for the 3-compartment sanitizing sink was not completed, filled out, and up to date and the temperature/sanitizer log for the dish machine was not completed, filled out, and up to date. During an observation on 8/14/2024 revealed the following: At 10:30 AM the cook failed to wear gloves when preparing pureed and ground food items for meal service. At 11:30 AM the cook failed to wear gloves while taking lunch meal temperatures and picking up ready to eat chicken leg quarters. During an interview on 8/14/2024 at 11:42 AM CK J said they had been instructed by DM to wear gloves when handling cold food such as salads and sandwiches. line CK J stated the staff do not wear gloves on the tray line they have just been instructed by DM to wash hands frequently. During an interview on 8/14/2024 at 3:26 PM the DM said gloves were worn when handling any ready to eat food during any process in the kitchen. The DM also said all food was to be labeled and dated upon receipt, with the preparation date, and with the discard date. The DM said all food was to be stored and sealed to prevent food contamination. The DM said all staff were responsible for cleaning the kitchen areas they work in. The DM said a negative impact of dietary staff not following professional standards for food service safety in the storage, preparation, distribution, and serving of food could be food contamination and possible food borne illness for the residents. During an interview on 8/15/2024 at 9:35 AM the DM said the facility followed the TFER (Texas Food Establishment Rules) guidelines as their policy for hand hygiene and labeling and dating. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/15/2024 at 3:53 PM the ADM said his expectation for hand hygiene and glove usage by dietary staff was for the dietary staff to wear gloves when touching food and to wash hands frequently. The ADM said a possible risk of not completing hand hygiene and glove usage would be possible bacteria and infection risk to the residents. The ADM said his expectation for labeling and dating of food products would be that items would be labeled and dated upon receipt and again when prepared with discard date. The ADM said the risk of dietary staff not storing, preparing, and serving food according to professional standards for food service safety could be serving food that was out of date, not safe, and has potential for food borne illness. Record review of hand hygiene / glove usage policy provided was excerpt of the TFER (Texas Food Establishment Rules) undated revealed: under 228.65 Preventing contamination by employees: a. Preventing contamination from hands 1. Food employees shall wash their hands as specified under 228.38 of this title relating to management and personnel. 2. Except when washing fruits and vegetables as specified under section 228.66f of this title or as specified in paragraphs 4 and 5 of this subsection, food employees may not contact exposed, ready to eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single use gloves, or dispensing equipment. 3. Food employees shall minimize bare hand and arm contact with exposed food that is not in a ready to eat form. (E) documentation that hands are washed before food preparation and as necessary to prevent cross contamination by food employees as specified under S228.38(a) -(b) and subsections (d) -(e) during all hours of operation when the specific ready-to-eat foods are prepared. (F) documentation is maintained at the food establishment that food employees contacting ready-to-eat foods with bare hands utilize two or more of the following control measures to provide additional safeguards to hazards associated with bare hand contact: (iv) where to wash their hands as specified under S228.38(e) of this (v) proper fingernail maintenance as specified under S228.39 of (vi) prohibition of jewelry as specified under S228 .40 of this title, (vii) good hygienic practices as related to S228.42(a) and (b) of (viii) employee health policies that detail how the food establishment complies with S228.35, 228.36, and 228. 3 7 of this title. (E)documentation that hands are washed before food preparation and as necessary to prevent cross contamination by food employees as specified under S228.38(a) -(b) and subsections (d) -(e) during all hours of operation when the specific ready-to-eat foods are prepared, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(F)documentation is maintained at the food establishment that food employees contacting ready-to-eat foods with bare hands utilize two or more of the following control measures to provide additional safeguards to hazards associated with bare hand contact: (i) double handwashing. (ii) nail brushes. (iii) a hand sanitizer after handwashing as specified under (iv) incentive programs that assist or encourage food employees not to work when they are ill such as paid sick leave; other control measures approved by the regulatory authority; and (G)documentation is maintained at the. food establishment-that corrective actions are taken when paragraph (5)(A)-(E) of this subsection are not followed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28689 Based on observations, interviews, and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 3 of 3 residents reviewed (Resident #49, #90, and #66) for medication administration, urinary catheter care, and wound care. as indicated by: 1. The facility failed to ensure MA H did not cross contaminate a medication cup and place medications in it for administration to Resident #49. 2. The facility failed to ensure nursing staff kept Resident #90's urinary catheter bag off of the floor. 3. The facility failed to ensure LVN G used proper infection control practices while providing wound care to Resident #66. These failures could place residents at risk for cross contamination and infection. Findings included: 1. Record review of an undated Face Sheet for Resident #49 reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy. The pancreas (gland) does not make enough insulin to carry sugar into cells to fuel the body), need for assistance with personal care, and unspecified visual loss. Record review of an annual MDS dated [DATE], for Resident #49 reflected she had a BIMS score of 15 indicating intact cognitive status. Observation on 08/14/2024 at 7:52 AM MA H placed her unsanitized finger inside of a medication cup which she then used to administer medications to Resident #49. In an interview on 08/14/2024 at 8:40 AM MA H stated placing her finger inside of a medication cup was cross contamination and could cause infection. 2. Record review of an undated Face Sheet for Resident #90 reflected he was an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of sepsis, (body's extreme reaction to infection which can lead to organ failure, tissue damage, and death) unspecified organism and benign (non-cancerous) prostatic hyperplasia (enlarged prostate gland) with lower urinary tract symptoms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/13/2024 at 8:58 AM revealed Resident #90 was ambulating in his wheelchair into the rotunda and his foley catheter bag was dragging on the floor. Observation on 08/14/2024 at 9:32 AM in Resident #90's room revealed he was resting in bed and his urinary catheter bag was laying on the floor under his bed. In an observation and interview on 08/14/2024 at 9:48 AM the RNC observed Resident #90's urinary catheter bag on the floor under his bed and stated it should be hooked to the side of the bed. She further stated by being on the floor it increased his risk of infection . In an interview on 08/14/2024 at 9:54 AM LVN G stated urinary catheter bags should be hooked to the side of a wheelchair or the bed. She further stated if it was on the floor, it could be an infection control issue . 3. Record review of an undated Face Sheet for Resident #66 reflected she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of severe intellectual disabilities, dysphagia (difficulty swallowing), and pressure induced deep tissue injuries to bilateral (both) heels. Record review of a Quarterly MDS for Resident #66 dated July 1, 2024, reflected she was unable to complete a BIMS evaluation as she was rarely or never understood. Section M - Skin Conditions reflected she had one Stage 2 Pressure Ulcer (partial thickness loss of the skin's epidermis (top layer of skin) that appears as an open wound or blister). Record review of the Care Plan for Resident #66 dated 07/01/2024 and revised on 08/14/2024 reflected she had a Stage 2 pressure ulcer to the coccyx (base of the spine). In an observation of wound care on 08/14/2024 at 10:50 AM for Resident #66, LVN G touched the wound care cart drawer with unsanitized hands and grabbed 4 stacks of 4 X 4 gauze and placed them on wax paper on a tray table. LVN G then sanitized her hands, grabbed a stack of gloves, and pushed the cart into the room. She washed her hands, paused the resident's tube feeding, and after donning gloves, she touched the resident's brief. The resident was having a bowel movement, so LVN G removed her soiled gloves, did not clean her hands, and then grabbed another stack of gloves from a box in the room and placed them on top of the other clean gloves on the tray table. She cleaned her hands, placed gloves on and cleaned and dried the coccyx pressure ulcer with contaminated 4 X 4 gauze. She then placed collagen into the wound using a sterile cotton swab and then placed an island dressing on the wound. In an interview on 08/14/2024 at 11:39 AM LVN G stated she had worked at the facility for [AGE] years in various positions. She stated by touching the 4 X 4 gauze with unclean hands, she could have transferred bacteria to the wound which could possibly cause an issue with infection control. She stated she could have transferred bacteria from the gloves to the wound. She further stated she had received in-services on wound care and attended a skills fair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/15/2024 at 11:15 AM ADON A stated her expectation was that nurses and medication aides know how to do hand hygiene. She stated they should not put their finger inside of a medication cup as it is an infection control risk. She stated regarding wound care, staff can contaminate the supplies by not cleaning their hands. She stated if the supplies [NAME] contaminated, they should be discarded. She stated LVN G should have sanitized her hands after removing her gloves and before gathering more clean supplies. She further stated using the contaminated supplies could infect the wound. Regarding Resident #90's urinary catheter, she stated the CNAs and nurses know to hang the urinary catheter bag where it [NAME] not touching the floor. She stated when a resident [NAME] in the bed, the catheter bag needs to be hooked on the side of the bed and not left on the floor. She further stated the potential risk to the resident was a urinary tract infection. In an interview on 08/15/2024 at 4:24 PM the ADM stated the Medication Aide placing her unclean finger in the medication cup, could possibly spread infection to a resident. He further stated the issue regarding Resident #90's urinary catheter bag being on the floor was a clinical question for nursing. Record review of an on-line federal government CDC article titled Guidelines for Prevention of Catheter Associated Urinary Tract Infection dated 2009 and attached to an article dated April 12, 2024, reflected page 13 of 61, III. Proper Techniques for Urinary Catheter Maintenance 2. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. (Category IB) This recommendation is based on maintaining proper hygiene and preventing contamination. Placing the catheter bag on the floor can lead to the introduction of pathogens [bacteria] and increase the risk of infection for the patient using the catheter. By keeping the bag off the floor, the chances of contamination are reduced, promoting better patient care, and reducing the risk of catheter-associated urinary tract infections (CAUTI). Record review of a facility Policy and Procedure titled Infection Prevention and Control Program dated 06/2021 and revised 10/2022 reflected Goals: recognize infection control practices while providing care. Ensure compliance with state and federal regulations related to infection control. Communicable disease is an infection transmissible by direct contact with an affected individual or the individuals body fluids or by indirect means (e.g., contaminated object). Record review of a facility Policy and Procedure titled Skin and Wound Monitoring and Management dated 03/2015 and last revised on 12/2023 reflected It is the policy of this facility that 2. A resident having pressure injury(s) receives necessary treatment and services to promote healing, prevent infection and prevent new, avoidable pressure injuries form developing. Purpose: Promote the healing of pressure injuries that are present (including prevention of infection to the extent possible).