STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675700	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookshire Residence and Rehabilitation Center	710 Hwy 359 S Brookshire, TX 77423

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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 - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 36918 Based on observation, interview and record review, the facility failed to ensure the residents' rights to privacy for 2 (Resident #168, and Resident 29) of 6 residents reviewed for personal privacy. The facility failed to ensure LVN A locked the computer screen, displaying the name of Resident #168's name and medications, while LVN A was in resident's room administering finger stick and insulin. -The facility failed to provide Resident #29 privacy when providing incontinent care. These failures could place residents' protected HIPAA information at risk of being shared place residents at risk of having their bodies exposed to the public, resulting in low self-esteem and a diminished quality of life. The findings included: 1. During an observation on 12/03/24 at 7:45 a.m., LVN A went into Resident 168's room, and performed a finger stick. LVN A left the computer screen open with Resident 168's medication information showing LVN A came out of the resident's room, prepared the insulin pen, returned to the resident's room, and administered the insulin to Resident #168. LVN A still left the computer screen open with the resident medication information visible. During an interview on 12/03/24 at 77:55 a.m., LVN A said she forgot to close or lock the computer so Resident #168's information would not be visible because it was a HIPAA issue. LVN A said Resident #168's information should only be seen by the staff not providing care or anybody the resident had permitted to look through her records. During an interview on 12/04/24 at 8:07 a.m., the Administrator said LVN A should have locked her computer and not display Resident 168's medical information. The Administrator said it was a HIPAA issue, and anybody could have seen Resident #168's information who did not have any reason to see the resident's information. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/24 at 2:59 p.m., the DON said LVN A should have locked the computer screen to prevent Resident #168's information from being revealed to anybody who walked past the computer screen because the resident's information should be private. 2. Record review of Resident #29's face sheet revealed reflected an 76-year- old female who was originally admitted to the facility originally on 09/19/2024. Resident #29 had with diagnoses anxiety disorder (a condition that causes excessive worry and fear that interferes with daily life), need for assistance with personal care, constipation, unspecified, major depressive disorder, recurrent (a mental health condition that involves persistent feelings of sadness, hopelessness, and a lack of interest in activities) severe with psychotic symptoms(a collection of symptoms that affect the mind , where there has been some loss of contact with reality),dementia (a chronic condition that causes a decline in cognitive functioning, such as thinking, remembering and reasoning to the point that it interferes with daily life) and depressive disorders(a common mental disorder. it involves a depressed mood or loss of pleasure or interest in activities for long periods of time). Record review of Resident #29's admission MDS, dated [DATE], revealed reflected the resident had a BIMS score of 03 which indicated the resident's cognition was severely impaired. Further review revealed Resident #29 required substantial to maximal assistance with toilet hygiene and the resident was frequently incontinent of bowel and bladder. Record review of Resident #29's care plan dated 10/23/24 reflected Resident #29 has an ADL self-care performance deficit, the goal was resident will improve current level of function in through the review date: Resident #29 required total assist 1 person assist or bathing/showering, dressing, bed mobility, eating, personal hygiene/oral. Toilet use, transfer. Observation on 12/03/2024 at 8:33 AM. CNA A went over to the resident bed and proceeded to provide incontinent care for Resident #29 . C.NA A did not close entrance door to the room. Resident #29's roommate was in the room who was disoriented to person, place, and time, but was awake. C.NA A did not pulled the privacy curtain wrap at the foot of the bed while performing incontinent care. Interview on 12/03/2024 at 1:45 PM CNA-A said she forgot to provide privacy for Resident #29 during incontinent care because she became nervous and forgot to pull the resident privacy curtain. The Interview on 12/04/24 at 4:16 PM, with DON , she said all residents should be provided dignity and privacy during care and she would have in-services. The DON said her expectation was for all residents to be treated with dignity and respect. Record review of the Revised., 10/2023, Nursing Policy on Resident Rights reflected in part: All residents have right guaranteed to the, under federal and state laws and regulations. Each resident has the right to be treated with dignity and respect, These rights are grouped in the following categories: Dignity and respect . . Privacy and confidentiality .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 36918 Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 3 of 5 halls (100-hall, 400-hall and 500-hall). - The facility failed to address discoloration on ceiling tiles throughout the facility. - The facility failed to address missing floor and wall tiles. - The facility failed to address exposed sheetrock in the halls and resident rooms. - The facility failed to address chipped wall paint in the halls and resident rooms. - The facility failed to address damaged exit door handles. - The facility failed to address damaged door frame and door handle to storage room. - The facility failed to address damaged handrails. These deficient practices could place residents at risk of living in an unsafe, unclean and unsanitary environment which could lead to a decreased quality of life. The findings include: An observation on 12/02/2024 between 08:45 AM and 10:00 AM, revealed the following: - room [ROOM NUMBER]'s bathroom with broken tiles near commode and the room's entry door, 402-B's baseboard not secured to wall. - room [ROOM NUMBER]-B baseboard not secured to the wall. - room [ROOM NUMBER]'s commode grayish in coloring, faucet in room off the wall and unsecured, room [ROOM NUMBER]-A baseboard not secured to wall. room [ROOM NUMBER]-B had dry brownish discoloration on bed frame, fitted sheet, and the floor had various areas of small, and crumped debris. - room [ROOM NUMBER]'s bathroom baseboard not secure and faucet had rust like coloration stains, and brown watermark like coloration on some of the white ceiling tiles. An observation on 12/02/2024 09:00 AM and 09:20 AM, revealed the following: - Throughout the 100-hall between room [ROOM NUMBER]-A to 112-B there were brown watermark like discoloration on multiple white ceiling tiles, and missing paint in various locations throughout the hall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- room [ROOM NUMBER] had a black zip tie serving as a door handle. - The door frame of room [ROOM NUMBER] was not flush and had flaking paint along each side. - The ceiling in the sitting and television area on the 100-hall had ceilings tiles with brown watermark like discoloration. - Several locations on the 100-hall walls had unfinished texture and lacked paint. An observation on 12/02/2024 11:19 AM and 12:00 PM, revealed the following: - room [ROOM NUMBER] had white ceiling tiles that were not flush/in placed with brown watermark like discoloration. - room [ROOM NUMBER] had brown watermark like discoloration by the room's entry door and brown watermark like discoloration on the white ceiling tiles. - room [ROOM NUMBER] had white ceiling tiles that were not flush/in place. - room [ROOM NUMBER] had brown watermark like discoloration by the entrance door inside the room. - room [ROOM NUMBER] had brown watermark like discoloration on the door and on the white ceiling tiles that were not flush/in place. - room [ROOM NUMBER] had brown watermark like discoloration by the door and on the white ceiling tiles. - room [ROOM NUMBER] had brown watermark like discoloration on the white ceiling tiles that were not flush/in place exposing the upper portion of the ceiling and black discoloration on the door, wall, and near the wall by a television. - room [ROOM NUMBER] had brown watermark like discoloration on the white ceiling tiles. An observation on 12/04/2024 at 10:40 AM, on all the facility's 100-hallway handrails revealed dark and light dirt like discoloration along the brown wooden rails. An observation on 12/04/2024 at 11:25 AM, revealed the following: - Aa hole in the ceiling of main dining room near a vent approximately 3-4 inches in length stuffed with a white paper towel like substance. - Wall in main dining area near a side exit with approximately 3 feet of paint and sheet rock peeling away and the corner wall of dining area paint and drywall missing exposing metal corner round. - Areas of floor tile missing in corridor between the 400 and 500-halls. An observation on 12/06/2024 between 11:45 AM and 12:09 PM, revealed the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Inside of the entry door to the 100-hall memory care unit had large, scuffed areas of missing paint. - The end caps to 2-handrailings were missing and the exposing metal was sharp to touch. - Entrance door to room [ROOM NUMBER] had 4-white ceiling tiles with brown watermark like discoloration. - room [ROOM NUMBER]'s white ceiling tiles in between bed-A and bed-B had 3-tiles partially off centered exposing the upper area of the ceiling. - room [ROOM NUMBER] had brown watermark like discoloration on the ceiling tile by bed-A's television and cracked paint from the top of the door frame to the ceiling. - Outside exit door at the end of the 100-hall had missing hardware and the exposed area was sharp to touch. In an interview on 12/02/2024 at 11:19 AM, Resident #118 in room [ROOM NUMBER] stated the brown watermark like discoloration on the white ceiling tiles had been there since he had resided in that room. In an interview on 12/03/2024 at 10:59 AM, FMD stated that he began employment with the facility in November of 2024. He stated that nobody or any of the staff had told him about any missing titles in the or loose facets in restroom, peeling paints, dark stain on the ceiling, with holes, loose baseboards. He stated he did not have any maintenance logs and that, It would be in working soon. In an interview on 12/03/2024 at 11:20 AM, the DON stated that was not aware of the missing titles in the restroom, peeling paint, dark stain on the ceiling with holes, baseboards not secured and had no maintenance logs to provide. In an interview on 12/03/2024 at 4:37 PM, the ADON stated that the facility used a water boiler and that brown watermark like discoloration on the tiles was from the condensation from the water. The ADON stated that the facility would be painting the celling, but the FMD would be able to share more light on what the facility would be doing for the celling areas. Interview on 12/04/2024 at 08:12 AM, the Administrator stated the FMD would be the person to answer the question on the ceiling tiles. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 12/04/2024 at 11:01 the Housekeeping Supervisor (HS) stated she has been employed with the facility the 5-months. She stated her team was responsible for cleaning and identifying stains throughout the facility. She stated if her team found any damages or defects to the resident's rooms her team was to inform her verbally and then she would notify the FMD verbally right away. She stated it was her expectation that her team check rooms every hour for cleaning needs. She stated that she also, checked behind her staff to ensure that the rooms were cleaned to standard. She stated that the staff cleaned picked up trash, swept and mopped as needed, ensured window and room dividing curtains were secure and in place, moved nightstand to ensure that there are no holes in the wall or in the tiles, debrie or signs of pest control issues. She stated she was not aware of any resident rooms or areas in the facility that had missing floor tiles, stains on the walls or statins on the ceiling. She then followed up and stated that she could not honestly say if there were any damages to any areas or rooms in the facility because she was not in every room every day. She stated the risk the resident was that they were not in a safe clean, and homelike environment. Interview on 12/04/2024 at 11:56 AM, CNA Q stated that on the 100-hall the stains on the ceiling, walls, missing tile on the floor, the damaged handrails and the damage to the back door have been like that since she could remember. In an interview on 12/04/2024 at 11:58 AM, CNA J stated that she last worked on 12/02/2024 in the memory care unit and at that time told the FMD that the privacy curtain was down in room [ROOM NUMBER] between bed-A and bed-B. She stated that there were two residents in room [ROOM NUMBER]. She stated the maintenance staff were on the hall 12/02/2024 hanging privacy curtains and must have missed the curtain in room [ROOM NUMBER]. She stated the importance of having a privacy curtain between resident's beds was to give residents their own space and privacy. She stated that the zip tie serving as a door handle for room [ROOM NUMBER] is not a resident's room. She stated room [ROOM NUMBER] was a storage unit for the hall. She stated that damaged door frame to room [ROOM NUMBER] had been that way for some time. In an interview on 12/04/2024 at 02:31 PM, the Administrator and DON were shown pictures of all the environmental areas of concern in the 100-hall, kitchen, dining area, and the 500-hall. The Administrator stated that the FMD had already begun painting discolored tiles throughout the facility. He stated that he would meet again with the FMD and the HS to address the concerns observed. He stated the risk of the resident's rooms and facility being properly maintained would affect residents' lack of dignity and infection control concerns. In an interview on 12/06/2024 at 11:51 AM, the Facility Maintenance Director (FMD) stated the vent in room [ROOM NUMBER] was rusted. The FMD stated that all the brown and black discoloration happened when the facility had a water leak that was fixed. He stated thereafter, the water mark like discoloration started popping up. The FMD stated he did not know when the facility had the leakage because it had been before his time at the facility. He stated the facility had begun painting the ceiling tiles. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of undated policy titled: Maintenance Service revealed Highlights Policy Statement Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and implementation. 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions 2. Functions of maintenance personnel include but are not limited to: 1. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. 2. Maintaining the building in good repair and free from hazards. 6. Establishing priorities in providing repair service. 9. Providing routinely scheduled maintenance service to all areas. Developing/Maintaining Maintenance Schedule 3. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. Availability 4. A copy of the maintenance schedule shall be provided to each department director so that appropriate scheduling can be made without interruption of services to residents. Recommended Preventive Maintenance Schedule 5. Maintenance personnel shall follow the manufacturer's recommended maintenance schedule. Recordkeeping 8. The Maintenance Director is responsible for maintaining the following records/ reports. 1. Inspection of building; 2. Work order requests; 3. Maintenance schedules; Maintenance Records Location 9. Records shall be maintained in the Maintenance Director's office. Safety 10. Maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned. Record review of revised dated 10/2023 policy titled Resident Rights revealed: All residents have rights guaranteed to them under Federal and State laws and regulations. Each resident has the right to be treated with dignity and respect. All activities and interactions with residents by any staff, temporary agency staff or volunteers must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident's, goals, preferences, and choices. When providing care and services, staff will respect each resident's individuality, as well as honor and value their input. 44669

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32422 Based on interview and record review the facility failed to accurately assess each resident's status for 1 of 5 Residents (Resident #7) reviewed for assessment accuracy in that: Resident #7 MDS and care plan were in accurate in that was indentified as being on anti-coagulants/antiplatelets when she was not. This failure could place residents at risk of not receiving the proper care and services due to inaccurate records. Findings include: Record review of Resident #7's admission record dated 12/3/24 revealed a she was a [AGE] year-old female with an initial admitted [DATE] and a re-admitted [DATE] with diagnoses of unspecified fracture of left femur unspecified fracture of left femur (broken left thigh bone, where the exact location of the fracture on the femur is not specified) and Parkinson's Disease without dyskinesia (Dyskinesias are involuntary, erratic, writhing movements of the face, arms, legs or trunk). Record review of Resident #7's Annual MDS assessment dated [DATE] revealed she had a BIM score of 3 out of 15 indicating severe cognitive impairment. Resident #7 was dependent and required substantial/maximal assistance with ADL's. The MDS assessment revealed that Resident #7 was on an anticoagulant and antiplatelet. Record review of Resident #7's care plan revealed a care plan for Antiplatelet therapy. Date Initiated: 11/13/2023. Revision on: 11/13/2023. Target Date: 02/12/2025. Record review of Resident #7's physician order summary report for December 2024 revealed there were no physician orders for anticoagulant or antiplatelet medication to be administered. During an interview on 12/3/24 at 12:17 PM with the MDS Coordinator, she said that she used the RAI manual for the policy for MDS assessments. An interview on 12/5/24 with the DON, she said that Resident #7 was not on an anticoagulant or antiplatelet. She said that the medication was discontinued before the MDS was done, she said that she would have the care plan and MDS corrected. She said a negative outcome would be staff not knowing the risk involved in the resident's care. Record review of the CMS's RAI Version 3.0 Manual dated October 2024 read in part . the assessment accurately reflects the resident's status . the RAI process is designed to enhance resident care, increase . and promote the quality of a resident's life.

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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** 32422 Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 5 residents (Resident #22 and Resident #65) reviewed for care plans. The facility failed to ensure Resident #22's comprehensive care plan addressed hospice. The facility failed to ensure Resident #65's comprehensive care plan addressed residing on the memory care unit. This deficient practice could affect residents by contributing to inadequate care. The findings included: Record review of the facility Admission Record dated 12/5/24 revealed that Resident #22 was a [AGE] year-old male with an initial admitted [DATE] and a re-admitted [DATE]. Resident #22 had diagnoses that included chronic obstruction pulmonary disease with acute exacerbation (a common lung disease that makes it difficult to breathe with a sudden worsening of COPD symptoms that lasts several days to weeks.) and encounter for palliative care (a specialized type of medical care that aims to improve quality of life for people with serious or life-threatening illnesses). Record review of Resident #22's Significant Change of Condition MDS assessment dated [DATE], revealed that Resident #22 had a Bim score of 13 out of 15 reflecting that he was cognitively intact or borderline with cognition. He required partial/moderate to supervision/touching assistance with ADL's. He also received hospice care which was reflected under special treatments/programs and procedures. Record review or Resident #22's care plan revealed a care plan for Do Not Resuscitate for his advanced directives date initiated 1/23/2023, revised on 9/25/24 with interventions that included to inform staff of code status, make sure code status is signed by appropriate parties and in the medical record and to monitor for decrease in change of condition-report to Medical Doctor and responsible party. Record review of the care plan revealed there was no care plan to address hospice care. Record review of Resident #22's December 2024 physician orders, an active order dated 7/12/2024 for hospice care consult. During an interview on 12/3/24 at 12:03 PM with the DON, she was asked if there was a comprehensive care plan for Resident #22 to address Hospice services, she said there was not but would have it added. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 12/5/24 at 12:25 PM with the DON, concerning Resident #22, she said there was no risk of not having hospice on the comprehensive care plan because he was still receiving hospice. The DON acknowledged that there was no care plan for Resident #65 to address residing on the memory care unit during this time. She said that the care plan process is an interdisciplinary process with all management involved. She added that the negative outcome for the lack of a comprehensive care plan would be staff not knowing the risk involved in the residents' care and behaviors of elopement and wandering without the plan of care. Resident #65 Record review of the facility Admission Record dated12/3/24 revealed that Resident #65 was a [AGE] year-old male, admitted on [DATE] with diagnoses that included encephalopathy (a general term for a brain disorder or disease that causes brain dysfunction) and Dementia without behavioral disturbances in other diseases classified elsewhere, Psychotic Disturbance, Mood Disturbance and Anxiety (this condition is characterized by moderate dementia that significantly impacts daily life and basic activities, requiring frequent assistance. Dementia without behavioral disturbances is less common than dementia with behavioral disturbances. Behavioral and psychological symptoms of dementia (BPSD) are a major part of dementia and include anxiety, agitation, depression, irritability, and more). Record review of Resident #65's Admission MDS dated [DATE] revealed a BIM score of 3 out of 15, severe cognitive impairment. He was dependent to requiring substantial/maximal assistance with ADL's. Resident #65 was assessed to exhibit feelings of being down, depressed, or hopeless for several days and behavior of wandering, presence, and frequency 1 to 3 days. Record review of Resident #65's care plan revealed care plans to address depression: which read in part . Resident #65 has a history of depression and is at risk for episodes of depression, adverse reactions, and depression driven behaviors. Date Initiated: 10/21/2024. Revision on: 10/22/2024. Record review of the care plans also included a care plan to address elopement risk/wanderer. Date Initiated: 11/07/2024. Revision on: 11/07/2024 Record review of Resident #65's care plan revealed there was no care plan to address residing on the memory care unit. Record review of Resident #65's December 2024 physician orders revealed an active order May admit to Memory Care dated 10/24/2024. During an interview on 12/3/24 at 12:17 PM with the MDS Coordinator, she said that she used the RAI manual for the policy for MDS assessments and that in the case of Resident #65, the Social Worker would have added the portion about Resident #65 residing on the memory care unit. During an interview o 12/3/2024 at 12:35 PM with the Social Worker, he said that he is responsible for the behaviors, wandering and he usually has the area of residing on the memory care unit as an intervention in the elopement/wandering portion of the care plan, he said the importance was for safety, prevention of elopement and exit seeking behaviors to promote safety. (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 the facility policy and procedure entitled Care Plans, Comprehensive Person-Centered, no date provided read in part .the Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident .The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .the comprehensive, person-centered care plan will: Include measurable objectives and timeframes .Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain nutrition, grooming and personal and oral hygiene for 2 of 6 residents (Resident #55 and Resident #28) reviewed for ADLs. The facility failed to ensure Resident #55, and Resident #28 was provided personal grooming(shaving) by facility staff. This failure could place residents at risk for discomfort, and dignity issues. Findings included: Resident #55 Record review of Resident #55's face sheet dated 12/03/24 revealed an [AGE] year-old female was admitted to the facility on 10//01/24. Resident #55 had diagnoses included: dementia (decline in thinking, remembering and reasoning), psychosis (lose touch with reality, heart failure(heart cannot pump enough blood to meet the body's needs), and anxiety disorder (experiences excessive feelings of fear, worry). Record review of Resident #55's admission MDS assessment dated [DATE] revealed Resident #55 had BIMS of 06 out of 15 which indicated severely impaired cognition. Further review revealed Resident #55 needed moderate assistance with ADLs. Record review of Resident 55's care plan dated 10/19/24 revealed Resident #55 had an ADL self-care performance. Interventions: - bathing/showing: The resident requires limited assistance by one staff. Personal hygiene: the resident requires supervision assist by one staff with personal hygiene. During observation and interview on 12/02/24 at 9:09 a.m., Resident #55 had white and black facial hair on her chain. Resident #55 said she needed to be shaved, and she told the aide who had showered her, but the aide did not shave her. Resident #55 said it may have been about a month since she last shaved when she came to the facility. During an interview on 12/02/ 24 at 3:14 p.m., LVN A said Resident #55 should be shaved during showers and as needed. LVN A said it would be very uncomfortable for Resident #55 if she were not shaved. LVN A said she had in-service for ADL. LVN A said she was not Resident #55 nurse, but she was covering for RN C because he went on break. During an interview on 12/02/24 at 3:17 p.m., RN C said what he knew was residents are shaved once every two weeks; RN C said he did not know who shaved the resident. RN C said Resident #55 would not feel happy if Resident #55 did not get shaved. RN C said he had not done any skills - check off on shaving or any in-service on shaving. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/02/24 at 3:22 p.m., RN C said he did not know who shaved female residents. RN C said if a female resident requested to be shaved, he would tell the DON and the management team would take care of the shaving. RN C said he told the DON last week that Resident #55 needed to be shaved, and the DON said she would schedule it. During an interview on 12/02/24 at 3:33 p.m., CNA E said residents are shaved during showers or when needed. CNA E said she made rounds when she came to work at 2:00 p.m. today (12/02/24) and did not notice Resident #55 had hair on her chain. CNA E said Resident #55 would feel bad if she wanted to be shaved and she was not shaved. CNA E went and looked at Resident #55 and returned and said she just saw the hair on Resident #55 chain. During an interview on 12/05/24 at 10:41 p.m., CNA D said Resident #55 shower days were Monday, Wednesday, and Friday. CNA D said the aides shaved or plucked on shower days. CNA D said Resident #55 would feel uncomfortable because she was not shaved. CNA D said the nurses monitored the aides when the nurses made random rounds. CNA D said she had skills - check off on ADL, which included shaving. CNA D stated the nurse in the hall monitored the aides when she made rounds. During an interview on 12/05/24 at 11:50 a.m., LVN I said the aides are responsible for shaving the residents on shower days and when facial hair was observed. LVN I said she worked with Resident #55 on Sunday (12/01/24) and did not notice any facial hair on her chain. LVN I said if Resident #55 wanted to be shaved and Resident #55 was not shaved, she would not be happy. LVN I said she monitored the aides when she came to work. LVN I said she would tell the aides to tell her if any resident refused to shower. LVN I said none of the aides had told her Resident # 55 refused to shave. LVN I said the ADON and the DON monitored the nurse when they made random rounds. During an interview on 12/05/24 at 3:02 p.m., the DON said the residents are supposed to get showered at least three times a week. The DON said she had not heard Resident #55 refuse to be shaved. The DON said the aides and the nurses should shave the residents on shower days, Sundays, and as needed. The DON said the nurse monitored the aides and made sure the residents were shaved when they made rounds, and the ADON and the DON monitored the nurses when they made random rounds. RESIDENT #28 Record review of Resident #28's sheet dated 12/04/24 revealed a [AGE] year-old female was initially admitted to the facility on [DATE] and readmitted o 09/29/23. Resident #43 had diagnoses included: end stage renal disease (kidney have permanently stopped working properly), hypertension (when the blood pressure in the blood vessels is too high), and blindness to the right eye category 3 (inability to or lack of vision). Record review of Resident #28's quarterly MDS assessment dated [DATE] revealed Resident #28 had BIMS of 10 out of 15 which indicated moderately impaired cognition. Further review revealed Resident #28 needed moderate assistance with ADLs. Record review of Resident 28's care plan revision dated 02/08/24 revealed Resident #28 had an ADL self-care performance deficit related to BKA. Interventions: - bathing/showing: The resident requires partial/moderate assistance by staff with (bathing/showering) (q 3x week) and as necessary. - personal hygiene: the resident requires supervision or touching assistance by staff with personal hygiene (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #28shower sheets from September through November 2024 revealed there was no section on the shower sheet if the resident was shaved and the aides did not document the resident refused to be shaved. During an observation and interview on 12/04/24 at 8:30 a.m., Resident #28 was sitting in her wheelchair, and observed white hair on her chin and under her chin. Resident #28 said her aide gave her a good bed bath, but she did not shave her. Resident #28 said she felt unkempt because she does not like facial hair. Resident #28 said she would have shaved herself, but she was blind on her right eyes, and she could not use razor blade. During an interview on 12/05/24 at 10:55 a.m., CNA G said she did not notice that Resident #28 had facial hair on and under the chain yesterday (Wednesday)morning when she assisted Resident #28. CNA G said Resident #28 should not have to ask any staff to shave her because the staff has to offer to shave Resident #28. CNA G said if the resident refused, the nurse should be notified and documented on the shower sheet. During an interview on 12/05/24 at 11:20 a.m., CNA H said Resident #28 showers are MWF. CNA H said Resident #28 preferred a bed bath, and she gave her a bath. CNA H said Resident #28 had facial hair on her chin and under her chain and refused to shave the hair. CNA H said the facial hair was more of a source of pride for her. CNA H said she did not know how Resident #28 would feel if she wanted to be shaved. CNA H said residents are shaved on shower days. CNA H said she had a skill - check off before she started to work on the floor. CNA H said the nurse monitored the aides on the floor when the nurses made rounds. During an interview on 12/05/24 at 12:00 p.m., LVN I said she was the nurse for Resident #28 yesterday (12/04/24). LVN I said she noted that Resident #28 had facial hair, and she offered to shave Resident#28, and Resident #28 said she was going to Dialysis. LVN I said she did not offer to shave Resident #28 when she came back from Dialysis yesterday. LVN I said she did not offer to shave Resident #28 this morning (12/05/24). During an interview on 12/05/24 at 3:09 p.m., the DON said she was unaware of Resident #28 refusing to be shaved or that her facial hair was a thing of pride for her. The DON said Resident #28 would be embarrassed to have facial hair if she did not want it. The DON said the nurses monitored the aides when the nurses made rounds, and the ADON made random rounds and monitored the nurses. Record review of facility RN/LNV skills checklist revealed RN C signed the checklist on 10/31/24. Record review of facility RN/LNV skills checklist revealed LVN A signed the checklist on 11/06/24. Record review of facility nurses aide skills performance checklist revealed CAN G signed the checklist on 03/07/24. Record review of the facility undated shaving the resident policy read in part .Purpose . The purpose of this procedure is to promote cleanliness and to provide skin care .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observations, interviews, and record reviews, the facility failed to ensure that a resident who was incontinent of bladder and bowel received appropriate treatment and services for 1 of 10 residents (Residents #29) reviewed for incontinent care, in that: CNA A did not clean Resident #29's groin, buttocks, or open labia to clean during incontinent care. CNA A used cleaning cloth wipe as the resident had bowel movement, and CNA A put the new brief under the resident's buttock without changing gloves, but the resident's buttock had residual of stool. These failures could place residents at-risk for infection due to improper care practices. The findings included: Record review of Resident #29's face sheet, dated 12/05/2024, reflected the resident was [AGE] years old, female, and admitted to the facility on [DATE] with diagnoses diagnosis of anxiety disorder (a condition that causes excessive worry and fear that interferes with daily life), history of falling, need for assistance with personal care, constipation, unspecified, major depressive disorder, dementia (a chronic condition that causes a decline in cognitive functioning) severity, with agitation, pain, unspecified osteoarthritis, (a degenerative joint disease, in which the tissues in the joint break down over time), mononeuropathy (damage to a single nerve, which results in loss of movement, sensation, or other function of that nerve), depressive disorder, anemia, protein-calorie malnutrition. Record review of Resident #29's admission MDS, dated [DATE], reflected the resident's BIMS score was 3 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was dependent to chair/bed-to-chair transfer and substantial/maximal assistance (helper does more than half the effort) to personal hygiene. Further record review of the MDS indicated Resident # 29 was frequent incontinent to bladder and bowel. Record review of Resident #29's care plan dated 10/23/24 reflected Resident #29 has an ADL self-care performance deficit, the goal was resident will improve current level of function in through the review date: Resident #29 requires required total assist with one person for bathing/showering, dressing, bed mobility, eating, personal hygiene/oral. Toilet use, transfer and follow principles of infection control and universal precaution to incontinent care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/03/2024 at 8:33 AM CNA A providing incontinent care to Resident #29. Resident #29 had small bowel movement. CNA A entered Resident #29's room did not wash hands before donning a clean gloves to perform incontinent care. Resident #29 was lying in bed on the scoop mattress awake. Resident #29's was left foot was contracted to the knee and left knee swollen resting on the right thigh. CNA A said Resident #29 could not extend her left foot and she was in a lot of pain when she tried to help her. CNA A said she did not know when the contracture started. CNA A explained procedure to Resident #29, she uncovered the resident, picked up a cleaned brief and wet wipes placed it on Resident #29's bed, then undid the soiled brief , using the draw sheet repositioned resident to her left side. Resident #29's had left foot contracted from the knee, with no separation device with left knee pressing resting on the right thigh. CNA did not open labia to clean and did not clean the groin. She removed the soiled brief and place on the floor, she open the clean brief and place under resident, CNA then threw the dirty wipes to a trash can across the foot of the bed and it fell on the floor, CNA picked the wipes from the floor and took the trash can. CNA A did not change gloves. CNA then pulled the cleaned brief to fasten, the brief had feces on it, CNA picked up a wet wipe and cleaned the feces on the brief and then fasten the same brief on Resident #29. CNA A did not cleaned the resident's buttock area completely and closed new brief to the resident. Interview on 12/03/2024 at 1:45 PM CNA-A said she just started working with facility in October 2024, stated should have cleaned the resident's buttock area and open the labia to clean but Resident was in a lot of pain. She said Resident #29 was only 1 person assist. CNA A said she saw residual fecal matter on the anal area. Interview with ADON on 12/5/24 at 10:10 AM, she said she had handwashing in-service, a month ago and she was not the one that trained CNA A. ADON said she does monitor CNAs randomly for incontinent care/infection control. Interview on 12/05/2024 at 4:55 PM with DON stated CNA A should have cleaned the resident's buttock area completely by several wipes because the resident had bowel movement. The DON said the ADON was responsible for overseeing incontinence care and monitor the care through skill check off for the CNA's. Record review of CNA A of personnel file revealed date of hired was 10/2024 and signed skilled check for incontinent care was done on 10/13/24. Record review of the facility policy and procedure, titled Perineal Care, revision date 02/2018, reflected . 3. If resident is heavily soiled with feces, turn resident on side and clean away feces with tissues, wipes, or incontinent brief. The policy did not address cleaning the labia and groin areaDiscard soiled gloves along with the soiled brief and/or wipes in trash bag. Cover the resident, provide safety measures and wash hands with soap and water.

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F 0697 Level of Harm - 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** 16352 Based on observations, interviews, 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' choices for 1 of 3 (Resident #29) residents reviewed for pain management. C.NA A failed to stop performing incontinent care while Resident #29 was in pain. C.NA A failed to notify the LVN B of Resident #29's pain in a timely manner after incontinent care in AM. This failure could place resident at risk for increased pain causing undo suffering. Findings included: Record review of Resident #29's face sheet, dated 12/05/2024, reflected the resident was [AGE] years old, female, and admitted to the facility on [DATE] with diagnoses of need for assistance with personal care, , pain, and unspecified osteoarthritis, unspecified site (a degenerative joint disease, in which the tissues in the joint break down over time),. Record review of Resident #29's admission MDS, dated [DATE], reflected the resident's BIMS score was 3 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was dependent to chair/bed-to-chair transfer and substantial/maximal assistance (helper does more than half the effort) to personal hygiene. Further record review of the MDS indicated Resident # 29 was frequent incontinent to bladder and bowel. Record review of Resident #29's care plan dated 10/23/24 reflected Resident #29 has an ADL self-care performance deficit, the goal was resident will improve current level of function in through the review date: Resident #29 requires total assist X1 for bathing/showering, dressing, bed mobility, eating, personal hygiene/oral. Toilet use, transfer and follow principles of infection control and universal precaution to incontinent care. Record review of physician's order dated 9/19/24 revealed Acetaminophen tablet 325 mg =Give 2tablets by mouth Q4 hours as needed for pain-Give 2 of 325mg tablets=650 mg Record review Resident #29's MAR documented Pain assessment dated [DATE] reflected Resident #29 used numerical scale. Administer medications as ordered if any pain verbalized/observed. No document of pain was administered. Record review of facility Pain assessment for months of November and December 2024 reflected Resident #29 did not have any documentation of have any pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Record review of Nurses note dated 12/3/2024 at 5:00PM reflected Note Text: Received Doppler results indicating positive for deep venous thrombosis in the right popliteal and mid femoral, and left middle femoral veins. NP made aware. No new orders received at the moment. NP will be in the building to see the resident. RP made aware. Will continue with plan of care. Record review of physician's orders dated 12/5/24 revealed Tramadol HCl Tablet 50 MG, Give 0.5 tablet by mouth two times a day for moderate to severe pain Give 0.5 of 50 mg tablet = 25 mg Observation on 12/03/2024 at 8:33 AM CNA-A providing incontinent care to Resident #29. Resident #29 had left foot contracted to the knee, , left knee pressing resting on the right thigh. C.NA A undid the soiled brief, while repositioning Resident #29 to her right side to clean her, resident was grimacing, moaning and saying No, No in pain, CNA A did not stop performing incontinent care, she continued to clean while Resident #29 was in pain. C.NA A repositioned to her left side, Resident #29 was grimacing, moaning and said No, No in pain. While C.NA A was fastening Resident #29's clean brief resident was grimacing and moaning in pain. Interview on 12/03/2024 at 1:45 PM C.NA A said she just started working with facility in October 2024, she stated Resident #29 was in a lot of pain. Interview with LVN B on 12/03/24 at 4:45 PM LVN B said she was not aware of Resident #29 being in pain during incontinence care and she was going to assessed resident and notified the NP. LVN B did call NP and obtain doppler order. In an interview with the DON on 12/05/24 at 12:52 PM she stated CNA A should have stopped incontinent when resident was in pain. The DON stated nurses were instructed to monitor for pain every shift. She stated the negative effects for not monitoring residents' pain would be the pain would be unmanaged. Interview with PT on 12/5/24 at 1:37 PM she said Resident #29 started having pain to her left knee over the weekend and doppler was done and she had DVT and he was applying the knee brace to her left knee to prevent contracture. Record review of facility policy titled Clinical Care-Pain undated reflected that . Procedure: Recognition: Identify Pain and Pain Risk, Predisposing Conditions: 1. The physician and staff will identify individuals who have pain or who are at risk for having pain. This includes a review of known diagnoses or conditions that commonly cause or predispose resident/patients to pain, for example, degenerative joint disease, rheumatoid arthritis, osteoporosis (with or without vertebral compression fractures), diabetic neuropathy, oral or dental pathology, and post-stroke syndromes. It also includes a review of any current treatments for pain, including all complementary (non-pharmacologic) treatments. Such assessments should occur on admission to the facility, periodically thereafter and, whenever there is a significant change in condition and at any time pain is suspected.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 36918 Based on observations, interviews, and record review, the facility failed to ensure that drugs and biologicals used in the facility were accurately acquired, received, dispensed, and administered in accordance with currently accepted professional standards and failed to remove medications for disposition from current medication supply that were discontinued or the residents had been discharged for 3 of 6 medication carts (100 and 200 hall MA medication cart C, 500 hall nurse cart A, and 400 hall nurse cart B) reviewed. 1. The facility failed to ensure 100 and 200 hall MA medication cart C did not contain discharged residents' medications. 2. The facility failed to ensure 500 hall nurse medication cart A did not have expired medications, discharged resident medication, and discontinued medications. 3. The facility failed to ensure 400 hall nurse medication cart B did not have expired medications, discharged resident medication and discontinued medications. These failures placed all residents at risk of harm or decline in health due to lack of potency of medications and expired medical supplies. The findings included: 100 and 200 hall MA medication cart C During an observation and interview of 100 and 200 hall MA medication cart C with ADON J and LVN B on 12/03/24 at 2:40 p.m., revealed the following medications: 1. Metoclopramide 5 mg two blisters which had 60 tablets 2. Atorvastatin 40 mg blister packet and it had 28 tablets 3. Metoprolol tartrate 25mg blister packet and it had 25 tablets 4. Potassium chloride ER 20meq blister packet it had 9 tablets 5. Amiodarone 200mg blister packet which had 26 tablets 6. Calcitriol 25mcg blister packet which had 26 tablets 7. Cinacalcet 30mg blister packet which had 13 tablets 8. Clopidogrel 75 mg blister packet which had 26 tablets 9. Folic acid 1 mg bottle had 26 tablets (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Furosemide 20mg blister packet had 22 tablets 11. Glipizide XL 10 mg blister packet and had 26 tablets 12. Januvia 25mg bottle had 12 tablets 13. Midodrine 3 mg blister packet had 30 tablets 14. Metoclopramide 5mg blister packet had 20 tablets 15. Metoprolol tartrate 25mg blister packet and it had 60 tablets 16. Furosemide 20mg blister packet which had 30 tablets 17. Clopidogrel 75 mg blister packet had 13 tablets were left in the cart after the residents were discharged from the facility. During an interview on 12/03/24 at 2:58 p.m., LVN B said the discharged resident's medication should be pulled from the cart by the medication aide, and the medication aide should have given the medication to the DON, and the DON would had placed the medications in the discontinued barrel. LVN B said the medications should have been pulled to prevent medication errors. LVN B said she had skills - check off on medication storage, and the ADON and the DON monitored the nurses during rounding. The DON and the ADON checked the medication cart for discontinued and discharged resident medications. During an interview on 12/06/24 at 1:00 p.m., MA D said all discontinued, discharged residents' medications should be removed from the cart so the medication aide would not have administered the medication to another resident, and it would be medication error. MA D said the nurse monitored the medication aide when the nurse made rounds. She said she had medication storage skills - check off. During an observation of 500 hall nurse medication cart A on 12/03/2024 at 3:53 p.m., with RN C and ADON J, it revealed the following medication: Breo Ellipta inhalation aerosol powder activated 200 - 25MCG/ACT had an open date of 10/05/24. During an interview on 12/03/24 at 4:25 p.m., RN C said Breo Ellipta had expired because the shelf life for opened foil was good for 6 weeks. RN C said if the nurse were to administer the medication to the resident after the open date expired, the medication would not be effective. RN C said the DON and the ADON monitored the nurses, and he had training on medication storage. During an interview on 12/05/24 at 7:51 p.m., ADON J said expired medication should be pulled from the cart to prevent nurses from administering expired medicines, which could cause harm to the resident. During an observation and interview of 500 hall nurse medication cart A with ADON J and RN C on 12/03/24 at 4:01 p.m., revealed the following medications: The control compartment contained a discharged residents' medications: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Acetaminophen - Codeine 300 - 30mg blister packet had 15 tablets 2. Tramadol 50 mg blister packet had 29 tablets. The control compartment contained discontinued residents' medications: 1.Clonazepam 0.5mg blister packet had 15 tablets 2. Clonazepam 0.5mg blister packet had 30 tablets During an interview on 12/03/24 at 4:01 p.m., RN C said discontinued control medications and discharged resident control medications should be removed from the cart to prevent medication errors and stolen medication. RN C said he had a skill check-off on medication storage, and the ADON and the DON monitored the nurses during random rounds. During an interview on 12/05/24 at 1:41 p.m., the DON said the nurse should have removed the medication from the control box from the medication cart as soon as the medicine was discontinued. The DON said the nurse would bring the discontinued control medication to her, and they would count it, and she would lock it up behind two locks in her office. The DON said the medications could be stolen or an error if given to another resident. During an observation of 400 hall nurse medication cart B on 12/03/2024 at 3:53 p.m., with LVN A and ADON J, revealed the following medications were expired: Albuterol Sulfate 0.083% was dated 08/11/24, and it had 15 vials. Lantus insulin pen was dated with an open date of 10/28/24, and it was also dated the open pen was good for 28 days from the opened date. During an interview on 12/03/24 at 5:20 p.m., ADON J said the breathing treatment (Albuterol Sulfate 0. 083%) had expired because the opened medication foil expired 30 days after it was opened. ADON J said medications would not be as effective for the reason the physician prescribed the drug for the resident. ADON J said the Lantus insulin pen expired 28 days after the medication was opened, and the medicine would be ineffective because the resident blood sugar would not be controlled. Interview on 12/05/24 at 8:20 a.m., ADON K said insulin pens were dated when opened to prevent nurses from administering expired insulin which could cause adverse reaction. ADON K said opened insulin pen was good for 30 days and if the medication was administered to any resident the medication would not effective because the resident blood sugar would still be elevated. During an interview on 12/05/24 at 8:37 a.m., ADON K said open breathing treatment foil was good for 2 weeks, and if it was given after 2 weeks, then the medication would not be effective, and the resident could also have an adverse reaction. ADON K did not respond when asked what adverse reaction the resident could get. During an interview on 12/05/24 at 2:48 p.m., the DON said the insulin pen was good for 28 days after the pen was opened and the insulin pen should be taken out from the cart when it was expired. The DON said if the resident was administered the expired insulin, the resident would not get the full effect of the medication, and the resident's blood sugar would still be high. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/06/24 at 8:32 a.m., LVN A said expired insulin should be removed from the care to prevent administering the expired insulin because the resident blood sugar would not be controlled. LVN A said the resident blood sugar would remain high, and it could cause an adverse reaction. LVN A said she had a skills check-off, which included medication storage. LVN A said the DON and the ADON monitored the nurses when they made random rounds. During an observation and interview of 400 hall nurse medication cart B with ADON J on 12/03/24 at 4:40 p. m., revealed the following medications: Discontinued resident medication left in the medication cart: fluticasone propionate and salmeterol inhalation powder 100mcg/50mcg discharged residents' medications left in the medication cart: Levetiracetam 11mg/ml, two bottles two full bottles of Lactulose 10mg/15ml, 473ml each Ipratropium Bromide and Albuterol Sulfate Inhalation Solution had five foil packets. During an interview on 12/05/25 at 7:47 a.m., ADON J said the discontinued and discharged medications should come off the cart and the nurses should give the medications to the DON. ADON J said the DON locked the medication in her office. ADON J said the medications were pulled to prevent drug diversion and proper use of medications. During an interview on 12/05/24 at 7:52 a.m., ADON J said the open breathing treatment foil should be dated by the nurses because the medication would not be effective if it had passed its use-by date. During an interview on 12/05/24 at 8:28 a.m., ADON K said discharged residents' medications were placed in the pharmacy return box in the DON's office. ADON K said discharged residents' medications were pulled to prevent the nurse from administering the medication to another resident and from drug diversion. During an interview on 12.05.24 at 8:30 a.m., ADON K said the nurse should give discontented and discharged resident's control medication to the DON, and she would lock the medications behind two locked compartments. ADON K said the discontinued narcotic medications have much more adverse reactions and to prevent drug diversion. ADON K said the unit supervisor, who would be her, should supervise the nurses when she did the medication review, and she said she did the review once a week. ADON K said the nurses were trained on medication administration and medication storage before the nurse started medication administration. Record review of the facility undated policy on pharmacy services overview H5MAPL30 read in part . policy interpretation and implementation #3l .help the facility develop a process for receiving, transcribing, and recapitulating medication . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of manufacturer of Lantus on lantus.com read in part . After 28 days, throw your opened Lantus pen away-even if it still has insulin in it . https://www.lantus.com/dam/jcr:817aed9c-a677-4cd6-a6b3-d93d8aba629a/lantus-solostar-pen-guide.pdf

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observations, interviews, and record review, the facility failed to ensure residents were free from any significant medication errors for 1 of 9 residents (Residents #39) reviewed for significant medication errors. - RN C failed to administer medications as ordered to Resident # 39 by attempting to administer crushed potassium CL micro 20meq ER, which had the instruction, do not crush as ordered. This failure could place residents at risk of abnormal heart rhythms, and potential hospitalization . The findings were: Resident #39 Record review of Resident #39's face sheet dated 12/05/24 revealed a [AGE] year-old male resident that was admitted to the facility on [DATE]. Resident #39 had diagnoses included: heart failure (when the heart cannot pump enough oxygen - rich blood to meet the body's needs), hypokalemia (lower than normal potassium level in the bloodstream), dementia (decline in thinking, remembering, and reasoning), and gastrostomy (a small opening into the abdomen and inserted a tube directly into the stomach allowing for food and liquids to be delivered directly into the stomach). Record review of Resident #39's physician order for December 2024 read in part . Potassium Chloride Crys ER 20 MEQ Tablet extended release Give 1 tablet via PEG-Tube one time a day for low potassium order date 11/01/24 . During an observation and interview on 12/03/24 at 9:50 a.m., the state surveyor intervened when RN C was about to administer crushed potassium ER to Resident #39. RN C said he had been administering crushed potassium ER to Resident #39 because the resident had a G tube. RN C said he knew that potassium ER was not supposed to be crushed, but the only way to give the medication through a G tube was to crush it. RN C said he did not know what could have happened to Resident #39 if he had administered the crushed potassium. RN C said the ADON, and the DON monitored the nurses when they made random rounds. RN C said he had skills - check off for medication administration before he started administering medications. During an interview on 12/05/24 at 1:34 p.m., the DON said potassium ER was not supposed to be crushed because it breaks down the extended-release, and the medication would be released at once. The DON said Resident #39 could not be getting the dosage required to maintain his potassium level, and Resident #39 could have signs and symptoms of hypokalemia. The DON said the ADON monitored the nurses when the ADON or herself made random rounds. The DON said the nurses had skills - check off for medication administration before the nurses passed out medication to residents. The DON said the skills check included crushed and do not crush medications. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility undated policy on medication administration and management read in part . step 111: administering the medication pass .#6 the authorized licensed or certified/permitted medication aide . seeks assistance from the nursing supervisor/designee and consulting pharmacist when any aspect of medication administration is in question . #7 E . medications which cannot be crushed: #2 . or extended - release tablets .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 36918 Based on observation, interview, and record review the facility failed to ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 of 6 medication carts (500 hall nurse cart A and 400 hall nurse cart B), and failed to ensure all drugs and biologicals were stored securely in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 3 medication carts (400 hall nurse medication B) reviewed for medication storage -The 500-hall nurse medication cart A contained opened undated medication and medication not stored in the original packaging delivered from the pharmacy. -The 400 hall nurses medication cart B contained opened and undated medication, medication not stored in the original delivered packet from the pharmacy, and handwritten resident's name on medication container. -LVN A left 400 hall nurse medication unlocked on 400 hall and to attend to Resident #20. These failures placed all the residents at risk of receiving expired, drug diversion, and improperly stored medications which could result in delayed healing. Findings Included: During an observation and interview of 500 hall nurse medication cart A with ADON J and RN C on [DATE] at 4:01 p.m., revealed the following medications: Opened and undated medication: Levetiracetam 100mg/ml bottle. 3 boxes of Ipratropium bromide and albuterol foils were opened. Insulin pens that were not stored in the original packets, and it did not have the manufactures and physician's instruction on the pens: Humalog kwikpen Fiasp Flex Touch Tresiba Flex touch (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Basaslar kwikpen During an interview on [DATE] at 4:16 p.m., ADON J said the nurse should store insulin pens in the original packets they were delivered from the pharmacy because the packet had information from the pharmacy, instructions from the manufacturer, and the physician administration instructions which would prevent resident being administered wrong dose or expired insulin. ADON J said the ADON monitored the nurses during random rounding. ADON J said the nurse had skills - checkoffs on medication storage before the nurse administered medication. During an interview on [DATE] at 4:20 p.m., RN C said the insulins should be in the original packets from the pharmacy because they had instructions from the physician on how to administer the medication and the manufacturer information, such as the expiration date. RN C said it was the nurse's responsibility to had stored the insulin pens in the original packet. RN C said he had skills - check off for medication storage before he started medication administration. During an observation and interview of 400 hall nurse medication cart B with ADON J on [DATE] at 4:40 p.m. , revealed the following medications: Opened medication and not dated: Fluticasone 50mcg/act spray Resident name was hand written on the medication container, the container was open and not dated: Breo ellipta 200mcg/25mcg Insulin pens not stored in the original packet, and it did not have the manufactures and physician's instruction on the pens: 2 Lantus insulin pen 1 Humalog insulin pen During an interview on [DATE] at 7:52 a.m., ADON J said the open breathing treatment foil should be dated by the nurses because the medication would not be effective if it had passed its use-by date. During an interview on 12.05.24 at 8:46 a.m., ADON K said the medication aides and nurses should store all medications in the original packet in which the medication was delivered from the pharmacy. ADON K said medication should have the resident information printed from the pharmacy and not handwritten. ADON K said the insulin pens should be stored in the packet that the pharmacy delivered the medication because it should have the manufacturer's instructions and physician's administration instructions . During an interview on [DATE] at 2:53 p.m., the DON stated the nurses should date the opened breathing treatment foil. The DON said if nurses opened the breathing treatment foil and the nurse did not date the medication, then the resident could be given expired medication. The DON said the medicines would not be effective for the treatment it was ordered. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:55 p.m., the DON said the nurses should have stored the insulin pens in the original packet because it had all the instructions from the manufacturer and physician order. The DON said it should be stored to prevent the wrong medication from being administered. During an interview on [DATE] at 2:57 p.m., the DON said medications should not be used or stored with handwritten names and should be removed from the cart because it was not acceptable because the medication did not have instructions from the pharmacy, and it could be another resident medication or even expired. Observation on [DATE] at 8:58 AM Resident#20 was lying in bed. ADON J (treatment Nurse) requested LVN B to premedicate before performing the pressure ulcer treatment. LVN B left the medication cart unlocked on the hallway and went to attend to another resident. She then went to the DON's office to clarify a medication order for Resident #20. At 9:03 AM LVN B came back to the cart to attend to Resident #20. In an interview with LVN B on [DATE] at 9:03 AM, regarding unlocked medication cart, she said please [NAME] me, I forget, I know the medication cart should be locked, so residents would access to it. Interview with the DON on [DATE] at 4:30 PM regarding medication cart left unlocked and unattended, she said medication cart should be kept locked at all time and leaving the cart unlocked was not apart of the facility practice.The DON stated she would immediatley in- service remaining nursing staff on the hall. Record review of the undated facility policy titled, nursing polices and procedures read in part It is the policy of this facility that the facility will implement a medication management program that incorporates systems with established goals to meet each resident's needs as well as regulatory requirements . Record review of the facility policy undated and titled, pharmacy services overview HM5APL0630 read in part policy interpretation and implementation .#3a .develop, implement, evaluate, and revise (as necessary) the procedures for the provision of all aspects of pharmacy services including ordering, delivery and acceptance, storage, distribution, preparation, dispensing, administration, disposal, documentation, and reconciliation of all medications and biologicals in the facility .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32422 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 1 of 1 kitchen (Kitchen #1) reviewed for food procurement. 1. The facility failed to ensure foods were dated as opened/prepared and discarded after 72 Hours (3 days) per facility policy in Kitchen #1 2. Discolored and debris covered kitchen ceiling vents 3. Discolored shelves in refrigerators This failure could place residents at risk of food borne illness and disease. Findings Include: Observation of the facility kitchen on [DATE] at 8:04 AM revealed the following. 1. A large rectangular pan with gelatin and fruit in the refrigerator/cooler uncovered and undated/labeled. 2. A square pan of pureed carrots that were not dated. 3. [NAME] residue and dust particles over serving table and food preparation areas in the kitchen. 4 The ice machine was observed to have stains and appearance of rust on the inside and outside of the machine. There was also a puddle of water in front of the water machine observed 3 times throughout observations on [DATE],[DATE] and [DATE]. 5. There were missing tiles (unknown number) on wall above 3-sink area and on lower wall to the right of the 3-sink area. Multiple spaces (unknown number) by sink area have dried stains on walls. 6. The Fryer was caked with stains, the grease in the fryer had multiple particles of food. An observation on [DATE] at 08:05 AM, revealed in the kitchen area brown and black like discoloration on the white ceiling tiles throughout the area, black like particles covering the white ceiling vents throughout the kitchen including vents over the food and prep counters and dish storage room, several missing tiles in the 3-sink area on the white wall, buckling wall and tiles in the 3-sink area, and multiple areas in the 3-sink area had what appeared to be dried food and/or discoloration on the wall. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 8:05 AM, in an interview with the Dietary Manager she stated we are planning to clean the whole ceiling and kitchen from top to bottom probably on Wednesday ([DATE]). During this observation the Dietary manager and Surveyor A observed the following: over the serving and preparation areas there was brown particles on the ceiling tiles, the Dietary Manager said it was dust. During observation of the missing tiles on the wall above the 3-sink area and multiple spaces by sink area having dried food or stains, the Dietary Manager confirmed that they were going to have a deep clean of the entire kitchen from top to bottom on the week of [DATE]. The Dietary Manager said she had been employed since May of this year (2024), and the kitchen had not been deep cleaned since she had been here to her knowledge. She stated the repairs that had been made were the tea/coffee maker and they (kitchen staff) were using a percolator right now. In a observation of the refrigerator there of was a large pan of gelatin, orange in color, the Dietary Manager acknowledged that the substance was Jello with peach chunks in it, she acknowledged that the Jello was uncovered and undated. The Dietary Manager said the Jello was prepared on [DATE] for lunch and the food should have been covered and dated to prevent cross contamination and to avoid making residents sick. During this observation there was also one pan of an orange substance labeled pureed carrots undated. During an interview with the Dietary Manager, she explained that the risk of serving outdated food was possible and this could lead to residents becoming sick. The Dietary Manager also acknowledged the consistent water puddle in front of the ice machine, she said it was from filling the ice machine. Observation of the deep fryer revealed there were multiple drippings of unknown substances on sides of the machine, there were multiple particles of unknown substance inside the oil which appeared to be deep brown in the fryer and caked onto the sides of the fryer and fryer basket. An observation on [DATE] at 11:33 AM, revealed in 1 of 1 kitchen all vents throughout the kitchen and dish room/dish storage area appeared to be covered in black thick like resin. Ceiling above handwashing station near pipes and fire suppression system mechanical release module appeared to be covered with a rust like coloring in various locations. Wall entering the dish room had green and red like substances on the wall. Tiles in dish room/dish storage are missing in various location exposing the wall and sheetrock. Serving ladles hanging off dish rack in in dish storage room appear to be covered in a white and black resin/particles. Vents located over 1 of 2 food prep tabled covered in a thick black like resin. Two of 2 resisted refrigerators appeared to have rusted areas on the white coated shelving. Food items (milk, juice, chopped garlic, vegetable and chicken base, cheese sauce, and beans) sitting on shelves in refrigerator. Two-section plate warmer holding plates with [NAME] like particles all around the rim of both sections. In an interview and observations on [DATE] at 08:05 AM, Dietary Manager (DM) stated that she began working at the facility in May of 2024. She stated that the facility had planned to clean the entire ceiling probably on [DATE], which would include the vents and brown particles on the ceiling tiles. The DM stated the brown particles covering the vents were dust and that there were missing tiles on wall above the 3-sink area. She stated since being employed; the staff had not performed a deep cleaning in the kitchen. She stated the water puddle in front of ice machine, was from ice that had fallen and melted after filling the ice machine and denied any water leaks or back flow issues. She stated that the facility would clean the kitchen from top to bottom [DATE]. A kitchen cleaning schedule had been requested and not received. During an interview on [DATE] at 9:52 AM, the Dietary Manager said that the food identified that was uncovered and unlabeled could have gotten full of bacteria and so she had staff throw those items away. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and Interview on [DATE] at 11:30 AM with the Dietary Manager , she said that they (unknown) will come clean the kitchen from top to bottom on ([DATE]) she added that the ice machine was cleaned last night, though the ice machine appeared to continue to have stains and rust like areas, she said that after the ice machine was cleaned, that was the outcome of the cleaning. A cleaning schedule was requested from the Dietary Manager and the Administrator. The Dietary Manager said the deep fryer was scheduled to clean the grease this week. In an interview on [DATE] at 02:31 PM, the Administrator and the DON were shown pictures of all the areas of concern in kitchen. The Administrator stated that the FMD had already begun painting discolored tiles throughout the facility. He stated that he would meet again with the FMD and the Housekeeping supervisor to address the concerns observed. Record review of the kitchen cleaning schedule for [DATE] revealed that from [DATE] through [DATE] the deep fryer initialed that the equipment was cleaned daily and checking labels, dates and discarding expired food from the freezer and refrigerator (cooler) was performed daily on both the AM and PM shifts. Record review of facility policy and procedure entitled Food Receiving and Storage no date provided read in part . Foods shall be received and stored in a manner that complies with safe food handling practices .All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date). Record review of the cleaning policy entitled Sanitization of Equipment dated ,d+[DATE] read in part .the facility will maintain the ice machine and scoop in a sanitary manner to minimize the risk of food hazards. The ice machine will be cleaned one per month or more often as needed .the facility will maintain the deep fryer in a clean and sanitary way to minimize the risk of food hazards .through cleaning will be done once a week or as needed .clean out remaining debris .fill the well with fresh oil. 44669

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 16352 Based on interviews and record review, the facility failed to electronically submit to CMS a complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS reviewed for administration (Fiscal year 2024 for the first quarter March 1, 2024 to November 30, 2024). The facility failed to submit PBJ staffing information to CMS for the 4th quarter of the fiscal year 2024. The facility's failure could place residents at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feelings of well-being within their living environment. Findings included: Review of the CMS PBJ report for FY Quarter 1 2024 (March 1- November 30) indicated the facility did not have licensed nursing/staff coverage 24 hours/day . In an interview with the Administrator on 12/06/24 at 1:17 PM he said he knows the PBJ was submitted and he was not sure if the BOM (Business office manager) did it or the DON, but he was going to check. In an interview with the BOM on 12/6/24 at 1:20 PM she said she did send the staffing time for the dietitian, the pharmacist, and PT (physical therapist) to the corporate. She stated she was not sure what the corporate office did with the time she sent, and she did not have the documentation for PBJ (Payroll-Based Journal). BOM said it could affect residents by not having enough staffs to provide the care they need. In an interview with the Administrator on 12/6/ 24 at 1:30PM, he said that corporate just called him at 1:25PM and that the PBJ was not submitted for about 2 quarters, that corporate just informed him that they would take the tag, and that corporate just fired the company group who was supposed to summit to CMS. The Administrator said his expectation was for corporate to do what they supposed to do by doing their job. Requested the facility policy for PBJ on 12/06/24 at 1:30 PM and 4:30PM from the Administrator, he said he did not have any policy.

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	675700	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookshire Residence and Rehabilitation Center	710 Hwy 359 S Brookshire, TX 77423

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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** 16352 Based on observations, interviews, and record review, the facility did not maintain an infection prevention program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 Staff (CNA A) reviewed for infection control. - The facility failed to ensure CNA A followed proper hand hygiene during incontinent care. These deficient practices could affect residents and place them at risk for infection, and reinfection. Findings included: Record review of Resident #29's face sheet, dated 12/05/2024, reflected the resident was [AGE] years old, female, and admitted to the facility on [DATE] with diagnoses that included anxiety disorder (a condition that causes excessive worry and fear that interferes with daily life),) gastro-esophageal reflux disease without esophagitis (gastric reflux), history of falling, need for assistance with personal care, constipation, unspecified, major depressive disorder, recurrent (a mental health condition that involves persistent feelings of sadness, hopelessness, and a lack of interest in activities) severe with psychotic symptoms (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), dementia (a chronic condition that causes a decline in cognitive functioning, such as thinking, remembering, and reasoning to the point that it interferes with daily life) severity, with agitation, pain, unspecified osteoarthritis, unspecified site (a degenerative joint disease, in which the tissues in the joint break down over time), atherosclerotic heart disease of native coronary artery without angina pectoris (a condition where a buildup of plaque in the coronary arteries narrows blood flow to the heart without causing chest pain), hyperlipidemia (a condition where there are too many fats or lipids in the blood), essential (primary) hypertension (a condition where the pressure of your blood is consistently higher than normal), vitamin deficiency, and primary insomnia (lack of sleep), mononeuropathy (damage to a single nerve, which results in loss of movement, sensation, or other function of that nerve), depressive disorders (a common mental disorder. it involves a depressed mood or loss of pleasure or interest in activities for long periods of time), anemia (a condition in which the body does not have enough healthy red blood cells) unspecified protein-calorie malnutrition, and acute myocardial infarction (a medical emergency that occurs when blood flow to the heart muscle is blocked, causing tissue damage and potentially death). Record review of Resident #29's admission MDS, dated [DATE], reflected the resident's BIMS score was 3 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was dependent to chair/bed-to-chair transfer and substantial/maximal assistance (helper does more than half the effort) to personal hygiene. Further record review of the MDS indicated Resident # 29 was frequently incontinent to bladder and bowel. (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 #29's care plan dated 10/23/24 reflected Resident #29 has an ADL self-care performance deficit, the goal was resident will improve current level of function in through the review date: Resident #29 requires total assist X1 for bathing/showering, dressing, bed mobility, eating, personal hygiene/oral. Toilet use, transfer and follow principles of infection control and universal precaution to incontinent care. Observation on 12/03/2024 at 8:33 AM of CNA-A providing incontinent care to Resident #29. Resident #29 had small bowel movement. CNA A entered Resident #29's room and did not wash hands before donning clean gloves to perform incontinent care. Resident #29 was lying in bed on the scoop mattress awake. Resident #29's left foot was contracted to the knee and the left knee was swollen resting on the right thigh. CNA A said Resident #29 could not extend her left foot and she was in a lot of pain when she tried to help her. C.NA A explained the procedure to Resident #29. She uncovered the resident, picked up a clean brief and wet wipes, placed it on Resident #29's bed, then undid the soiled brief, using the draw sheet repositioned the resident to her left side. C.NA A did not open labia to clean, she removed the soiled brief and placed it on the floor, she opened the clean brief and placed it under the resident, CNA A then threw the dirty wipes to a trash can across the foot of the bed and it fell on the floor, and CNA A then picked the wipes up from the floor to the trash can. CNA A did not change gloves. CNA A then pulled the clean brief to fasten it, the brief had feces on it, CNA A picked up a wet wipe and cleaned the feces on the brief, and then fastened the same brief on Resident #29. CNA-A did not clean the resident's buttock area completely and closed the new brief on the resident. C.NA A used the same gloves throughout the procedure. On 12/3/24 at 8:42AM., C.NA A took off the dirty gloves without washing her hands, went to the clean linen packed cart in the hallway, and got clean linen to change Resident #29's bedding. In an interview on 12/03/2024 at 1:45 PM CNA-A said she just started working with facility in October 2024. She stated she should have cleaned the resident's buttock area and opened the labia to clean, but Resident #29 was in a lot of pain and she forgot to change gloves and wash her hands. She said Resident #29 was only 1 person assist. In an interview with ADON K on 12/5/24 at 10:10 AM, she said she had a handwashing in-service a month ago and she was not the one that trained CNA A. ADON K said she did monitor CNAs randomly for incontinent care/infection control . ADON K's expectations was for staff to perform hand hygiene before and after contact with Residents in the facility. In an interview on 12/05/2024 at 4:55 PM the DON stated C.NA A should have cleaned the resident's buttock area all round by using several wiping because the resident had bowel movement . The DON said the ADON was responsible for overseeing incontinence care and monitor the care through skill check offs for the C. NA's. Record review of C.NA A of personnel file revealed date of hire was 10/2024 and a signed skilled check was done on 10/13/24. (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 the facility's policy titled Handwashing/Hand Hygiene (revised 10/23) revealed: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 2. All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; Or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin; m. After removing gloves; 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare associated infections.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observations, interviews, and record review the facility failed to conduct regular inspections and maintenance of resident bed frames, mattresses, and bed rails, leading to potential entrapment hazards for 1 (Resident #3) of 6 residents reviewed for safety in rooms. The facility failed to conduct regular inspections of resident bed frames and mattresses to identify risks and problems. Resident #3's bed had a significant gap between the mattress and bedframe. These failures could place residents at risk of injury resultant from equipment malfunction, entrapment, or falls. The finding included: Record review on 12/04/24 at 9:00 am of Resident #3's admission face sheet revealed she was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses that included bipolar disorder, current episode manic severe with psychotic features (a serious mental illness that causes extreme mood swings, along with changes in energy, thinking, behavior, and sleep) type 2 diabetes mellitus with hyperglycemia (high glucose in the blood), other specified hypothyroidism, essential tremor, major depressive disorder, epilepsy (a disorder of the brain characterized by repeated seizures), not intractable, with status epilepticus, elevated white blood cell count, unspecified, unspecified fall, subsequent encounter, unspecified fracture of t11-t12 vertebra (compression fractures of the spine usually occur at the bottom part of the thoracic spine), and muscle wasting and atrophy, not elsewhere classified, unspecified site, other lack of coordination. Record review of Resident #3's MDS dated [DATE], revealed a BIMS score of 13, which indicated slight cognitive impairment to make decisions . Section GG (function abilities) revealed Resident#3 needed substantial assistance for bed mobility. Record review of Resident #3's care plan 10/1/23 revealed the resident required supervision or touching assistance by staff with personal hygiene. The resident required supervision or touching assistance by staff to turn and reposition in bed as needed, sit to lying: the resident required supervision or touching assistance by staff to turn and reposition in bed as necessary. Lying to sitting: the resident required supervision or touching assistance by staff to turn and reposition in bed as necessary. - Sit to stand: the resident required supervision. Observation on 12/2/24 at 8:30 AM Resident#3's bed mattress had gaps at the foot and head of the bed. There were gaps between the mattress and bed frame. Observation and interview on 12/03/2024 at 11:00 AM revealed Resident #3 sitting in a manual wheelchair at bedside. Resident #3 had a skin tear to his right lateral arm, left swollen 4th finger, and was slightly contracted and he stated it was painful to extend the finger. In an interview with Resident #3 on 12/3/24 at 11:15AM, he said he fell 3 days ago about 1:00 AM out of bed. Resident said he notified the social worker. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3's mattress was not fitting well on the bed, there was a gap (bed frame and the mattress) at the head of the bed (mattress gap from the bed frame was 4 inches and foot of the bed was 2 inches). In an interview with the DON on 12/4/24 at 12:00 PM regarding Resident #3's bed, the DON said when the HOB was elevated it moved the mattress and it was the right mattress (the mattress only shift if the bed was raised). She was going to have in-services with the staff to ensure all nursing staff checked the mattresses and ensured that the mattress fits well on the bed . During an interview on 12/05/2024 at 4:30 PM with the Administrator, he stated he expected any staff member who saw the mattress and bed frame were mismatched to report it to maintenance. The Administrator stated the maintenance team and nursing staffs were responsible for monitoring the equipment and making sure the frames and mattresses monthly as well and the bedframe fits well. The Administrator stated the risks of the wrong mattress on a bed frame could range from the bed mechanics being impacted, linens would not fit correctly, to the resident experiencing discomfort.