STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675740	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knopp Nursing & Rehab Center Inc	202 Billie Dr Fredericksburg, TX 78624

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564 Based on interview and record review, the facility failed to ensure residents and/or the residents' representatives the right to participate in the development and implementation of his or her person-centered plan of care for 1 of 6 residents (Resident #28) reviewed for care plans. The facility failed to invite and include the input of Resident #28 and/or residents' representative as members of the interdisciplinary team in Care Plan Conference meetings. This failure could place residents at risk of not receiving the interventions, treatments, and care necessary for the resident to reach their highest practicable physical, mental, and psychosocial well-being by not involving the resident and/or the residents' representative in Care Plan Conference meetings. The findings included: Record review of Resident #28's face sheet, dated 10/18/2024, reflected a [AGE] year-old male resident initially admitted on [DATE] with diagnosis including diabetes mellitus, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (a condition that affects one side of the body after a stroke causing paralysis), and dysphagia (difficulty swallowing). No diagnosis of dementia was present on Resident #28's face sheet. Record review of Resident #28's MDS Assessment, dated 10/8/2024, reflected Resident #28 had a BIMS score of 8, suggesting moderate impairment. No diagnosis of dementia was present on Resident #28's MDS assessment. During an interview on 10/14/2024 at 12:39 PM, Resident #28 and FM stated that they had not been invited to any care plan conference meeting prior to the one they were invited to which was being held that day, 10/14/2024. Resident #28's wife stated she was confident she had not been invited to any care plan conference meetings around the time Resident #28 arrived at the facility because she visits almost daily and would not have missed any care plan conference meeting or any meeting that related to Resident #28. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/18/2024 at 4:42 PM, the ADON, DON, and ADM, the ADON stated that she had a folder with care plan conference invitations in them. No invitation for Resident #28 and/or Resident #28's family member was found in the folder. The ADON stated that she was confident the facility invited Resident #28 and/or Resident #28's family member to their care plan conference meeting, but that Resident #28 and Resident #28's FM likely had dementia. The ADM stated that her expectation is for residents and their family members be involved in their care plan conference meetings. Record review of Resident #28's Electronic and Paper Health Record did not reflect any care plan conference invitations for any care plan conferences prior to 10/14/2024. Record review of facility policy, dated copyrighted 2005, titled, Care Plan/Comprehensive Interdisciplinary, reflected, The interdisciplinary team shall develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment. The interdisciplinary team shall include: Resident (if possible), Residents family or POA, Social Worker, Dietary supervisor, Activities staff member, Director of Nurses, Any other staff member pertinent to residents care at the time.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on interviews and record reviews the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective se rvices where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures, for 3 of 8 residents (Residents #5, #17, and #140) reviewed for reporting allegations of abuse, neglect, and exploitation. 1. The administrator failed to report an allegation of neglect, with serious injury, when Resident #140 was assisted with a mechanical lift transfer by 1 staff member, CNA A. Resident #140 fell during the transfer, suffered a broken right leg, and was hospitalized with a need for surgical repair. Prior to the fall Resident #140 was assessed with a need for more than 1 staff for assistance with transfers. 2. The administrator and the Social Worker failed to report an allegation of abuse on behalf of Resident #17. Resident #17 reported to CNA M, when she (Resident #17) was out on pass with a family member, she was nude and scared by a drunken, bloodied , family member and had to crawl to safety. 3. The administrator and the Social Worker failed to report an allegation of neglect on behalf of Resident #5 when CNA M alleged Resident #17 removed Resident #5's oxygen nasal cannula and oxygen concentrator because Resident #17 stated it was too loud and she (Resident #17) could not fall asleep. This deficient practice could place residents at risk for harm by not reporting allegations of abuse, neglect, and exploitation to the state agency. The findings included: 1. A record review of Resident #140's admission and discharge record dated [DATE] revealed an admitted [DATE] and a discharge date of [DATE] with diagnoses which included dementia (a group of symptoms affecting memory, thinking and social abilities. In people who have dementia, the symptoms interfere with their daily lives), psychotic disturbance (a condition of the mind or psyche that results in difficulties determining what is real and what is not real), mood disturbance and anxiety. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #140's quarterly MDS assessment dated [DATE] revealed Resident #140 was an [AGE] year-old female admitted for long term care and assessed with a BIMS score of 01 out of a possible of 15 which indicated severe cognition impairment. Further review revealed Resident #140 was assessed as Dependent - helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the Resident to complete the activity for all of Resident #140's needs for transfers, sit to stand, chair / bed to chair transfer, and toilet transfers. A record review of Resident #140's care plan dated [DATE] revealed, (Resident #140) is dependent on staff for meeting . physical . needs . related to dementia . the Resident needs assistance / escort to activity functions A record review of the facility's fall incident report dated [DATE] revealed Resident #140 suffered a fall during a 1-person mechanical lift transfer . During an interview on [DATE] at 03:00 PM, the ADON stated Resident #140 was discharged to the hospital on [DATE] for evaluation and treatment for pain to her right leg and was diagnosed with a broken right leg which was surgically repaired. The ADON stated Resident #140's family did not return Resident #140 to the facility and moved Resident #140 to their home where they continued to care for her. The ADON stated on [DATE] CNA A alerted LVN B that she needed assistance with Resident #140 because CNA A lost control of Resident #140 during a transfer from the bed to a wheelchair. During an interview on [DATE] at 02:17 p.m., Resident #140's representative stated she received a report from LVN B on the evening of [DATE]. Resident #140's representative stated LVN B reported that CNA A alerted LVN B for assistance with Resident #140 and, when LVN B entered the room, she observed Resident #140 sitting on the floor on her bottom with her legs to the right and the mechanical lift nearby. LVN B assessed Resident #140 to be without pain and with one small skin tear to her arm. Resident #140's representative stated LVN B reported Resident #140 was placed in bed, her physician was called, and an order for an x-ray was obtained. Record review of Resident #140's nursing progress notes, revealed the DON documented on [DATE] at 09:00 AM, Resident #140 was in pain when CNAs attempted incontinent care. The DON communicated with the physician and transferred Resident #140 to the hospital for evaluation. A record review of Resident #140's admission Hospital records dated [DATE], revealed that Resident #140 was diagnosed with a right femur (leg) fracture. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 02:25 p.m., the ADON stated she learned CNA A had transferred Resident #140 from her bed to a wheelchair with a mechanical lift, a sit to stand lift, by herself. The ADON stated she learned this from the Administrator. The ADON stated the Administrator possessed written statements and audio recordings from CNA A and LVN B that confirmed CNA A transferred Resident #140 alone. ADON stated Resident #140 was assessed on the MDS as needing more than 2 persons assistance with all transfers. ADON stated her expectation, and the facility policy was residents who were assessed as needing 2 persons assistance with transfers would receive 2 persons assistance with transfers. ADON stated LVN B and CNA A were no longer employed by the facility, specifically CNA A was a temporary agency employee and was no longer invited back, and LVN B was terminated for other infractions. ADON stated Resident #140 had a history of not following commands, not cooperating with transfers, biting, and scratching staff when staff attempted assist Resident #140 with a transfer. ADON stated she and the Administrator reviewed the details of the fall with injury and concluded the event was not a reportable event since the injury, a broken leg, was not from an unknown source. During an interview on [DATE] at 02:50 PM, the Administrator and the ADON, ADON stated CNA A transferred Resident #140 by herself after LVN B warned her not to, due to Resident #140's lack of following commands and combativeness. Administrator and ADON stated CNA A and LVN B have been dismissed due to their poor performance and have not worked at the facility since [DATE] after the incident. Administrator stated she had audio recordings of her interviews with CNA A and LVN B and learned LVN B had warned CNA A not to transfer Resident #140 alone, but CNA A had transferred Resident #140 by herself with a sit to stand mechanical lift. Administrator stated she understood Resident #140 was assessed as needing more than 1 person to assist with all transfers due to residents' inability to follow commands and history of combativeness. Administrator stated she and the ADON reviewed the details of the incident and believed the incident with a broken leg would not be a reportable incident to the state agency because the injury was witnessed. Administrator stated she had not considered the 1-person mechanical lift was neglect. 2. A record review of the Resident #17's quarterly MDS assessment dated [DATE] revealed an admitted [DATE] with diagnoses which included cerebral palsy (damage to brain areas that control muscle movement, or when those areas don't develop as they should), anxiety disorder, and psychotic disorder (a condition of the mind or psyche that results in difficulties determining what is real and what is not real). Further review revealed Resident #17 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 13, out of a possible 15, which indicated intact cognition. A record review of Resident #17's nursing progress notes revealed Resident #17 went out on pass with her family member on [DATE] and returned on [DATE]: Effective Date: [DATE] 09:26:00 Department: Nursing Position: Registered Nurse Created By: RN (C) Created Date: [DATE] 10:31:17; Note Text: LEFT FOR 2 DAY PASS AT HOME WITH (family). LEFT VIA PRIVATE AUTO WITH WHEELCHAIR. MEDICATION FOR 2 DAYS SENT WITH PATIENT. INSTRUCTIONS FOR ADMINISTRATION GIVEN TO PATIENT AND (family). LEFT IN STABLE CONDITION. Activity Participation Note, Effective Date: [DATE] 15:28:00 Department: Activities Position: Activities Director Created By: (Activity Director) Created Date: [DATE] 15:28:21 Note Text: OOP (out on pass) for the day. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administration Note Effective Date: [DATE] 15:05:00 Department: Nursing, Position: Registered Nurse Created By: (RN G) Created Date: [DATE] 15:05:52, Note Text: Patient may have 6 ounces of wine QD. in the afternoon for Per patient's request, I just don't want the wine today. A record review of the facility's grievance logbook which covered January to [DATE] revealed a grievance form for Resident #17 signed by the Social Worker, dated [DATE]. Further review revealed a written statement, dated [DATE], authored by CNA M which revealed Resident #17 while out on pass with family felt vulnerable while nude and threatened by a bloodied , drunken family member, I (CNA M) who works weekends was walking by Resident #17 and she stopped me to ask me how my New Year's was and I told her I was good. She then laughed and shook her head and told me she needed to talk to me later I said OK. I then after breakfast went in to get her bed made-up for the day and she told me her New Year's wasn't good. I ask why not and I'm sorry to hear that she then said her (family member) was drunk with a bloody nose and she was on the bed naked, and she was so scared she threw herself off the bed and pulled herself across the room to the restroom to get dressed and she just was so scared and wanted to (call for) help but couldn't call for any help. Further review revealed the social worker documented on the written statement, Resident is being seen by (psychiatric consultant) who has addressed this issue with the Resident. Social Worker spoke with resident about this on [DATE]. Resident stated she does not plan to go home out on pass with family member in the future. Signed Social Worker. During an interview on [DATE] at 08:50 a.m., Resident #17 did not want to participate in an interview regarding her New Year's Eve pass. During an interview on [DATE] at 3:30 PM, CNA M stated she recalled writing the statement on behalf of Resident #17's bad new year's pass and recalled the Social Worker was aware of the incident. CNA M stated the Social Worker (SW) had asked her to write the statement. During a joint interview on [DATE] at 03:05 PM, with the Administrator (ADM), the DON, and the ADON; DON and ADON stated they were not the DON and ADON during February 2024. The ADM stated she and the previous DON reviewed the grievances daily and had not recognized the second page of the grievance which was the written statement of by CNA M. The ADM stated her expectation was for the SW to have reported the allegation of abuse to her. The ADM stated the allegation of abuse could have been reported and investigated. The ADON stated Resident #17 had a diagnosis of psychotic disorder and had voluntarily gone out on pass with family since February 2024. 3. A record review of Resident #5's admission record dated [DATE] revealed an admitted [DATE] with diagnoses which included heart failure, presence of cardiac pacemaker (a small implanted electrical device to periodically shock the heart to keep a regular heartbeat), and atrial fibrillation (an irregular heart beat out of sequence contributing to the formation of harmful blood clots.) (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #5's annual MDS assessment dated [DATE] revealed Resident #5 was a [AGE] year-old female admitted for long term care, assessed with a debility with breathing and circulation, and assessed with a BIMS score of 06 out of a possible 15 which indicated severe cognitive impairment. Further review revealed Resident #5 was assessed with shortness of breath or trouble breathing with exertion (e.g., walking, bathing, transferring); shortness of breath or trouble breathing when sitting at rest; and shortness of breath or trouble breathing when lying flat. Resident #5 was assessed as having a life expectancy of less than 6 months. A record review of Resident #5's care plan dated [DATE] revealed Resident #5 was received oxygen therapy and had interventions which included, . for residents who should be ambulatory, provide extension tubing or portable oxygen apparatus A record review of the facility's grievance logbook which covered January to [DATE] revealed a grievance form dated [DATE], for Resident #17 which involved Resident #5, and was signed by the Social Worker. Further review revealed CNA M documented (Resident #17) has turned off (Resident #5's) O2 (oxygen) concentrator during the night shift because it is to (too) loud and she has an go up and took off her nasal cannula and put it in her drawer beside her bed when (Resident #5) does not get up out of bed as she does have a bed alarm. Further review revealed the SW documented, Findings: 3 concerns on this issue - SW spoke with Resident on [DATE] when concerns were submitted. Resident admitted to removing O2 cannula because Resident wasn't using it and turning the O2 concentrator off because it was too noisy and she couldn't sleep. Resolution: SW advised Resident (#17) that she is endangering her roommate (Resident #5). Resident (#17) became tearful and stated she would no longer turn the O2 concentrator off. Resident (#17) to be moved to another room ASAP. Resident (#17) advised she would be moving and agreed to do so. (signed by the SW). During an interview on [DATE] at 09:10 AM, Resident #5 could not recall any incidents regarding her use of oxygen. During an interview on [DATE] at 08:50 AM, Resident #17 did not want to participate in an interview regarding her previous roommate. During an interview on [DATE] at 08:50 AM, Resident #5 could not participate in an interview due to confusion. An attempt to interview Resident #5's representative was unsuccessful. During a joint interview on [DATE] at 03:05 PM, with the Administrator, the DON, and the ADON; DON and ADON stated they were not the DON and ADON during February 2024. The ADM stated she and the previous DON reviewed the grievances daily and had not recognized the allegation of neglect and or abuse on behalf of Resident #5. The ADM stated the SW had not brought the allegation to her attention. The ADM stated the allegations of abuse and or neglect could have been reported to the state. A record review of the facility's undated Residents Abuse, Neglect or Mistreatment policy revealed, Policy: Each Resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include physical harm, pain, mental anguish, verbal abuse (derogatory terms), sexual abuse or involuntary seclusion. All facility staff shall be in-serviced upon employment and annually regarding residents right and freedom form abuse, neglect, mistreatment, and misappropriation of property. suspected or substantiated cases of Resident abuse, neglect, misappropriation of property or mistreatment shall thoroughly be investigated and documented by the administrator and reported to the appropriate state agencies.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on interviews and record reviews the facility failed to ensure allegations of abuse, neglect, exploitation, or mistreatment have evidence that all alleged violations were thoroughly investigated and prevented further potential abuse, neglect, exploitation, or mistreatment while the investigation was in progress and reported the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action were taken, for 3 of 8 residents (rResidents #5, #17, and #140) reviewed for allegations of abuse, neglect, and exploitation. 1. The administrator failed to investigate and report an allegation of neglect, with serious injury, when Resident #140 was assisted with a mechanical lift transfer by 1 staff member, CNA A. Resident #140 fell during the transfer, suffered a broken right leg, and was hospitalized with a need for surgical repair. Prior to the fall Resident #140 was assessed with a need for more than 1 staff for assistance with transfers. 2. The administrator and the Social Worker failed to investigate and report an allegation of abuse on behalf of Resident #17. Resident #17 reported to CNA M, when she (Resident #17) was out on pass with a family member, she was nude and scared by a drunken, bloodied , family member and had to crawl to safety. 3. The administrator and the Social Worker failed to investigate and report an allegation of neglect on behalf of Resident #5 when CNA M alleged Resident #17 removed Resident #5's oxygen nasal cannula and oxygen concentrator because Resident #17 stated it was too loud and she (Resident #17) could not fall asleep. This deficient practice could place residents at risk for harm by not investigating and reporting allegations of abuse, neglect, and exploitation to the state agency. The findings included: 1. A record review of Resident #140's admission and discharge record dated [DATE] revealed an admitted [DATE] and a discharge date of [DATE] with diagnoses which included dementia (a group of symptoms affecting memory, thinking and social abilities. In people who have dementia, the symptoms interfere with their daily lives), psychotic disturbance (a condition of the mind or psyche that results in difficulties determining what is real and what is not real), mood disturbance and anxiety. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #140's MDS assessment dated [DATE] revealed Resident #140 was an [AGE] year-old female admitted for long term care and assessed with a BIMS score of 01 out of a possible of 15 which indicated severe cognition impairment. Further review revealed Resident #140 was assessed as Dependent - helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the Resident to complete the activity for all of Resident #140's needs for transfers, sit to stand, chair / bed to chair transfer, and toilet transfers. A record review of Resident #140's care plan dated [DATE] revealed, (Resident #140) is dependent on staff for meeting . physical . needs . related to dementia . the Resident needs assistance / escort to activity functions A record review of the facility's fall incident report dated [DATE] revealed Resident #140 suffered a fall during a 1-person mechanical lift transfer. During an interview on [DATE] at 03:00 PM, the ADON stated Resident #140 was discharged to the hospital on [DATE] for evaluation and treatment for pain to her right leg and was diagnosed with a broken right leg which was surgically repaired. ADON stated Resident #140's family did not return Resident #140 to the facility and moved Resident #140 to their home where they continued to care for her. ADON stated on [DATE] CNA A alerted LVN B that she needed assistance with Resident #140 because CNA A lost control of Resident #140 during a transfer from the bed to a wheelchair. During an interview on [DATE] at 02:17 pm, Resident #140's representative stated she received a report from LVN B on the evening of [DATE]. Resident #140's representative stated LVN B reported that CNA A alerted LVN B for assistance with Resident #140 and, when LVN B entered the room, she observed Resident #140 sitting on the floor on her bottom with her legs to the right and the mechanical lift nearby. LVN B assessed Resident #140 to be without pain and with one small skin tear to her arm. Resident #140's representative stated LVN B reported Resident #140 was placed in bed, her physician was called, and an order for an x-ray was obtained. Record review of Resident #140's nursing progress notes revealed the DON documented on [DATE] at 09:00 AM Resident #140 was in pain when CNAs attempted incontinent care. The DON communicated with the physician and transferred Resident #140 to the hospital for evaluation. A record review of Resident #140's admission Hospital records dated [DATE], revealed that Resident #140 was diagnosed with a right femur (leg) fracture and was surgically repaired. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 02:25 pm ADON stated she learned CNA A had transferred Resident #140 from her bed to a wheelchair with a mechanical lift, a sit to stand lift, by herself. ADON stated she learned this from the Administrator. ADON stated the Administrator possessed written statements and audio recordings from CNA A and LVN B that confirmed CNA A transferred Resident #140 alone. ADON stated Resident #140 was assessed on the MDS as needing more than 2 persons assistance with all transfers. ADON stated her expectation, and the facility policy was residents who were assessed as needing 2 persons assistance with transfers would receive 2 persons assistance with transfers. ADON stated LVN B and CNA A were no longer employed by the facility, specifically CNA A was a temporary agency employee and was no longer invited back, and LVN B was terminated for other infractions. ADON stated Resident #140 had a history of not following commands, not cooperating with transfers, biting, and scratching staff when staff attempted assist Resident #140 with a transfer. The ADON stated she and the Administrator reviewed the details of the fall with injury and concluded the event was not a reportable event since the injury, a broken leg, was not from an unknown source. During a joint interview on [DATE] at 02:50 PM with the Administrator and the ADON, ADON and ADM stated CNA A transferred Resident #140 by herself after LVN B warned her not to due to Resident #140's lack of following commands and combativeness. Administrator and the ADON stated CNA A and LVN B have been dismissed due to their poor performance and have not worked at the facility since [DATE] after the incident. Administrator stated she had audio recordings of her interviews with CNA A and LVN B and learned LVN B had warned CNA A not to transfer Resident #140 alone but CNA A transferred Resident #140 by herself with a sit to stand mechanical lift. Administrator stated she understood Resident #140 was assessed as needing more than 1 person to assist with all transfers due to residents' inability to follow commands and history of combativeness. Administrator stated she and her ADON reviewed the details of the incident and believed the incident with a broken leg would not be a reportable incident to the state agency because the injury was witnessed. Administrator stated she had not considered the 1-person mechanical lift was neglect and thus there was no investigation and report to the state agency. 2. A record review of the Resident #17's quarterly MDS assessment dated [DATE] revealed an admitted [DATE] with diagnoses which included cerebral palsy (damage to brain areas that control muscle movement, or when those areas don't develop as they should), anxiety disorder, and psychotic disorder (a condition of the mind or psyche that results in difficulties determining what is real and what is not real). Further review revealed Resident #17 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 13 out of a possible 15 which indicated intact cognition. A record review of Resident #17's nursing progress notes revealed Resident #17 went out on pass with her family member on [DATE] and returned on [DATE]: Effective Date: [DATE] 09:26:00 Department: Nursing Position: Registered Nurse Created By: RN (C) Created Date: [DATE] 10:31:17; Note Text: LEFT FOR 2 DAY PASS AT HOME WITH (family). LEFT VIA PRIVATE AUTO WITH WHEELCHAIR. MEDICATION FOR 2 DAYS SENT WITH PATIENT. INSTRUCTIONS FOR ADMINISTRATION GIVEN TO PATIENT AND (family). LEFT IN STABLE CONDITION. Activity Participation Note, Effective Date: [DATE] 15:28:00 Department: Activities Position: Activities Director Created By: (Activity Director) Created Date: [DATE] 15:28:21 Note Text: OOP (out on pass) for the day. (continued on next page)

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	675740	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knopp Nursing & Rehab Center Inc	202 Billie Dr Fredericksburg, TX 78624

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administration Note Effective Date: [DATE] 15:05:00 Department: Nursing, Position: Registered Nurse Created By: (RN G) Created Date: [DATE] 15:05:52, Note Text: Patient may have 6 ounces of wine QD. in the afternoon for Per patient's request, I just don't want the wine today. A record review of the facility's grievance logbook which covered January to [DATE] revealed a grievance form for Resident #17 signed by the Social Worker, dated [DATE]. Further review revealed a written statement, dated [DATE], authored by CNA M which revealed Resident #17 while out on pass with family felt vulnerable while nude and threatened by a bloodied , drunken family member, I (CNA M) who works weekends was walking by Resident #17 and she stopped me to ask me how my New Year's was and I told her I was good. She then laughed and shook her head and told me she needed to talk to me later I said OK. I then after breakfast went in to get her bed made-up for the day and she told me her New Year's wasn't good. I ask why not and I'm sorry to hear that she then said her (family member) was drunk with a bloody nose and she was on the bed naked, and she was so scared she threw herself off the bed and pulled herself across the room to the restroom to get dressed and she just was so scared and wanted to (call for) help but couldn't call for any help. Further review revealed the social worker documented on the written statement, Resident is being seen by (psychiatric consultant) who has addressed this issue with the Resident. Social Worker spoke with resident about this on [DATE]. Resident states she does not plan to go home out on pass with family member in the future. Signed Social Worker. During an interview on [DATE] at 08:50 Resident #17 did not want to participate in an interview regarding her New Year's Eve pass. During an interview on [DATE] at 3:30 PM CNA M stated she recalled writing the statement on behalf of Resident #17's bad new year's pass and recalled the Social Worker was aware of the incident. CNA M stated the Social Worker had asked her to write the statement. During a joint interview on [DATE] at 03:05 PM with the Administrator, the DON, and the ADON; DON and ADON stated they were not the DON and ADON during February 2024. The ADM stated she and the previous DON reviewed the grievances daily and had not recognized the second page of the grievance which was the written statement of by CNA M. ADM stated her expectation was for the SW to have reported the allegation of abuse to her. ADM stated the allegation of abuse could have been reported and investigated. ADON stated Resident #17 had a diagnosis of psychotic disorder and had voluntarily gone out on pass with family since February 2024. 3. A record review of Resident #5's admission record dated [DATE] revealed an admitted [DATE] with diagnoses which included heart failure, presence of cardiac pacemaker (a small implanted electrical device to periodically shock the heart to keep a regular heartbeat), and atrial fibrillation (an irregular heart beat out of sequence contributing to the formation of harmful blood clots.) (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #5's annual MDS assessment dated [DATE] revealed Resident #5 was a [AGE] year-old female admitted for long term care, assessed with a debility with breathing and circulation, and assessed with a BIMS score of 06 out of a possible 15 which indicated severe cognitive impairment. Further review revealed Resident #5 was assessed with shortness of breath or trouble breathing with exertion (e.g., walking, bathing, transferring); shortness of breath or trouble breathing when sitting at rest; and shortness of breath or trouble breathing when lying flat. Resident #5 was assessed as having a life expectancy of less than 6 months. A record review of Resident #5's care plan dated [DATE] revealed Resident #5 was received oxygen therapy and had interventions which included, . for residents who should be ambulatory, provide extension tubing or portable oxygen apparatus A record review of the facility's grievance logbook which covered January to [DATE] revealed a grievance form dated [DATE], for Resident #17 which involved Resident #5, and was signed by the Social Worker. Further review revealed CNA M documented (Resident #17) has turned off (Resident #5's) O2 (oxygen) concentrator during the night shift because it is to (too) loud and she has an go up and took off her nasal cannula and put it in her drawer beside her bed when (Resident #5) does not get up out of bed as she does have a bed alarm. Further review revealed the SW documented, Findings: 3 concerns on this issue - SW spoke with Resident on [DATE] when concerns were submitted. Resident admitted to removing O2 cannula because Resident wasn't using it and turning the O2 concentrator off because it was too noisy and she couldn't sleep. Resolution: SW advised Resident (#17) that she is endangering her roommate (Resident #5). Resident (#17) became tearful and stated she would no longer turn the O2 concentrator off. Resident (#17) to be moved to another room ASAP. Resident (#17) advised she would be moving and agreed to do so. (signed by the SW). During an interview on [DATE] at 09:10 AM Resident #5 could not recall any incidents regarding her use of oxygen. During an interview on [DATE] at 08:50 Resident #17 did not want to participate in an interview regarding her previous roommate. During an interview on [DATE] at 08:50 Resident #5 could not participate in an interview due to confusion. An attempt to interview Resident #5's representative was unsuccessful. During a joint interview on [DATE] at 03:05 PM with the Administrator, the DON, and the ADON; DON and ADON stated they were not the DON and ADON during February 2024. The ADM stated she and the previous DON reviewed the grievances daily and had not recognized the allegation of neglect and or abuse on behalf of Resident #5. ADM stated the SW had not brought the allegation to her attention. ADM stated the allegations of abuse and or neglect could have been investigated and reported to the state. A record review of the facility's undated Residents Abuse, Neglect or Mistreatment policy revealed, Policy: Each Resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include physical harm, pain, mental anguish, verbal abuse (derogatory terms), sexual abuse or involuntary seclusion. All facility staff shall be in-serviced upon employment and annually regarding residents right and freedom form abuse, neglect, mistreatment, and misappropriation of property. suspected or substantiated cases of Resident abuse, neglect, misappropriation of property or mistreatment shall thoroughly be investigated and documented by the administrator and reported to the appropriate state agencies.

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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** 47564 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 6 residents (Resident #18) reviewed for care plans. The facility failed to develop a person-centered care plan with interventions that addressed Resident #18's diagnoses of mental illness including depression. This failure could place residents at risk for not having their needs and preferences met. The findings included: Record review of Resident #18's face sheet, dated 10/18/2024, reflected a [AGE] year-old resident, initially admitted on [DATE], with diagnoses including pneumonia (a lung infection that causes the air sacs in the lungs to fill with fluid or pus, making it difficult to breathe), depression, and dysphagia (difficulty swallowing). Record review of Resident #18's MDS Assessment, dated 9/22/2024, reflected Resident #18's takes antidepressants. Resident #18's MDS Assessment also reflected a BIMS of 14, indicating cognitively intact. Record review of Resident #18's Care Plan, undated, reflected a 5-page document without any interventions or mention of Resident #18's diagnosis of depression or antidepressant therapy. Interview on 10/18/2024 at 5:20 PM, the ADON stated she is responsible for care plans and ensuring they are done correctly and address all areas of care. The ADON stated she was not certain why Resident #18 did not have her diagnosis of depression on her care plan . The ADON stated she looks at assessments to complete care plans, and any input from other staff. Interview on 10/18/2024 at 5:25 PM, the ADM stated her expectation was for care plans to be done correctly. Record review of facility policy, dated copyrighted 2005, titled, Care Plan/Comprehensive Interdisciplinary, reflected, The care plan must include measurable objectives and timetables to meet a resident's medical, nursing, and psychosocial needs as identified in the comprehensive assessment.

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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** 47564 Based on interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 6 residents (Resident #28) reviewed for personal hygiene. The facility failed to provide Resident #28, 18 of 30 scheduled showers between 7/2/2024 and 10/15/2024. This failure could place residents who require assistance from staff for personal hygiene at risk of not receiving care and services contributing to overall poor hygiene, risk of experiencing a diminished quality of life, and possible skin infections. The findings included: Record review of Resident #28's face sheet, dated 10/18/2024, reflected a [AGE] year-old male resident initially admitted on [DATE] with diagnoses including diabetes mellitus, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (a condition that affects one side of the body after a stroke causing paralysis), and dysphagia (difficulty swallowing). Record review of Resident #28's MDS Assessment, dated 10/8/2024, reflected Resident #28 had a BIMS score of 8, suggesting moderate impairment. No diagnosis of dementia was present on Resident #28's MDS assessment . Resident #28's MDS assessment indicated that Resident #28 needed Partial/moderate assistance for bathing. Record review of Resident #28's Care Plan, undated, reflected interventions stating the resident had an ADL self-care performance deficit related to diagnosis of hemiplegia and hemiparesis. Interview on 10/14/2024 at 12:39 PM, Resident #28 and FM stated that Resident #28 only got showered once a week and would prefer to be showered at least twice a week, ideally on Tuesday and Saturday. Resident #28 stated he was not aware he should have been getting showered more than once weekly and was thankful to hear he could be showered more than once weekly. Record review of Resident #28's shower log reflected that the resident's shower days were Tuesday, Thursday, and Saturday. Further review revealed Resident #28 did not receive 18 of 30 instances of scheduled showers, with 1 instance of refusing a shower. Interview on 10/18/2024 at 5:22 PM, with the ADON, DON, and ADM, the ADON stated that Resident #28 and Resident #28's FM likely did not remember his showers correctly, as they likely had dementia. The ADON requested to interview Resident #28 in front of the surveyor and stated that she was confident Resident #28 would not say he only received showers once a week if the ADON asked Resident #28 in front of the surveyor. The ADM stated that her expectation was for residents to receive showers on their scheduled shower dates . (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 facility policy, undated, titled, Bath, Shower reflected Residents are showered a minimum of three times weekly on one of two shower schedules either a Monday, Wednesday, & Friday or a Tuesday, Thursday, Saturday schedule which is determined by that patients charge nurse.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 8 residents (Resident #140) reviewed for neglect with serious injuries and lack of supervision, in that: On 09/01/2024 CNA A assisted Resident #140 with a mechanical lift transfer by herself. Resident #140 fell during the transfer, suffered a broken right leg, and was hospitalized with a need for surgical repair. Prior to the fall Resident #140 was assessed with a need for more than 1 staff for assistance with transfers . An Immediate Jeopardy (IJ) was identified on 10/17/2024. The IJ Template was provided to the facility on [DATE] at 04:30 PM. While the IJ was removed on 10/18/2024, the facility remained out of compliance at a scope of isolated with risk for harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective actions. This deficient practice could place residents who needed more than 1 staff assistance with mechanical transfers at risk for harm by neglect to include serious injury, or death. The findings included: A record review of Resident #140's admission and discharge record dated 10/17/2024 revealed an admitted [DATE] and a discharge date of [DATE] with diagnoses which included dementia (a group of symptoms affecting memory, thinking and social abilities. In people who have dementia, the symptoms interfere with their daily lives), psychotic disturbance (a condition of the mind or psyche that results in difficulties determining what is real and what is not real), mood disturbance and anxiety. A record review of Resident #140's MDS assessment dated [DATE] revealed Resident #140 was an [AGE] year-old female admitted for long term care and assessed with a BIMS score of 01 out of a possible of 15 which indicated severe cognition impairment. Further review revealed Resident #140 was assessed as Dependent - helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the Resident to complete the activity for all of Resident #140's needs for transfers, sit to stand, chair / bed to chair transfer, and toilet transfers. A record review of Resident #140's care plan dated 10/17/2024 revealed, (Resident #140) is dependent on staff for meeting . physical . needs . related to dementia . the Resident needs assistance / escort to activity functions A record review of the facility's fall incident report dated 09/01/2024 revealed Resident #140 suffered a fall during a 1-person mechanical lift transfer performed by CNA A, (agency aid CNA A) notified skill nursing that resident is on the floor. When entering residence room Resident (#140) was laying on left side hidden between the legs of the sit to stand. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/16/2024 at 03:00 PM, the ADON stated Resident #140 was discharged to the hospital on 09/02/2024 for evaluation and treatment for pain to her right leg and was diagnosed with a broken right leg which was surgically repaired. The ADON stated Resident #140's family did not return Resident #140 to the facility and moved Resident #140 to their home where they continued to care for her. The ADON stated on 09/01/2024 CNA A attempted to transfer Resident #140 by herself from the bed to a wheelchair. CNA A alerted LVN B that she needed assistance with Resident #140 because CNA A lost control of Resident #140 and lowered her to the floor. The ADON stated Resident #140 was assessed by LVN B without serious injury and or pain and was placed in bed. During an interview on 10/16/2024 at 02:17 p.m., Resident #140's representative stated she received a report from LVN B on the evening of 09/01/2024. Resident #140's representative stated LVN B reported that CNA A alerted LVN B for assistance with Resident #140, when LVN B entered the room, she observed Resident #140 sitting on the floor on her bottom with her legs to the right and the mechanical lift nearby. LVN B assessed Resident #140 to be without pain and with one small skin tear to her arm. Resident #140's representative stated LVN B reported Resident #140 was placed in bed, her physician was called, and an order for an x-ray was obtained. Record review of Resident #140's nursing progress notes revealed the DON documented on 09/02/2024 at 09:00 AM, Resident #140 was in pain when CNAs attempted incontinent care. The DON communicated with the physician and transferred Resident #140 to the hospital for evaluation. A record review of Resident #140's admission Hospital reco rds dated 09/02/2024 revealed Resident #140 was diagnosed with a right femur (leg) fracture which was surgically repaired. During an interview on 10/16/2024 at 02:25 p.m., the ADON stated she learned from the Administrator that CNA A had transferred Resident #140 from her bed to her wheelchair with a sit to stand mechanical lift by herself. The ADON stated the Administrator possessed written statements and audio recordings from CNA A and LVN B that confirmed CNA A transferred Resident #140 alone. The ADON stated Resident #140 was assessed by the RAI and documented on Resident #140's MDS as needing more than 2 persons assistance with all transfers. The ADON stated her expectation, and the facility policy was residents who were assessed as needing 2 persons assistance with transfers would receive 2 persons assistance with transfers. The ADON stated LVN B and CNA A were no longer employed by the facility, specifically CNA A was a temporary agency employee and was no longer invited back, and LVN B was terminated for other infractions. The ADON stated Resident #140 had a history of not following commands, not cooperating with transfers, biting, and scratching staff when staff attempted assist Resident #140 with a transfer. The ADON stated she and the Administrator reviewed the details of the fall with injury and concluded the event was not a reportable event since the injury, a broken leg, was not from an unknown source. During an interview on 10/16/2024 at 03:00 PM, CNA U stated she was an agency CNA and had worked here since the end of September - beginning of October. CNA U stated she had not received any in-services during her 2 weeks employment. CNA U stated she would refer to the shower book binder for instructions for which residents required assistance with transfers. During an interview on 10/16/2024 at 03:03 PM, RN G stated she was the Monday through Friday 02:00 PM to 10:00 PM nurse and had been a nurse for the facility during the past year. RN G stated she received regular in-services every payday (2 weeks) to include hand washing, infection control, etc. RN G could not recall any in-services for transferring residents with mechanical lifts. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/16/2024 at 03:05 PM, LVN H stated she was the 06:00 AM to 10:00 PM nurse and stated she received regular in-services every payday (2 weeks) to include hand washing, infection control, etc. LVN H could not recall any in-services for transferring residents with mechanical lifts. During an interview on 10/16/2024 at 03:10 PM, the DON stated the facility routinely provides in-services every 2 weeks and as needed. The DON provided copies of the most recent in-services since August 2024. A record review of the facility's in-services from the time period August 01, 2024, through October 16, 2024, revealed no in-services regarding transferring residents with mechanical lifts or any transfers. During an interview on 10/17/2024 at 11:58 AM, Nurse Practitioner T (NP T) stated Resident #140 was under his care when Resident #140 resided at the facility. NP T stated his expectations for residents who were assessed for the need for transfers as dependent on staff should receive transfer care with 2 or more staff to include the use of mechanical lifts. NP T stated he had not received a report to include Resident #140 had been transferred with only 1 staff during the incident which led to her broken leg. NP T stated Resident #140 should have received a 2-person assisted mechanical lift care. During a joint interview and record review on 10/17/2024 at 12:58 PM, with DON and ADON confirmed that the shower book binder was the resource provided to staff for care details to include 1 person or 2 person assists with ADL's and transfers. The DON and ADON reviewed the shower book binder and stated Resident #140 was not included in the details for care. The ADON stated she could not recall if at the time of Resident #140's transfer incident, Resident #140 was or was not included in the shower book binder. During a joint interview on 10/17/2024 at 02:50 PM with the Administrator and the ADON, ADON stated CNA A transferred Resident #140 by herself after LVN B warned her not to due to Resident #140's lack of following commands and combativeness. Administrator and ADON stated CNA A and LVN B have been dismissed due to their poor performance and have not worked at the facility since September 2024 after the incident. Administrator stated she possessed audio recordings of her interviews with CNA A and LVN B and learned LVN B had warned CNA A not to transfer Resident #140 alone but CNA A transferred Resident #140 by herself with a sit to stand mechanical lift. Administrator stated she understood Resident #140 was assessed as needing more than 1 person to assist with all transfers due to residents' inability to follow commands and history of combativeness. During a joint interview on 10/17/2024 at 02:50 PM, with the Administrator and the ADON a policy regarding a safe environment related to accidents and hazards was requested and not received. The Administrator was notified on 10/17/24 at 04:30 PM, an IJ situation had been identified due to the above failures. The IJ template was given to the administrator on 10/17/24 at 02:45 PM, and a POR was requested. The POR was accepted on 10/18/24 at 04:36 PM and indicated the following : Plan of Removal and Verification (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Please accept this POR for citation F689 on 10/17/2024 The following in-services were done on 10/17/2024 per DON (DON) and ADON (ADON). On the following topics: Hoyer and stand assist. Suspicious injuries Proper and timely documentation Reporting abuse or neglect and abuse coordinator Nurse aide information binder (Radiology Contractor) Xray Communication with Physicians Nursing Judgement Pain assessment Incident report and documentation Who to call for injuries. The following nurses attended: (DON) (ADON) (LVN H) (LVN I) (LVN G) (LVN J) (LVN K) (LVN L) Attached is the sign in log. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knopp Nursing & Rehab Center Inc	202 Billie Dr Fredericksburg, TX 78624

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In-services held for CNAs per (ADON) ADON, on the following topics at 10/17/2024 5:30pm: Hoyer lift Stand assist. CNA information binder and its location Abuse coordinator Abuse and neglect Suspicious scenarios and how to identify injuries. CNAs that attended: (CNA M) (CNA N) (CNA O) (CNA P) (CNA R) (CNA Q) (CNA E) (agency) The ADON will make sure that the Kardex for residents is updated on Mondays and PRN to include new admissions. This will be ongoing to make sure of resident's safety. Updates to include changes in status, transfers, and ADL'S. This will be included in the Kardex and in the same information binder for CNA'S to access. Frequency of monitoring for incoming shifts and outgoing shifts for exchange in report the agency CNA will check in with charge nurse. Charge nurse will make sure the agency CNA knows where the information binder will be located and will ensure they will access it for any question and guidance. This will be monitored by the charge nurse every shift. Agency staff has all their credentials on their profile on the agency app. Agency restricts agency CNA'S from picking up shifts if out of compliance for CNA certification requirements. Effective 10/17/2024 ongoing process monitored per ADON/ DON. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Any suspicious injuries should not wait for (Radiology Contractor) Xray company to communicate to MD that our STAT orders are greater than 4 hours per mobile Xray, advocate for your residents. Effective immediately. This ongoing process is to be monitored by ADON and DON - effective 10/17/2024 all STAT or suspicion of injury and or STAT X rays will be sent to the ER per physician orders. The CNA binder holds the following information: Kardex from POC on each resident reflecting information and current transfer status. The binder will be located at the nurse's station for quick reference and guidance. Effective 10/17/2024Agency CNA will be educated on binder location and for reference upon the beginning of all shifts. CNA will receive report from DON, ADON, floor nurses, and or previous CNA to make sure the oncoming CNA is educated on resident care. Effective 10/17/2024. Shift change report exchange per CNAs will be mandatory for all incoming and leaving shifts. This will be monitored per ADON/ DON and an ongoing process and monitoring. All agency CNA's will sign a log in sheet located in the front of the binder acknowledging they have reviewed the residents. Effective 10/17/2024 The Kardex info binder reflects transfer status, dentures, diets, special instructions, If NPO person etc . this information reflects from the MDS on PCC per CNA documentation. Effective 10/18/2024 this will be monitored per ADON (ADON) daily to ensure compliance and safety to our residents. POR Validation: Training: Record review of facility's sign in sheet dated 10/17/24 reflected that 100% of nursing staff received training on Hoyer transfer, standing assist transfer, ADLs, NA information Binder, Abuse/Neglect, (radiology contractor) X-ray, Pain Assessment, Suspicious Injuries, Documentation, Send to ER and Binder Documentation (Total Working Nursing staff was 17 (94 % completion rate). During interviews on 10/18/24 from 1:45 PM to 2:47 PM of 4 day shift staff (6 A-2 P) (1 RN, 2 LVN, 1 CNA) and 3 evening shift (2 P to 10 P) (1 RN, 2 LVN) , 2 night shift staff (10 P-6A) (1 LVN, 1 CNA) and 2 weekend staff (2 CNA) reflected the training highlights were: machinal lift required 2 staff members; standing transfer could be done if the resident was non-combative; ADLs required to check on the level of assistance; and the NA binder contained information on assistance for showers, transfer, and mobility. Further the training highlights were report abuse/neglect to the Administrator and any suspicion of abuse/neglect; do not wait on the (radiology contractor)-Xray if there is harm to a resident; notify physician and send to the ER; pain assessments are routinely done; and signs and symptoms are documented. Also, the Binder containing information about a resident was found at the nurse station . Kardex During an interview on 10/18/24 at 2:49 PM, ADON stated: the Kardex was in the Nurse Station and contained transfers, dentures, feeding assistance, and shower list. ADON stated the Kardex is updated every Monday and at new admissions. ADON stated that the Kardex was put into effect on 10/17/24 and there were no new entries into the Kardex. Observation on 10/18/24 at 2:54 PM, reflected that the Kardex was at the Nurse Station. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Kardex dated 10/27/24 reflected items contained the Kardex included transfers, dentures, feeding assistance, and shower list. Suspicious injuries/(radiology contractor) X-ray: During a joint interview on 10/18/24 at 3:00 PM, the DON and ADON stated that: any suspicious injury requiring an X-ray would not wait for an X-ray and the resident will be sent to the ER; and notify the physician and RP. The ADON stated she monitored incidents by telephone calls from staff, reviewing (electronic record), and reviewing Change of Condition report. The DON stated in addition to what the ADON relayed, she would confirm and review the incident report. The ADON that she was called on a witness fall with no injury on 10/17/24. Her actions included after the call: she checked that nursing staff did vitals, skin breakdown and inquired on nursing assessment for further action requiring calling the MD; and verified that the incident was documented on (electronic record). The DON added that she reviewed the nurse's notes for accuracy and timely. CNA Knowledge of Kardex During a joint interview on 10/18/24 at 3:15 PM, CNA R and CNA S stated: Kardex contained shower list, dining list, Hoyer residents, and standing to assist list. They stated the Kardex was checked before doing an ADL for the resident. They stated that no attempt would be made to transfer a 2 person lift by one person. Agency CNA S was educated on 10/17/24 before she came on duty and the education involved the Kardex and the lists in the binder. She added that at shift change she would share information about ADLs and incidents with the on-coming shift. CNA R stated that at shift change she would communicate ADLs performed and any change of condition or incident. An Immediate Jeopardy (IJ) was identified on 10/17/2024. The IJ Template was provided to the facility on [DATE] at 04:30 PM. While the IJ was removed on 10/18/2024, the facility remained out of compliance at a scope of isolated with risk for harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective actions.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564 Based on interview and record review the facility failed to ensure that residents who had not used psychotropic drugs were not given psychotropic drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 of 3 residents (Resident #13) reviewed for unnecessary medications. The facility failed to ensure Resident #13 was taking a psychotropic medication (Mirtazapine (an antidepressant)), to treat a specific diagnosed condition. This deficient practice could place residents at risk for receiving medications that were not necessary for their care. The findings include: Record review of the Admission Record reflected Resident #13 was a [AGE] year-old resident who was initially admitted to the facility on [DATE]. Resident #13 had diagnoses which included essential hypertension (abnormally high blood pressure), and a pressure ulcer of the sacral region, stage 4. A diagnosis of depression was not documented. Record review of the comprehensive MDS assessment, dated 9/23/2024, reflected Resident #13's Section I - Active Diagnosis section of her MDS did not reflect a diagnosis of Depression. Resident #13' s BIMS score reflected a BIMS of 13, which indicated moderate cognitive impairment. Record review of Resident #13' s Order Summary Report, dated 10/18/2024, reflected an order for Mirtazapine Oral Tablet 15 MG with the instruction, Give 15 mg by mouth one time a day for depression. Record review of Resident #13' s MAR for October 2024, dated 10/18/2024, reflected Resident #13 was receiving Mirtazapine Oral Tablet 15 MG for depression. Interview on 10/18/2024 at 5:32 PM, the ADON stated she was not sure why Resident #13 did not have a diagnosis of depression . The ADON stated she was not certain who was responsible for ensuring residents have the correct diagnosis for psych medications. Record review of the facility's policy titled, Medications, Drug Regimen Reviews undated, reflected, Unnecessary Drugs: Drugs that are given in excessive doses, for excessive periods of time, without adequate monitoring, or in the absence of a diagnosis or reason for the drug.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observation, interviews, and record reviews the facility failed to ensure its medication error rates were not 5% or greater. The facility had a medication error rate of 7.69%, based on 2 errors out of 26 opportunities which involved 2 of 6 residents (Resident #8 and #24) reviewed for crushed medication administration and medication errors. 1. RN G administered Resident #8's medications: a. ranolazine 500mg extended-release tablet by crushing the tablet. Ranolazine is used to treat heart related chest pain. 2. RN G administered Resident #24's medications: a. duloxetine 30mg delayed-release capsule by opening the capsule. Duloxetine is used to treat depression and anxiety. These deficient practices could place residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. The findings included: 1. A record review of Resident #8's admission record dated 10/17/2024 revealed an admitted [DATE] with diagnoses which included dysphagia oropharyngeal and pharyngoesophageal phases (difficulty swallowing, oropharyngeal airway refers to the pharynx, the hollow tube inside the neck that starts behind the nose and stops at the top of the windpipe and esophagus) as a result from a stroke. A record review of Resident #8's admission MDS assessment dated [DATE] revealed Resident #8 was an [AGE] year-old female admitted under hospice care and assessed with a BIMS score of 07 out of a possible 15 which indicated severe cognitive impairment. Further review revealed resident #8 was assessed as medically complex and had a surgery for her gastrointestinal tract . including creation . percutaneous feeding tubes (a peg-tube) and was assessed with a feeding tube. Further review revealed Resident #8 used high risk drugs which included anti-depressants. A record review of Resident #8's physicians' orders dated 10/18/2024 revealed Resident #8 was to receive crushed medications as follows, may alter meditation by crushing, opening caps, or administering in food or fluids. (Only open or crash if manufacturer allows) Further review revealed Resident #8 was prescribed ranolazine extended release 12-hour 500mg give 500mg via peg tube two times daily for antianginal (heart pain) A record review of Resident #8's October 2024 Medication Administration record revealed RN G documented she administered ranolazine extended release 12-hour 500mg give 500mg via peg tube two times daily for antianginal at 07:00 PM. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of The United States of America's Food and Drug Administrations website https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/021526s012lbl.pdf accessed 10/18/2024 revealed, . (ranolazine) extended-release tablets - Initial U.S. Approval: 2006 ----------INDICATIONS AND USAGE---------- (Brand name ranolazine) is indicated for the treatment of chronic angina. DOSAGE AND ADMINISTRATION 2.1 Dosing Information Initiate (Brand name ranolazine) dosing at 500 mg twice daily . Take (Brand name ranolazine) with or without meals. Swallow (Brand name ranolazine) tablets whole; do not crush, break, or chew. During an observation on 10/18/2024 at 07:00 PM revealed RN G prepared and administered to Resident #8 ranolazine 500mg one tablet extended release by crushing the tablet and administering the medication via Resident #8's indwelling a Peg tube. 2. A record review of Resident #24's admission record dated 10/17/2024 revealed an admitted [DATE] with diagnoses which included Parkinson's disease with dyskinesia (involuntary, erratic, writhing movements of the face, arms, legs or trunk). A record review of Resident #24's annual MDS assessment dated [DATE] revealed Resident #24 was an [AGE] year-old female admitted for long term care under hospice services and assessed with a BIMS score of 04 out of a possible 15 which indicated severe cognitive impairment. Resident #24 was assessed with a life expectancy of less than 6 months. Further review revealed Resident #24 received antidepressant medications. A record review of Resident #24's physicians' orders dated 10/18/2024 revealed Resident #24 was to receive crushed medications as follows, may alter meditation by crushing, opening caps, or administering in food or fluids. (Only open or crash if manufacturer allows) Resident #24 was prescribed to receive a regular diet with a pureed diet and an antidepressant medication duloxetine oral capsule delayed-release sprinkle 30mg give 1 capsule two times a day for depression A record review of The United States of America's Food and Drug Administrations website https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/021427s049lbl.pdf accessed 10/18/2024 revealed, . (Brand Name) (duloxetine hydrochloride) Delayed-Release Capsules for Oral Use. Initial U.S. Approval: 2004 . DOSAGE AND ADMINISTRATION---------- o (Brand name duloxetine) should generally be administered once daily without regard to meals. (Brand name duloxetine) should be swallowed whole and should not be chewed or crushed, nor should the capsule be opened and its contents be sprinkled on food or mixed with liquids (2.1). 2 DOSAGE AND ADMINISTRATION (Brand name duloxetine) should be swallowed whole and should not be chewed or crushed, nor should the capsule be opened and its contents sprinkled on food or mixed with liquids. All of these might affect the enteric coating. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #24's October 2024 Medication Administration record revealed RN G documented she administered duloxetine oral capsule delayed release sprinkle 30mg give 1 capsule by mouth two times a day for depression on 10/18/2024 at 07:00 PM. During an observation on 10/18/2024 at 06:50 PM revealed RN G prepared and administered to Resident #24 duloxetine 30mg 1 oral capsule by opening the capsule and mixing it with apple sauce. During an interview on 10/18/2024 at 07:05 PM RN G stated she did not recognize Resident #8's and nor Resident #24's extended-release medications and should have not crushed the medications. RN G stated extended release, delayed release medications should not be opened and or crushed. RN G stated she would report the medication errors to the DON and the medical director. During a joint interview on 10/18/2024 at 5:30 PM with the DON and ADON, the DON stated delayed release medications should not be crushed and or opened. A record review of the facility's undated Medication Error policy revealed, it is the policy of (the facility) to be free of significant medication errors and error rates. A medication error will be filled out for each medication or treatment error. medication error: federal regulations state a medication error is a discrepancy between what the physician ordered and what is actually administered. Significant medication error causes the resident discomfort or jeopardizes his or her health . examples are listed below : . wrong dosage form