STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675788	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Manor of Commerce Nursing and Rehabilitation	2901 Sterling Hart Dr Commerce, TX 75428

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on observation, interviews, and record review the facility failed to ensure residents have the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives and to choose the option he or she prefers for 2 of 5 residents reviewed for the right to be informed. (Resident's #1 and #9) 1. The facility failed to ensure Resident #1's psychotropic consent for trazadone (antidepressant), Xanax (antianxiety), lorazepam (antianxiety), and sertraline (antidepressant) reflected the clinical indication for use, the benefits of the medication, and the statement of consent. 2. The facility failed to ensure Resident #9's psychotropic consent form for Zyprexa (antipsychotic) reflected the resident or resident representative's signature for consent. These failures could place residents at risk for treatment or services provided without their informed consent. The findings included: 1. Record review of the face sheet, dated 11/07/24, reflected Resident #1 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (neurological disorder that involves irreversible worsening changes in the ability to think and remember), anxiety disorder, and depression. Record review of the quarterly MDS assessment, dated 08/29/24, reflected Resident #1 had clear speech and was usually understood by others. The MDS reflected Resident #1 was usually able to understand others. The MDS reflected Resident #1 had a BIMS score of 1, which indicated severe cognitive impairment. The MDS reflected Resident #1 had no behaviors or refusal of care. The MDS reflected Resident #1 received an antianxiety medication and an antidepressant medication during the 7-day look back period. Record review of the comprehensive care plan, edited 10/04/24, reflected Resident #1 received an antianxiety medication related to a diagnosis of anxiety disorder. The care plan further reflected Resident #1 received an antidepressant medication related to a diagnosis of depression. Record review of the general order received and started on 09/28/23, reflected Resident #1 had an order for trazadone (antidepressant) 100 mg - give one tablet by mouth at bedtime. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's informed consent for use of psychotropic medication form for trazadone (antidepressant), dated 02/09/24, had no clinical indications for use, no benefits from medications, and no statement of consent (I DO, or I DO NOT) checked or filled out. Record review of the general order received and started on 11/29/23, reflected Resident #1 had an order for Xanax (antianxiety) 0.25 mg - give one tablet by mouth twice daily. Record review of Resident #1's informed consent for use of psychotropic medication form for Xanax (antianxiety), dated 03/11/24, had no clinical indications for use, no benefits from medications, and no statement of consent (I DO, or I DO NOT) checked or filled out. Record review of the general order received and started on 02/01/24, reflected Resident #1 had an order for sertraline (antidepressant) 50 mg - give 2 tablets by mouth once per day. Record review of Resident #1's informed consent for use of psychotropic medication form for sertraline (antidepressant), dated 02/09/24, had no clinical indications for use, no benefits from medications, and no statement of consent (I DO, or I DO NOT) checked or filled out. Record review of the general order received and started on 10/14/24, reflected Resident #1 had an order for lorazepam (antianxiety) 0.5 mg - give one tablet by mouth every 6 hours as needed. Record review of Resident #1's informed consent for use of psychotropic medication form for lorazepam (antianxiety), dated 03/11/24, had no clinical indications for use, no benefits from medications, and no statement of consent (I DO, or I DO NOT) checked or filled out. During an observation and attempted interview on 11/04/24 beginning at 1:36 PM, Resident #1 was wheeling herself down the hallway. Resident #1 had a WanderGauard to her left ankle. Resident #1 had Geri-sleeves to both arms and non-skid socks to both feet. Resident #1 was non-interviewable as evidenced by confused conversation. 2. Record review of the face sheet, dated 11/06/24, reflected Resident #9 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnosis of bipolar disorder (serious mental illness characterized by extreme mood swings). Record review of the significant change MDS assessment, dated 10/01/24, reflected Resident #9 had clear speech and was usually understood by others. The MDS reflected Resident #9 was usually able to understand others. The MDS reflected Resident #9 had a BIMS score of 15, which indicated he was cognitively intact. The MDS reflected Resident #9 had no behaviors or refusal of care. The MDS reflected Resident #9 received an antipsychotic medication during the 7-day look back period. Record review of the comprehensive care plan, edited 09/24/24, reflected Resident #9 had bipolar and was currently taking an antipsychotic medication. Record review of the general order received and started on 06/05/24, reflected Resident #9 had an order for Zyprexa (antipsychotic) 5 mg - give one tablet by mouth at bedtime. Record review of the Consent for Antipsychotic or Neuroleptic Medication Treatment form, dated 03/13/24, reflected Resident #9 had not signed the form. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/04/24 beginning at 1:45 PM, Resident #9 said he knew he was taking an antipsychotic for his bipolar disorder. Resident #9 said he knew and understood the risks and benefits, but he needed the medication. Resident #9 stated he had not signed a consent form. During an interview on 11/07/24 beginning at 11:48 AM, LVN D stated when the nurse received an order for a psychotropic medication, it was their responsibility to ensure a consent form was completed. LVN D stated consent forms should have been filled out completely. LVN D stated consent forms should have had a signature from the resident or responsible party. LVN D was unsure why Resident #1's consent forms were missing the clinical indication for use, the benefits from use, and a statement of consent. LVN D was unsure why Resident #9's psychotropic consent form was missing his signature. LVN D stated it was important to ensure psychotropic consent forms were filled out completely so the facility could prove the resident, or the responsible party made an informed decision. During an interview on 11/07/24 beginning at 11:54 AM, the DON stated the ADON was previously responsible for ensuring the psychotropic consent forms were completely filled out and placed in a binder. The DON stated the ADON walked out of the facility at the beginning of last month (October 2024). The DON stated she was to be responsible for ensure psychotropic consent forms were completely filled out and uploaded in the electronic health record moving forward. The DON stated she expected the nurses to have completed or filled out every part of the psychotropic consent forms. The DON stated it was important to ensure consent forms were completely filled out and signatures were in place, so the resident or responsible party were fully aware of the risks and benefits. The DON said so they could have made an informed decision. During an interview on 11/07/24 beginning at 12:20 PM, the Administrator stated she did not have a clinical background. The Administrator stated she expected the nursing management to monitor to ensure psychotropic consent forms were filled out completely with all required signatures. The Administrator stated it was important to ensure consent forms were completely filled out with all required signatures for good documentation and so the resident or responsible party clearly understood the risk and benefits of the psychotropic medication. Record review of the Psychoactive Medications policy, dated July 2024, reflected Consent must be obtained from the resident or resident representative prior to administering a psychotropic medication A consent from for antipsychotic medication .must be completed and signed by the resident or resident representative . consent must be obtained in writing .a consent form for other psychotropic medications must be completed and signed by the resident or resident representative using the psychotropic consent form

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interview, and record review, the facility failed to ensure the right to formulate an advanced directive was provided for 2 of 19 residents (Residents #40 and #44) reviewed for advanced directives. 1. The facility did not ensure Resident #40's OOH-DNR included the physician signature and licensed number. 2. The facility did not ensure Resident #44's full code status was discontinued after Resident #44 signed a DNR. These failures could place residents at risk of not receiving care and services to meet their needs. Findings included: 1. Record review of Resident #40's face sheet, dated [DATE], indicated Resident #40 was a [AGE] year-old male, originally to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of Resident #40's physician order report, dated [DATE]-[DATE], indicated an active physician's order for code status: DNR with an order date [DATE]. Record review of Resident #40's quarterly MDS, dated [DATE], indicated Resident #40 made himself understood, usually understood others. Resident #40's BIMS score was 9, which indicated his cognition was moderately impaired. Record review of the comprehensive care plan, revised [DATE], indicated Resident #40 was a DNR. The care plan interventions included, CPR will not be initiated, and DNR status will be documented in Resident #40's chart. Record review of Resident #40'ss OOH-DNR form dated [DATE] reflected a missing physician signature and physician licensed number. 2. Record review of Resident #44's face sheet, dated [DATE], indicated Resident #44 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included liver cell carcinoma (liver cancer). Record review of Resident #44's general order, dated [DATE] indicated an active physician's order for code status: full code. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #44's quarterly MDS, dated [DATE], indicated Resident #44 made himself understood and understood others. Resident #44's BIMS score was 15, which indicated his cognition was intact. Record review of the comprehensive care plan, revised [DATE], indicated Resident #44 was a DNR. The care plan interventions included, will review on admission, quarterly and PRN. Record review of Resident #44's OOH-DNR form dated [DATE] reflected a completed DNR that was signed by all responsible parties. During an interview on [DATE] at 1:10 PM, Resident #44 stated he signed an OOH-DNR at the facility and that was his wishes. During an interview on [DATE] at 9:35 a.m., the Social Worker stated she was responsible for completing DNRs. The Social Worker stated she started working at the facility around [DATE]. After reviewing Resident #40's electronic medical record, stated Resident #40 OOH-DNR was missing a signature and date by the physician. After reviewing Resident #44's electronic medical records, the Social Worker stated once Resident #44 completed the DNR the full code should have been discontinued. The Social Worker stated the risk associated with not discontinuing the full code or ensuring DNRs were completed would means their wishes were not carried out. During an interview on [DATE] at 12:39 p.m., the Administrator stated he expected DNRs to be filled out completely, including signatures. The Administrator stated he expected Resident #44 order to match the documents that were in the charts as long the documents were accurate. The Administrator stated the previous social worker was responsible was for overseeing and monitoring the DNR. The Administrator stated it was important to ensure residents code status was up to date and DNRs completed to respect the resident preference. Record review of the facility's policy titled Advanced Directive revised 2.29.24 indicated . it is the policy of this facility to adhere to residents' rights to formulate advance directive. In accordance with these rights, the facility will implement procedures to communicate a resident's code status to those individuals who need to know this information .4. The nurse who notates the physician order is responsible for documenting the directive in all relevant sections of the medical record .9. The Social Services Director shall maintain a list of residents who had an advance directive on file . 14. A code status audit will be conducted by the DON or designee quarterly or as needed . 47006

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47006 Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable homelike environment for 1 of 19 residents (Resident #42) reviewed for reasonable accommodation of needs. The facility did not ensure Resident #42 was able to easily use the door to her room. This failure could place residents at risk for unmet needs and decreased quality of life. The findings included: Record review of the face sheet, dated 11/07/24, reflected Resident #42 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of chronic pain, difficult in walking, muscle weakness, unsteadiness of feet, and lack of coordination. Record review of the quarterly MDS assessment, dated 10/16/24, reflected Resident #42 had clear speech and usually understood others. The MDS reflected Resident #42 was usually able to understand others. The MDS reflected Resident #42 had a BIMS score of 12, which indicated moderately impaired cognition. The MDS reflected Resident #12 was independent with bed mobility and transfers and used a walker. Record review of the comprehensive care plan, edited 08/26/24, reflected Resident #42 had impaired ADL function and was at risk for falls. The interventions did not address easy use of functional items. Record review of the work orders from 05/01/24 - 11/05/24, reflected no work orders had been put in the system for Resident #42's hard to open room door. During an observation and interview on 11/04/24 beginning at 11:28 AM, Resident #42's room door was hard to open upon entrance to her room. Surveyor had to put weight into the shoulder which was pressed against the door for it to open. Resident #42 stated her door to her room was extremely hard to get open. Resident #42 stated she had reported it to the facility staff several times. Resident #42 stated the Maintenance Supervisor had looked at it and said he would fix it but has not fixed it yet. Resident #42 said she had to shove, push, or use her butt to open the door. Surveyor had to push her body weight into her shoulder, which was pressed against the door in order to exit the room. During an interview on 11/06/24 beginning at 2:47 PM, the Maintenance Supervisor stated he was aware Resident #42's door was hard to open. The Maintenance Supervisor stated multiple rooms on the hall were hard to open because the whole building had shifted. The Maintenance Supervisor stated he had started making calls to have contractors come out to the facility to place bids on lifting the facility. The Maintenance Supervisor stated there were other things he could have tried to ensure the doors were easy to open but he had not had time. The Maintenance Supervisor stated it was important to ensure Resident #42 could get in and out of her room easily. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/07/24 beginning at 12:20 PM, the Administrator stated she expected Resident #42's door to have been fixed. The Administrator stated when the facility staff noticed or found out about an issue, it should have been placed into the system that generated a work order for the Maintenance Supervisor. The Administrator said the system used for work orders, alerted the team as a whole so it could have been followed up on. The Administrator stated the Maintenance Supervisor was responsible for monitoring to ensure environmental issues were addressed. The Administrator stated it was important to ensure the accommodations were made to promote an environment that was easily accessible to residents. Record review of the Accommodation of Needs policy, revised March 2021, reflected Our facility's environment and staff behaviors are directed toward assisting the resident in maintain and/or achieving safe independent functioning, dignity, and well-being .the resident's individual needs and preferences are accommodated to the extent possible .the resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis .in order to accommodate individual needs and preferences, adaptation may be made to the physical environment, including the resident's bedroom and bathroom .

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on observations, interviews, and record review, the facility failed to promptly resolve grievances for 3 out of 24 residents (Resident's #42, #44, #47) reviewed for grievances. The facility did not ensure Resident's #42, #44, and #47 grievances concerning coffee temperature were addressed. This deficient practice could place the residents at risk for decreased quality of life and feelings of neglect. The findings included: 1. Record review of the face sheet, dated 11/07/24, reflected Resident #42 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of COPD (an ongoing lung condition caused by damage to the lungs resulting in limited air flow into and out of the lungs). Record review of the quarterly MDS assessment, dated 10/16/24, reflected Resident #42 had clear speech and usually understood others. The MDS reflected Resident #42 was usually able to understand others. The MDS reflected Resident #42 had a BIMS score of 12, which indicated moderately impaired cognition. The MDS reflected Resident #12 was independent eating, which included bringing liquid to the mouth. Record review of Resident #42's comprehensive care plan, edited 08/26/24, reflected she was at risk for nutritional impairment. The interventions included: determine likes/dislikes; regular diet with thin liquids; monitor meal percentages. Record review of the general order, start date 04/21/23, reflected Resident #42 had an order for a regular diet texture with a thin fluid consistency. Record review of the grievance form dated 07/16/24, reflected all residents complained of the coffee temperatures being lukewarm. During an interview on 11/04/24 beginning at 11:28 AM, Resident #42 stated the coffee was served cold. Resident #42 said the facility staff said it was the state's fault. Resident #42 said everyone gripes about the coffee. Resident #42 stated she wanted hot coffee. Resident #42 said the facility staff were aware of the coffee being served cold, but they have not addressed the issue. 2. Record review of the face sheet, dated 11/06/24, reflected Resident #47 was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease (neurological disorder that involves irreversible worsening changes in the ability to think and remember). (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the quarterly MDS assessment, dated 10/20/24, reflected Resident #47 had clear speech and was understood by others. The MDS reflected Resident #47 was able to understand others. The MDS reflected Resident #47 had a BIMS score of 9, which indicated moderately impaired cognition. The MDS reflected Resident #47 was independent with eating, which included bringing liquid to the mouth. Record review of the comprehensive care plan, edited 10/04/24, reflected Resident #47 was at risk for nutritional impairment. The interventions included: determine likes/dislikes; regular diet with thin liquids; and monitor meal percentages. Record review of the general order, start date 03/06/24, reflected Resident #47 had an order for regular diet texture with a thin fluid consistency. Record review of the grievance form dated 07/29/24, reflected Resident #47 complained that the coffee was cold. During an interview on 11/04/24 beginning at 12:06 PM, Resident #47 stated the coffee was served cold. Resident #47 stated multiple complaints had been made but it has not gotten better. Resident #47 said she has drunk hot coffee her whole adult life and wanted her coffee to have been served hot, not cold. During an observation and interview on 11/05/24 beginning at 8:28 AM, Resident #47 was standing at the coffee thermos outside the dining room. Resident #47 said she was getting some coffee. Resident #47 took a sip of the coffee and said it was cold. 3. Record review of the face sheet, dated 11/05/24, reflected Resident #44 was a [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis of liver cell carcinoma (liver cancer). Record review of the quarterly MDS assessment, dated 09/17/24, reflected Resident #44 had clear speech and was understood by others. The MDS reflected Resident #44 was able to understand others. The MDS reflected Resident #44 had a BIMS score of 15, which indicated he was cognitively intact. The MDS reflected Resident #44 was independent with eating, which included bringing liquids to his mouth. Record review of the comprehensive care plan, edited 10/30/24, reflected Resident #44 was on a regular diet with a thin fluid consistency. The interventions included: determine likes/dislikes. Record review of the general order, start date 08/09/24, reflected Resident #44 had an order for regular diet texture with a thin fluid consistency. Record review of the grievance form dated 08/22/24, reflected Resident #44 complained that the coffee was cold. During an interview on 11/04/24 beginning at 1:10 PM, Resident #44 said the coffee was cold. Resident #44 said someone burnt themselves on the coffee so they could not serve it unless it was at 140 degrees or less. Resident #44 said it would be fine if by the time they got it was actually at 130 - 140 degrees. Resident #44 said by the time it got to his room it was much colder. Resident #44 said he liked drinking hot coffee and it was not pleasurable drinking cold coffee. Resident #44 stated when he has complained or filed a grievance, it was not addressed. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 11/05/24 beginning at 8:34 AM, DA C temped the coffee in the thermos outside the dining room. DA C read the thermometer at 119.8 degrees F. DA C stated the coffee could have been hotter. DA C stated the temperature should have been at 140 degrees F or below. DA C stated she waited until the coffee was at least 135 degrees F before she served it. DA C stated she had received numerous complaints about the coffee being too cold. DA C said, the residents were always on her back about the coffee. DA C stated the residents were used to having coffee that was scalding hot. DA C stated she did not have a set schedule for checking the coffee, but she checked it periodically for temperature and refreshed it when it became cold. DA C stated she made coffee throughout the day. DA C stated the CNAs placed the coffee on the trays before they were passed out. DA C stated she had to follow the policy and she was not allowed to serve the coffee above 140 degrees F. During an interview on 11/06/24 beginning at 12:33 PM, the DM stated she had received complaints about the coffee being too cold. The DM said the coffee had to be served between 130- and 140-degrees F. The DM stated the residents hate it and she did not blame them. The DM stated coffee served at 119.8 degrees F could have been considered luke warm. She said it could have been warmer. The DM stated when the residents complained she took the policy to educate them or had the Administrator or Social Worker talk to them. During an interview on 11/07/24 beginning at 12:20 PM, the Administrator stated she had received grievances on the coffee temperature being too cold. The Administrator stated when she received a grievance regarding coffee temperatures, she notified the DM and the DM started monitoring the coffee temperatures. The Administrator stated random temperatures were obtained to ensure the coffee was staying hot in thermos. The Administrator stated she had not identified any problems with the coffee temperatures. The Administrator stated she expected coffee to be served at 140 degrees F or less. The Administrator stated coffee served at 119.8 degrees could have been warmer. The Administrator stated it was important to ensure grievances were resolved or addressed for the residents so they could feel satisfied with the temperature of the coffee. Record review of the Grievances, Recording and Investigating policy, revised 01/12/23, reflected the resident grievance form will be filed with the Administrator of designee and the resolution will be identified within three working days of the concern .

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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 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** 45879 Based on observation, interview, and record review the facility failed to provide appropriate treatment and service of care for 1 of 3 residents (Resident #30) reviewed for indwelling catheter. The facility failed to ensure Resident #30's indwelling catheter securement device was in place. The facility failed to ensure Resident #30's indwelling catheter drainage bag was kept from touching and resting on the floor. These failures could affect residents with an indwelling urinary catheter and place them at risk of at risk for urethral tears, discomfort, infection, and hospitalization . Findings included: Record review of a face sheet dated 11/07/24 indicated Resident #30 was a [AGE] year-old male, admitted on [DATE] and readmitted on [DATE] with a diagnosis of Obstructive uropathy (a urinary tract disorder that occurs when urine flow is obstructed, either structurally or functionally),. Record review of a significant change in condition MDS dated [DATE] indicated Resident #30 rarely made himself understood and rarely understood others. Resident #30 had severely impaired cognitive skills. The MDS indicated Resident #30 required total dependence with transfers, dressing, toileting, bed mobility, personal hygiene, bathing, and eating. The MDS for Resident #30 indicated that he had an indwelling catheter. Record review of the care plan revised on 11/06/24 indicated Resident #30 required the need for an Indwelling catheter (16 french 10 cubic centimeters bulb) related to a diagnosis of Obstructive uropathy secondary to Prostate cancer. Interventions: Change the indwelling catheter and drainage bag as needed for indications of blockage, increased sediment, infection, and displacement. Record review of Resident #30's physician orders dated 03/24/24 indicated, that the Foley catheter was to be secured to the leg to promote comfort and minimize catheter tension/tissue trauma. Record review of Resident #30's MAR dated 11/01/24 through 11/07/24 revealed the staff signed indicating a Foley catheter strap was secured to his leg. During an observation on 11/04/24 at 11:50 a.m., Resident #30 was lying in his bed without an indwelling catheter securement device in place, and the indwelling catheter bag was on the floor. During an observation on 11/05/24 at 9:01 a.m., Resident #30 was lying in his bed without an indwelling catheter securement device in place, and the indwelling catheter bag was on the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/05/24 at 1:47 p.m., CNA G verified by looking and said Resident #30 did not have a leg strap on and his indwelling catheter bag was on the floor. She said Resident #30 should have an indwelling catheter securement device on to keep it from pulling out. She said the indwelling catheter bag should not be on the floor because it was cross-contamination. During an interview on 11/05/24 at 1:54 p.m., LVN D said all residents with indwelling catheters should have a leg strap. She said a leg strap would be applied to prevent tension or someone pulling them out. She said indwelling catheter bags should not be on the floor for infection control reasons. During an interview on 11/07/24 at 10:37 a.m., the DON said nurses should ensure residents always had a leg strap on to prevent dislodgement. She said the indwelling catheter should not be on the floor for infection control issues. She said all staff should ensure the residents who had indwelling catheters had on a leg strap and the indwelling drainage bag was not on the floor. During an interview on 11/07/24 at 11:22 a.m., the Administrator said she expected for the residents to have on an indwelling catheter leg strap to prevent it from pulling out. Record Review of policy titled, Indwelling Catheter Use and Removal revised 2022 indicated Policy: It is the policy of this facility to ensure indwelling urinary catheters that were inserted or remain in place justified or removed according to regulations and current standards of practice. #7 Additional care practices included: D. Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodgement of the catheter; and E. Securement of the catheter to facilitate flow of urine, prevention of kinks in the tubing, and positioning below the level of the bladder. Record review of Lippincott procedures, Indwelling urinary catheter (Foley) care and management revised 11/27/22, Lippincott procedures - Indwelling urinary catheter (Foley) care and management (lww.com), quoted in part, Keep the drainage bag below the level of the patient's bladder to prevent backflow of urine into the bladder, which increases the risk of CAUTI (catheter associated urinary tract infection) . However, do not place the drainage bag on the floor to reduce the risk of contamination and subsequent CAUTI.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 2 of 5 residents (Resident's #15 and Resident #11) reviewed for respiratory care. 1. The facility failed to ensure Resident #11's oxygen was placed on 2 liters per nasal cannula as ordered by the physician. 2. The facility failed to change oxygen tubing weekly on Sunday nights for Resident #11 and Resident #15. These failures could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care. Finding included: 1.Record review of Resident #11's face sheet, dated 11/06/24 indicated she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease also known as COPD, (a chronic inflammatory lung disease that causes obstructed airflow from the lungs),. Record review of Resident #11's quarterly MDS assessment, dated 09/20/24, indicated Resident #11 usually understood and sometimes understood others. The MDS assessment indicated she had a BIMS score of 12 indicating she was moderately cognitively impaired. Resident #11 required assistance with bathing, toileting, dressing, bed mobility, and set-up assistance with personal hygiene, and eating. The MDS indicated she required oxygen. Record review of Resident #11's physician's order dated 10/23/23 indicated Oxygen at 2 liters per nasal cannula every shift as needed for shortness of breath. Record review of Resident #11's comprehensive care plan, dated 10/09/24, indicates Resident #11 required oxygen therapy related to COPD. The intervention of the care plan was for staff to administer oxygen at 2 liter per nasal cannula. During an observation on 11/04/24 at 12:37 p.m., Resident #11 was lying in her bed with oxygen set at 5 liters per nasal cannula. The oxygen tubing was dated 10/28/24. During an observation on 11/05/24 at 9:04 a.m., Resident #11 was lying in her bed with oxygen set at 3 liters per nasal cannula. The oxygen tubing was dated 10/28/24. 2. Record review of Resident #15's face sheet, dated 11/06/24 indicated a [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (no airflow for breathing). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #15's quarterly MDS assessment, dated 09/10/24, indicated Resident #15 was usually understood and was usually understood by others. Resident #15's BIMS score was 10, which indicated she was moderately cognitively impaired. The MDS indicated Resident #15 required assistance with dressing, personal hygiene, toileting, bathing, bed mobility, transfers, and set-up for eating. The MDS during the 7-day look-back period indicated Resident #15 was receiving oxygen. Record review of Resident #15 physician orders dated 08/12/23 indicated, Nasal Cannula Continuous at 2-4 liters per minute for dyspnea or shortness of breath. Record review of Resident#15's care plan dated 08/26/24 indicated, Resident #15 had a diagnosis of COPD. The intervention was for staff to administer oxygen as ordered, monitor for signs or symptoms of respiratory infection, and report to the doctor. During an observation on 11/04/24 at 12:32 p.m., Resident # 15 was lying in her bed with her eyes closed. Her nasal cannula tubing was dated 10/25/24. During an interview on 11/05/24 at 1:54 p.m., LVN D looked at Resident #11's oxygen rate and said it was at 3 liters per nasal cannula. She said she thought she was supposed to run at 2-4 liters. She looked in the electronic medical records for Resident #11 and read her order for oxygen at 2 liters per nasal as needed for shortness of breath. She said she would fix her order. LVN D said the oxygen tubing should be changed on Sunday nights. She went to look and verified Resident #11 and Resident #15 oxygen tubing had not been changed since 10/25/24. She said she was not aware it had not been changed. She said she was also responsible for looking on Monday to ensure it had been changed and she did not. She said she would get them changed. During a telephone interview on 11/06/24 at 2:22 p.m., LVN K said he was the nurse on duty Sunday night (11/03/24). He said they did not have any nasal cannulas to change out Resident #11 and Resident #15 oxygen tubing. He said the weekend supervisor called the DON, but he said he was not sure of the whole conversation. He said he signed the medication administration record out of habit, but he did not change Resident #11 or Resident #15's nasal cannula because they did not have any in the facility. During an interview on 11/07/24 at 10:37 a.m., the DON said the charge nurses were responsible for following the physician's orders. She said not following the orders could cause respiratory issues. She said the charge nurses were responsible for ensuring the oxygen tubing was changed and dated weekly on Sunday night. She said she did receive a call from the weekend supervisor on Sunday (11/03/24). She said the weekend supervisor asked her where the nasal cannulas were located, and she told her in the blue bind; she said did not realize they were out until LVN D told her on Tuesday (11/05/24). She said she was the overseer for making rounds on Resident #15 and Resident #11. She said she did not make rounds on Monday (11/04/24) or Tuesday (11/05/24). The DON said oxygen tubing should be changed and dated for infection control. During an interview on 11/07/24 at 11:22 a.m., the Administrator said she was not clinical and did not know all the requirements for oxygen. The administrator said the DON was the overseer of orders and oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled, Oxygen revision date as of February 2010, indicated Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview and record review, the facility failed to ensure that residents who required dialysis (treatment that filters water and waste from the blood when the kidneys are no longer able to do so) received such services, consistent with professional standards of practice for 1 of 1 resident (Resident #49) reviewed for dialysis. The facility failed to ensure all pre and post-dialysis assessments were completed for Resident #49. This deficient practice could affect residents who received dialysis treatments and place them at risk for complications and not receiving adequate care and treatment to meet their needs. Findings included: Record review of Resident #49's face sheet, dated 11/06/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including fluid overload (which happens when there is too much fluid in your body. It can raise blood pressure, cause swelling, and impact organ function), End-Stage Renal Disease also known as ESRD (a permanent condition that occurs when the kidneys stop working and require dialysis or a kidney transplant to sustain life), high blood pressure, and depression (sadness). Record review of Resident #49's 5-day MDS Assessment, dated 10/14/24 indicated Resident #49 usually made himself understood and usually understood others. Resident #49 had a BIMS score of 01 indicating his cognition was severely impaired. The MDS indicated Resident #49 required assistance with transfers, dressing, toileting, bed mobility, personal hygiene, bathing, and set-up for eating. The MDS for Resident #49 indicated he received hemodialysis (while a resident and on admission). Record review of the care plan initiated on 10/27/24 indicated he had a diagnosis of ESRD and was dependent on dialysis. He went to dialysis on Tuesday, Thursday, and Saturday. He had a left fistula on his inner arm. The interventions were for staff to administer medications as ordered, monitor the fistula site, and report any abnormalities to the physician. Record review of Resident #49's Order Summary, dated 10/17/24, revealed orders: Hemodialysis: AV Fistula/AV Graft to the left upper arm. Auscultate bruits and palpate thrill every shift. Hemodialysis performed on Tuesday, Thursday, and Saturday with a chair time of 6 a.m. Special Instructions: Fill out the form (Pre-Dialysis Assessment), and send medications, snacks, and a blanket with the resident. Record review of Resident #49's Dialysis Notebook undated revealed the following: *10/10/24 Pre-dialysis and post-dialysis assessment completed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*10/12/24 Pre-dialysis and post-dialysis assessment completed. *10/19/24 Pre-dialysis and post-dialysis assessment completed. *10/29/24 Pre-dialysis and post-dialysis assessment completed. Further review revealed there were no pre-dialysis or post-dialysis communication sheets located for following dates: 10/10/24, 10/15/24, 10/17/24, 10/22/24, 10/24/24, 10/26/24, 10/31/24 and 11/2/24. Record review of Resident #49's electronic medical records revealed there were no pre-dialysis or post-dialysis assessments for the following dates: 10/10/24, 10/15/24, 10/17/24, 10/22/24, 10/24/24, 10/26/24, 10/31/24 and 11/2/24. During an interview on 11/05/24 at 9:07 a.m., LVN E said Resident #49 had a dialysis communication book. She said sometimes Resident #49 did not bring back the communication sheets. She said if he did not bring back the communication sheet, she would assess him, but she did not place the assessment (communication sheet) in his book or document the assessment his electronic medical records. She said it was reported (unknown source) to her that Resident #49 had thrown his communication sheets in the trash or out the window of the van. She said she had never called the dialysis center to inquire about his communication sheets, any new orders, or any concerns during dialysis. During an interview on 11/05/24 at 12:24 p.m., Resident #49 was sitting on the side of his bed eating lunch. He said the staff usually gave him some paperwork to take to dialysis and he brought it back. He said he sometimes gave it to the van person or someone at the facility. During an interview on 11/07/24 at 10:37 a.m., the DON said the nurses sent communication forms with Resident #49 to dialysis. She said she expected the nurses to do the pre and post-dialysis assessment to ensure the resident was okay before and after dialysis. She said Resident #49 had a communication book, but she wanted to change the process and start scanning them into his electronic medical records. During an interview on 11/07/24 at 11:22 a.m., the Administrator said all dialysis residents should have communication sheets for any changes. She said the DON was the overseer of Dialysis. Record review of the facility policy titled, End-Stage Renal Disease, Care of a Resident with . revised date of September 2010, indicated, Policy Interpretation and Implementation: 1. Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. 2. Education and training of staff includes, specifically: The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis. Signs and symptoms of worsening condition and/or complications of ESRD; Timing and administration of medications, particularly those before and after dialysis; The care of grafts and fistulas; and the handling of waste. 3. Education and training of staff in the care of ESRD/dialysis residents may be managed by the contracted dialysis facility or by a clinician with special training in ESRD and dialysis care. 4. Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: How the care plan will be developed and implemented and how information will be exchanged between the facilities.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interviews, and record review, the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 3 residents (Resident # 49) reviewed for trauma-informed care. The facility did not ensure Resident #49 had a trauma screening upon admission that identified possible triggers when Resident 49 had a history of trauma. This failure could put residents at an increased risk for severe psychological distress due to re-traumatization. Findings included: Record review of a face sheet dated 11/07/24 indicated Resident #30 was a [AGE] year-old male, admitted on [DATE] and readmitted on [DATE] with diagnoses including stroke, Obstructive uropathy (a urinary tract disorder that occurs when urine flow is obstructed, by either structurally, or functionally), anxiety (a feeling of fear, dread, or uneasiness), depression (a mood disorder that causes a persistent feeling of sadness), and post-traumatic stress disorder also known as PTSD (is a mental health condition that can develop after a person experienced or witnessed a traumatic event). Record review of a significant change in condition MDS dated [DATE] indicated Resident #30 rarely made himself understood and rarely understood others. Resident #30 had severely impaired cognitive skills. The MDS indicated Resident #30 required total dependence on transfers, dressing, toileting, bed mobility, personal hygiene, bathing, and eating. The MDS for Resident #30 indicated he had PTSD. Record review of the care plan revised on 11/06/24 indicated Resident #30 was at risk for adverse consequences related to administering medication for the diagnosis of anxiety and post-traumatic stress disorder. The interventions were to give medication as ordered. The care plan did not indicate any triggers. Record review of Resident #30's trauma assessment was not located in his electronic medical records. During an attempted interview on 11/04/24 at 9:01 a.m., Resident #30 was lying in his bed. He did not respond when asked about his history of trauma. During an interview on 11/07/24 at 9:40 AM, the Social Worker said she was not sure of the process for trauma-informed care. The Social Worker said she was new to the facility and had only been employed for a few weeks. The Social Worker said she thought the trauma assessments should have been completed on admission and quarterly. The Social Worker said Resident 30's assessment should have been completed. The Social Worker said it was important to ensure trauma assessments were completed to ensure the residents' needs were met and they were safe and comfortable. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/07/24 at 10:25 a.m., the MDS nurse said the previous SW did the care plans on trauma. She said she was the overseer of care plans and should have ensured Resident #30 had his trauma or PTSD triggers on the care plan. She said having triggers on the care plan would alert staff of things not to do and how to help him through his triggers. During an interview on 11/07/24 at 10:37 a.m., the DON said the SW was responsible for the trauma-informed care assessment. She said the trauma assessment was done to see if a resident had any underlying trauma or behaviors. She said she was not sure if the MDS nurse or the SW put the PTSD/trauma care on the care plan. She said she was not aware Resident #30 did not have a trauma assessment done on admission as she was new to the facility. The DON said it was important for any triggers to be on the care plan so staff would know how to address them and provide the resident with the best care for their overall well-being. During an interview on 11/07/24 at 11:22 a.m., the Administrator said it was important for the trauma assessment to be completed and for staff to have access to that information so they could accurately meet the resident's needs. Record review of the facility's policy titled Trauma Informed Care last revised 12/2019, indicated, Policy: The facility ensures residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice. The care accounts for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Resident-Care Strategies: #1 As part of the comprehensive assessment, identify the history of trauma or interpersonal violence when possible. Identifying past trauma or adverse experiences may involve record review or the use of screening tools.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview and record review, the facility failed to establish a system of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and determine that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 1 storage area reviewed for expired and discontinued medications. The facility failed to keep a record of receipt of controlled medications awaiting disposition to allow accurate and periodic reconciliation. This failure could place residents at risk for loss of prescribed medications, resident's safety, and drug diversion. Findings included: During an observation and interview on [DATE] at 09:54 AM, the following medications were observed in a basket located inside the controlled medication closet located inside the DONs office, and were awaiting to be disposed: *Ativan/Benadryl 1mg/25mg/ml gel- 25 mls RX# ,d+[DATE] *Hydrocodone-apap ,d+[DATE]mg tablet (label 1 of 3)- 8 tablets RX# 400219 *Hydrocodone-apap ,d+[DATE]mg tablet (label 2 of 3)- 60 tablets RX# 400219 *Alprazolam 0.25mg tablet- 52 tablets RX# 423615 *Tramadol 50mg tablet- 6 tablets RX 123278 The DON said the controlled medications awaiting to be disposed were kept in the closet behind the locked door and lock. The DON said she was the only one with the key to the door and lock. The DON said her process when she reconciled medications that need to be disposed of was as follows: when medications were brought to her, she checked the narcotic medication count and verified the count with the nurse, the nurse and herself signed the narcotic sheet, logged the medication on the destruction log that was kept with the medications, then she placed the medication in the double locked closet. The DON said she had not found where the facility kept a copy of the blank destruction log so she could log the medications. The DON said she was the only person with the keys therefore medications would not come up missing. The DON said she was responsible for ensuring narcotic medications were being logged. (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 [DATE] at 09:48 AM, the Administrator said she expected narcotic medications to be logged and locked up appropriately. The Administrator said she expected the narcotic medications to be logged so they were appropriately accounted for. The Administrator said there were no risks for not logging the narcotic medications as the DON was the only one with the key. The Administrator said the DON was responsible for accurately reconciling the narcotic medications. Record review of the facility's policy Controlled Substance Storage dated [DATE], indicated . Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are retained in the facility in a securely locked area with restricted access until destroyed. Accountability records for discontinued controlled substances are maintained with the unused supply until it destroyed or disposed of, and then store for 5 years or as required by applicable law or regulation. The consultant pharmacist or designee routinely controlled substance storage, records [i.e., change if shift sheets, individual controlled substance accountability sheets, MARs, delivery confirmation sheets], and expiration dates during routine medication storage inspec

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview and record review, the facility failed to ensure that it was free of medication error rate of 5 percent or greater. The facility had a medication error rate of 24.24%, based on 8 errors out of 33 opportunities, which involved 2 of 6 residents (Resident #4 and Resident #25) reviewed for medication administration. The facility failed to ensure Resident #4 medications were administered during the scheduled time on 11/04/24. The facility failed to ensure LVN appropriately dosed Resident #25's MiraLAX on 11/05/24. These failures could place residents at risk for not receiving the intended therapeutic benefit of their medications or receiving them as prescribed, per physician orders. Findings included: 1. Record review of Resident #4's face sheet dated 11/06/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses which included dementia (memory loss), depression (persistent feeling of sadness and loss of interest), chronic pain, essential hypertension (high blood pressure), and congestive heart failure (an impairment in the heart's ability to fill with and pump blood). Record review of Resident #4's quarterly MDS assessment dated [DATE], indicated Resident #4 was able to make herself understood and understood others. The MDS assessment indicated Resident #4 had a BIMS score of 6, indicating her cognition was severely impaired. The MDS assessment indicated Resident #4 received scheduled pain medication and did not have pain within the last 5 days of the look back period. The MDS assessment indicated Resident #4 had received an anticoagulant and a diuretic within the last 7 days of the 7-day look back period. Record review of Resident #4's comprehensive care plan dated 10/04/24, indicated Resident #4 had polyosteoarthritis (arthritis that affects multiple joints simultaneously) and was at risk for increased discomfort. The comprehensive care plan also indicated Resident #4 had congestive heart failure and hypertension. The care plan interventions included to administer medications as prescribed. Record review of Resident #4's physician order report dated 10/06/24-11/06/24, indicated Resident #4 had the following orders: *Bumetanide 1mg give one tablet by mouth once a day with a start date of 05/26/23. *Vitamin D3 125mcg give one tablet once a day on Monday with a start date of 05/26/23 *Eliquis 2.5mg give one tablet twice a day with a start date of 05/26/23. *Isosorbide mononitrate 30mg give one tablet once a day with a start date of 05/25/23. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Tylenol 650mg give one tablet twice a day with a start date of 05/26/23. *Potassium chloride 20mEq give one tablet twice a day with a start date of 05/26/23. *Ranolazine 500mg give one tablet twice a day with a start date of 10/16/23. During an observation and interview on 11/04/24 at 12:36 PM, LVN A said the medications she was about to prepare for Resident #4 were late because she was the only person who gave medications in the entire building. LVN A prepared and administered Resident #4's medications: *Bumetanide 1mg one tablet *Vitamin D3 125mcg one tablet *Eliquis 2.5mg one tablet *Isosorbide mononitrate 30mg one tablet *Potassium chloride 20 mEq one tablet *Ranolazine 500mg one tablet LVN A failed to administered Tylenol 650mg tablet as ordered to Resident #4. Record review of Resident #4's medication administration record dated 11/01/24-11/06/24, indicated the following medications were scheduled to have been administered from 6:00 AM-10:00 AM on 11/04/24: *Bumetanide 1mg one tablet *Vitamin D3 125mcg one tablet *Eliquis 2.5mg one tablet *Isosorbide mononitrate 30mg one tablet *Potassium chloride 20 mEq one tablet *Ranolazine 500mg one tablet *Tylenol 650mg on tablet 2. Record review of Resident #25's face sheet dated 11/06/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included gastrointestinal hemorrhage (forms of bleeding in the gastrointestinal tract), constipation, atrial fibrillation (irregular heart rhythm), and congestive heart failure (impairment in the heart's ability to fill with and pump blood). (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #25's admission MDS assessment dated [DATE], indicated Resident #25 was understood and understood others. The MDS assessment indicated Resident #25 had a BIMS score of 15, indicating her cognition was intact. The MDS assessment did not indicate Resident #25 had constipation. Record review of Resident #25's comprehensive care plan dated 11/01/24, did not address Resident #25's diagnosis of constipation. Record review of Resident #25's physician order report dated 10/06/24-11/06/24, indicated Resident #25 had an order for MiraLAX 17grams/dose give 17 grams by mouth once a day with a start date of 10/26/24. Record review of Resident #25's medication administration record dated 11/01/24-11/06/24 indicated Resident #25 had received MiraLAX 17gram by mouth daily. During an observation on 11/05/24 at 08:22 AM, LVN A opened the MiraLAX bottle and poured the MiraLAX in a medicine cup between the 15ml-20ml lines. LVN A failed to use the MiraLAX cap as instructed on the directions on label of the MiraLAX bottle to obtain the 17 grams as prescribed. During an interview on 11/06/24 at 1:27 PM, LVN A said she was responsible for administering the medications to the entire facility. LVN A said by administering medications late could cause the medications to be less effective. LVN A said if medications were ordered more than one time a day, it could cause medications to be administered to close to the second dose. LVN A said she was responsible for ensuring medications were administered as scheduled. LVN A said she should have administered Resident #4's Tylenol as ordered and failure to do so could have caused Resident #4 pain. LVN A said the medications rights were the right time, right dosage, right amount, right resident and right route. LVN A said no one trained her on the medication pass when she started in October of 2024. LVN A said had told the DON and the Administrator the medication load was too heavy for one person and medications were not being given on time. LVN A said they had the liberalized medication pass and the one-hour rule before and after still applied. LVN A said she should have used the cap on the MiraLAX bottle for the measurement of the MiraLAX for Resident #25. LVN A said failure to do so could have resulted in either under or over administration of the prescribed dosage. LVN A said she was responsible for ensuring the correct dosage was administered. During an interview on 11/07/24 at 09:30 AM, the DON said she had not received any reports that LVN A was having any issues. The DON said the pharmacy consultant had reported LVN A was doing great. The DON said she was unable to answer the risks of what could occur with medication being administered late. The DON said by Resident #4 not receiving the Tylenol as ordered she could potentially be in pain. The DON said she expected LVN A to have used the lid of the MiraLAX bottle to measure Resident #25's MiraLAX, as it was to have been used for the correct measurement. The DON said by not using the lid of the MiraLAX, Resident #4 could have received the incorrect amount and could have caused Resident #4 constipation. The DON said the medication aide, nurse, and herself were responsible for ensuring the medications were given on time and by physician orders. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/07/24 at 09:48 AM, the Administrator said she expected medications to be given correctly and in a timely manner. The Administrator said the DON and the clinical staff oversaw the medication pass. The Administrator said since the MiraLAX was not given as prescribed the resident could potentially be given the incorrect dosage. The Administrator said she was unable to answer the risks of what could happen for medications not being administered on time. The Administrator said the medication aide was responsible for ensuring medications were being administered as scheduled and per physician orders. Record review of the facility's policy Medication Administration- General Guidelines dated 06/01/22, indicated . Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so . 4. Five rights- right resident, right drug, right dose, and right time are applied for each medication being administered . 12) Medications are administered within [60 minutes] of scheduled time, except before, with, or after meal orders, which are administered [based on mealtimes]. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility.

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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 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** 46928 Based on observation, interview, and record review, the facility failed to ensure that residents were free of significant medication errors for 1 of 6 residents (Resident #4) reviewed for pharmacy services. The facility failed to ensure Resident #4 medications were administered during the scheduled time of 6:00 AM and 10:00 AM on 11/04/24 which resulted in medications being administered 1 hour and 36 minutes late after the 1-hour grace period. The facility failed to ensure Resident # 4's medications were administered during the scheduled time of 6:00 AM and 10:00 AM on 11/05/24 which resulted in medications being administered 4 hour and 55 minutes late after the 1-hour grace period. These failures could place residents at risk of medical complications and not receiving the therapeutic effects of their medications. Findings included: 1. Record review of Resident #4's face sheet dated 11/06/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses which included dementia (memory loss), depression (persistent feeling of sadness and loss of interest), chronic pain, essential hypertension (high blood pressure), and congestive heart failure (an impairment in the heart's ability to fill with and pump blood). Record review of Resident #4's quarterly MDS assessment dated [DATE], indicated Resident #4 was able to make herself understood and understood others. The MDS assessment indicated Resident #4 had a BIMS score of 6, indicating her cognition was severely impaired. The MDS assessment indicated Resident #4 received scheduled pain medication and did not have pain within the last 5 days of the look back period. The MDS assessment indicated Resident #4 had received an anticoagulant and a diuretic within the last 7 days of the 7-day look back period. Record review of Resident #4's comprehensive care plan dated 10/04/24, indicated Resident #4 had polyosteoarthritis (arthritis that affects multiple joints simultaneously) and was at risk for increased discomfort. The comprehensive care plan also indicated Resident #4 had congestive heart failure and hypertension. The care plan interventions included to administer medications as prescribed. Record review of Resident #4's physician order report dated 10/06/24-11/06/24, indicated Resident #4 had the following orders: *Eliquis (anticoagulant medication) 2.5mg give one tablet twice a day with a start date of 05/26/23. *Ranolazine (used to treat chronic chest pain) 500mg give one tablet twice a day with a start date of 10/16/23. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 11/04/24 at 12:36 PM, LVN A said the medications she was about to prepare for Resident #4 were late because she was the only person who gave medications in the entire building. LVN A prepared and administered Resident #4's medications. An Eliquis 2.5mg tablet and a ranolazine 500mg tablet were included in Resident #4's medications. LVN A administered Resident #4's medications 1 hour and 36 minutes late from the scheduled time of 6:00 AM-10:00 AM after the 1-hour grace period. Record review of Resident #4's medication administration record dated 11/01/24-11/06/24, indicated the following medications were scheduled to have been administered from 6:00 AM-10:00 AM on 11/04/24: *Eliquis 2.5mg one tablet *Ranolazine 500mg one tablet The medication administration history also indicated on 11/05/24 the following medications were scheduled to be received from 6:00 AM to 10:00 AM and 5:00 PM- 10:00 PM. LVN A charted the medications as being late for the 6:00AM- 10:00 dose: *Eliquis 2.5mg one tablet twice a day was charted at as being administered at 3:55 PM. *Ranolazine 500mg one tablet twice a day was charted as being administered at 3:54 PM . LVN A administered Resident #4's medications 4 hours and 55 minutes late from the scheduled time of 6:00 AM-10:00 AM after the 1-hour grace period. During an interview on 11/06/24 at 1:27 PM, LVN A said she was responsible for administering the medications to the entire facility. LVN A said by administering medications late could cause the medications to be less effective. LVN A said if medications were ordered more than one time a day, it could cause medications to be administered to close to the second dose. LVN A said she was responsible for ensuring medications were administered as scheduled. LVN A said the medications rights were the right time, right dosage, right amount, right resident and right route. LVN A said no one trained her on the medication pass when she started in October of 2024. LVN A said had told the DON and the Administrator the medication load was too heavy for one person and medications were not being given on time. LVN A said they had the liberalized medication pass and the one-hour rule before and after still applied. LVN A said she was responsible for ensuring the correct dosage was administered. During an interview on 11/07/24 at 9:30 AM, the DON said she had not received any reports that LVN A was having any issues. The DON said the pharmacy consultant had reported LVN A was doing great. The DON said she was unable to answer the risks of what could occur with medication being administered late. The DON said the medication aide, nurse, and herself were responsible for ensuring the medications were given on time and by physician orders. During an interview on 11/07/24 at 9:48 AM, the Administrator said she expected medications to be given correctly and in a timely manner. The Administrator said the DON and the clinical staff oversaw the medication pass. The Administrator said she was unable to answer the risks of what could happen for medications not being administered on time. The Administrator said the medication aide was responsible for ensuring medications were being administered as scheduled and per physician orders. (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's policy Medication Administration- General Guidelines dated 06/01/22, indicated . Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so . 4. Five rights- right resident, right drug, right dose, and right time are applied for each medication being administered . 12) Medications are administered within [60 minutes] of scheduled time, except before, with, or after meal orders, which are administered [based on mealtimes]. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46928 Based on observation and interview the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel, and labeled and dated correctly for 1 of 4 medication carts (south nurse's treatment cart) and 2 of 7 residents (Resident #3) observed for medication storage. 1. The facility did not ensure the south side nurse's treatment cart was secured and unable to be accessed by unauthorized personnel on 11/05/24. 2. The facility failed to ensure Resident #3's insulin lispro pen was properly secured when LVN B left it on top of the nurse's treatment cart on 11/05/24. 3. The facility failed to ensure Resident #38 wound care supplies was properly safe and secured. These failures could place residents at risk for not receiving drugs and biologicals as needed and a drug diversion. Findings included: Record review of Resident #3's face sheet dated 11/06/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included cerebral palsy (movement disorder that appears in early childhood), type 2 diabetes mellitus (body has trouble controlling blood sugar and using it for energy), essential hypertension (high blood pressure), and weakness. Record review of Resident #3's quarterly MDS assessment dated [DATE], indicated Resident #3 was able to be understood and understood others. The MDS assessment indicated Resident #3 had a BIMS score of 15 which indicated her cognition was intact. The MDS assessment indicated Resident #3 received insulin 7 days out of the 7-day look back period. Record review of Resident #3's comprehensive care plan dated 08/15/24, indicated Resident #3 had diabetes mellitus with interventions to administer medications per ordered and received insulin. Record review of Resident #3's physician order report dated 10/06/24- 11/06/24, indicated Resident #3 had an order for insulin lispro 100 unit/ml pen per sliding scale before meals and at bedtime with a start date of 05/20/24. Record review of Resident #3's medication administration record dated 11/01/24-11/06/24, indicated Resident #3 received insulin lispro pen per sliding scale before meals and at bedtime. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 11/05/24 at 11:30 AM, LVN B obtained the glucometer, a small gauze, an alcohol pad, a lancet and a glucometer test strip from inside the nurse's cart and placed them on top of the cart on a piece of wax paper. LVN B then obtained Resident #3's insulin lispro pen from inside the cart and placed it on the wax paper on top the cart. LVN B proceeded to enter Resident #3's room to obtain her blood sugar. LVN B left the nurse's treatment cart unlocked with the insulin pen on top of cart and closed Resident #3's door. LVN B proceeded to obtain Resident #3's blood sugar. LVN B said she had thought about not locking the nurse's cart but since she was right inside the room, she said she could have heard someone getting inside the cart. LVN B said she was responsible for ensuring the cart was locked when left unattended and medications secured. LVN B said by leaving the cart unlocked and the insulin pen on top of the cart, someone could have taken medications from inside the cart or taken the insulin pen. During an interview on 11/07/24 at 9:30 AM, the DON said she expected the medications cart to be locked when not in view of the nurse. The DON said she expected medications to be always secured. The DON said by leaving the medication cart and the insulin pen unsecured, someone could have taken medications or could have potentially administered the insulin. The DON said the person in charge of the medication cart was responsible for ensuring the medication cart and medications were properly secured when not in view. During an interview on 11/07/24 at 9:48 AM, the Administrator said she expected the medication carts to be locked when the staff stepped away from them. The Administrator said she expected medications to be properly always secured. The Administrator said she was unable to answer what risks could occur when leaving the cart unlocked or the insulin pen unsecured. The Administrator said the nurse providing the medications was responsible for ensuring the cart was locked when left unattended and ensuring medications were properly secured. 43047 3. Record review of Resident #38's face sheet, dated 11/6/24, indicated Resident #38 was a [AGE] year-old female, originally to the facility on [DATE] with diagnoses which included pressure ulcer of sacral (bone of the spine that connects the spine to the lower body) region. Record review of Resident #38's physician order report, dated 10/6/24-11/6/24, indicated an active physician's order for: wound Treatment Order: Location: Coccyx, Clean with Normal Saline/Wound Cleanser, Apply: Wound Vac at 150 mmhg. Once A Day on Mon, Wed, Fri with a start date 10/24/24. Record review of Resident #38's quarterly MDS, dated [DATE], indicated Resident #38 made himself understood, usually understood others. Resident #38's BIMS score was a 15, which indicated his cognition was intact. Resident #38 had a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device that required treatment. Record review of the comprehensive care plan, dated 09/14/23, indicated Resident #38 had a stage IV pressure wound to her coccyx (tailbone). The care plan interventions included staff to apply treatment to stage IV as ordered via physician, monitor and document size, drainage, infection, appearance of wound peri wound and pain and notify doctor of worsening of wound. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 11/5/24 at 8:45 a.m., Resident #38 was sitting in her wheelchair. There was a bottle labeled Gentell dermal wound cleanser (wound care supplies) and a tube labeled Anasept skin and wound gel (wound care supplies) sitting on her dresser. Resident #38 stated those items were used for her wound to her bottom. Resident #38 stated staff had brought it in her room when they performed wound care. During a telephone interview on 11/7/24 at 9:56 a.m., LVN B stated she was the charge nurse for Resident #38 on 11/5/24. LVN B stated she did not see the wound care supplies on her dresser. LVN B stated wound care supplies should be stored in the nurse's cart when not in use. LVN B stated this failure could potentially residents at risk for their safety. During an observation and interview on 11/7/24 at 10:15 a.m., with the Regional Compliance Nurse a tube labeled Anasept skin and wound gel was noted sitting on Resident #38's dresser. The Regional Compliance Nurse stated wound care supplies should be stored in the nurse's treatment cart. The Regional Compliance Nurse stated it was important to ensure wound care supplies were stored properly for the safety of residents. During an interview on 11/7/24 at 12:14 p.m., the DON stated she expected the wound cleanser to be labeled with the resident name. The DON stated all wound care supplies should be stored in the treatment cart. The DON stated during angel rounds the staff should be ensuring wound care items were stored in the treatment cart. The DON stated the MDS Coordinator was responsible for Resident #38 angel rounds. The DON stated it was important that wound care supplies were not left at bedside for overall safety. During an interview on 11/7/24 at 12:20 p.m., the MDS Coordinator stated she conducted rounds for Resident #38. The MDS Coordinator stated she was only there a couple days a week. The MDS Coordinator stated she did make rounds this week, but she did not actually go in Resident #38 room. The MDS Coordinator stated she should have gone in the room and inpect. The MDS Coordinator stated it was ensuring items were stored properly for resident safety. During an interview on 11/7/24 at 12:39 p.m., the Administrator stated she expected wound care items to be stored in the treatment cart. The Administrator stated she expected the nurse that was providing the wound care to take the items and store back in the treatment cart. The Administrator stated she expected the individual that was assigned for angel rounds to keep an eye out also. The Administrator stated it was important to ensure wound care supplies were stored properly for resident safety. Record review of the facility's policy Medication Administration- General Guidelines dated 06/01/22, indicated . 16) During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart . Record review of the facility's policy titled Storage of Medications revised 11/20 indicated . the facility stores all drugs and biologicals in a safe, secure, and orderly manner 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner 6. Compartment (including, but not limited to, drawers, cabinets, rooms, refrigerator, carts, and boxes) containing drugs and biologicals are locked when not in use . unlocked medication carts are not left unattended .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 46928 Based on observations, interviews, and record review, the facility failed to ensure the meals served met the nutritional needs of residents for 1 of 1 meal (the lunch meal) reviewed for nutritional adequacy. The facility did not ensure an 8 oz scoop size was used to serve the chicken alfredo during the lunch meal on 11/05/24. This failure could affect all residents in the facility by placing them at risk of not receiving adequate nutritive food value needed to promote/maintain health. Findings included: Record review of the facility dietary spreadsheet dated 06/04/24, indicated an 8 oz scoop size should be used to serve chicken alfredo. During an observation on 11/05/24 at 11:52 AM, a 6 oz scoop was being used to serve chicken alfredo. Approximately 10 resident trays had already been served and delivered. During an observation and interview on 11/05/24 at 11:56 AM, the Dietary Manager said the size of the scoop that was needed was documented on the dietary spreadsheet. The Dietary Manager said she posted the colors of each scoop size on the window in front of the serving table. The Dietary Manager looked at the scoop size that was being used to serve the chicken alfredo and said a 6oz scoop was being used. The Dietary Manager said an 8 oz scoop was needed to be used instead of the 6 oz per the spreadsheet. The Dietary Manager said she was responsible for ensuring the correct scoop size was being used and failure to do so placed the residents at risk for receiving less food. During an observation and interview on 11/05/24 at 11:59 AM, [NAME] E said she when had looked at the spreadsheet she saw it said to use a 6oz scoop for the chicken alfredo. [NAME] E went and looked at the spreadsheet again and said it indicated to use an 8 oz scoop. [NAME] E said she was responsible for ensuring the correct scoop was being used and failure to do so placed the residents at risk for not receiving enough food. During an interview on 11/07/24 at 9:30 AM, the DON said she expected the Dietary staff to use the correct size scoop so residents could receive the correct portions. The DON said failure to use the correct scoop size placed residents at risk for not receiving the nutrition intended. The DON said the Dietary Manager and the Dietician Consultant were responsible for ensuring the correct scoop size was being used to serve the resident's meals. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/07/24 at 9:48 AM, the Administrator said she expected the dietary staff to read the menu and use the correct scoop size. The Administrator said if the dietary staff noticed an error, they needed to correct it immediately so the residents could receive the correct amount of food. The Administrator said all residents were provided with the correct nutritional value of their food and they could always provide an alternate or give them more food if necessary. The Administrator said the Dietary Manager and the [NAME] were responsible for ensuring the correct scoop size was being used when serving the meals. Record review of the facility's policy and procedure Tray Service dated 2018, indicated . The facility believes that accurate tray service and adequate portion sizes are essential to the resident's wellbeing and safety. The facility will ensure that diets are serviced accurately and in the correct portions and that resident preferences are met . Record review of the facility's policy and procedure Portion Control dated 2018, indicated . The facility will use standard portion control procedures and utensils to ensure that adequate portions are served to residents . 3. Portions for each food group should follow the specific portion sizes listed om the menu .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47006 Based on observation, interview, and record review, the facility failed to provide food that was palatable and served at an appetizing temperature for 4 of 19 residents (Resident's #22, #42, #44, and #47) reviewed for palatable food. The facility failed to provide palatable food served at an appetizing temperature or taste to Resident #22, #42, #44, and #47 who complained the food was served cold, was bland, and did not taste good. This failure could place residents who ate food from the kitchen at risk of weight loss, altered nutritional status, and diminished quality of life. The findings included: During an interview on 11/04/24 at 11:28 AM, Resident #42 stated the food was cold and did not have flavor. During an interview on 11/04/24 at 12:02 PM, Resident #22 said she wished the facility had better food. Resident #22 said the food was bland. During an interview on 11/04/24 at 12:06 PM, Resident #47 stated she did not like the food. Resident #47 stated the vegetables were musty and very bland. Resident #47 said the food was cold when she received it. During an interview on 11/04/24 at 1:10 PM, Resident #44 stated he was getting hungrier and hungrier. Resident #44 said he has had traumatic experiences with the food at the facility. Resident #44 said gravy had the consistency of milk, eggs were dry like popcorn. Resident #44 said the food was nasty. Resident #44 said he breakfast meal was cold most of the time. During an observation and interview on 11/05/24 at 12:40 PM, a lunch tray was sampled by the Dietary Manager and 4 surveyors. The sample tray consisted of fettuccini alfredo, capri vegetables, and a roll. The Dietary Manager said the lunch meal did not look appetizing and it was hard to tell what the fettuccini alfredo was. The Dietary Manager said the vegetables were bland, warm, and mushy. The Dietary Manager said it was always an ordeal with complaints from the residents. During an interview on 11/06/24 beginning at 12:33 PM, the DM stated she received food complaints constantly. The DM stated the food complaints were mainly about having the same things over and over again. The DM stated she had not received any complaints about the temperature of the food being too cold recently. The DM stated resident council complained of the food being over seasoned so in response they used less seasoning. The DM stated she was unaware of any complaints the food was bland or the vegetables were over-cooked until she tasted it on the test tray. The DM stated it was important to ensure food was served at an appropriate temperature and looked appetizing to ensure residents ate and received the appropriate nutrition. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/06/24 beginning at 12:20 PM, the Administrator stated she received food complaints at least monthly. The Administrator stated she was unaware of complaints regarding the food being bland. The Administrator stated expected the food to have been served at the appropriate temperature. The Administrator she expected the food to have an appetizing appearance. The Administrator stated the DM was responsible for monitoring to ensure the food was served correctly. The Administrator stated it was important to ensure the food was appetizing and served at the appropriate temperature to prevent weight loss from the residents not eating. Record review of the Food and Nutrition Services policy, revised September 2021, reflected Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature . 46928

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 2 residents (Resident #1) reviewed for hospice services. The facility did not ensure Resident #1's updated plan of care and most recent medication list from the hospice were a part of their current medical records in the facility. This deficient practice could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. The findings included: Record review of the face sheet, dated 11/07/24, reflected Resident #1 was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis that included Alzheimer's disease (neurological disorder that involves irreversible worsening changes in the ability to think and remember). Record review of the quarterly MDS assessment, dated 08/29/24, reflected Resident #1 had clear speech and was usually understood by others. The MDS reflected Resident #1 was usually able to understand others. The MDS reflected Resident #1 had a BIMS score of 1, which indicated severe cognitive impairment. The MDS reflected Resident #1 had no behaviors or refusal of care. The MDS reflected Resident #1 received hospice services while a resident at the facility. Record review of the comprehensive care plan, revised 10/04/24, reflected Resident #1 had a terminal illness and was receiving hospice services. Record review of the general order, start date 06/30/23, reflected Resident #1 had an order for hospices care and services. Record review of the hospice binder, accessed on 11/07/24, reflected Resident #1's most current plan of care update report was on 10/02/24, the plan of care update report should have been completed every 2 weeks. Record review of the hospice binder, accessed on 11/07/24, reflected Resident #1's most current hospice medication report was completed on 09/17/24. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/07/24 beginning at 11:48 AM, LVN D said hospice binders were kept at the nurses' station. LVN D stated the hospice paperwork was kept on the tablets brought in by the hospice staff. LVN D stated she was required to sign the hospice tablet when the hospice staff came to the facility. LVN was unsure if physical copies of the information was kept at the facility. LVN D stated she only signed the tablets and did not really deal with the paperwork in the hospice binders. LVN D stated someone in management probably dealt with that. During an interview on 11/07/24 beginning at 11:54 AM, the DON said the ADON was responsible for ensure the hospice binder had updated information. The DON stated the ADON walked out the first of last month (October 2024). The DON stated she had recently started working at the facility and had not had a chance to ensure the hospice binders were updated. The DON stated it was important to ensure the hospice paperwork was up to date for continuity and coordination of care. During an interview on 11/07/24 beginning at 12:20 PM, the Administrator stated she expected the hospice binder to have updated paperwork. The Administrator stated nursing management was responsible for ensuring the hospice binders had the most updated paperwork. The Administrator stated it was important to ensure the hospice paperwork was up to date to promote communication and continuity of care between the teams. Record review of the hospice contract signed 06/20/23, reflected the facility shall maintain an accurate patient medical record. Required documentation provided by hospice will be included in a designated area/section. Facility will ensure that these forms are not removed facility will keep accurate, detailed, and complete accounts and records of all services and events provided . Record review of the Hospice Program policy, revised July 2017, reflected .obtaining the following information from the hospice: the most recent hospice plan of care specific to each resident .hospice medication information specified to each resident .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review the facility failed to effectively maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, including hand hygiene for 3 of 7 residents (Resident #48, Resident #44 and Resident#3) reviewed for infection control. 1. The facility failed to ensure LVN H changed gloves or performed hand hygiene while providing wound care for Resident #48's coccyx area. 2. The facility failed to ensure CNA F did not wear Personal protective equipment and gloves in the hallway after assisting Resident #44 with his breakfast tray who was in contact isolation. 3. The facility failed to ensure LVN B performed hand hygiene when she removed her gloves after she obtained Resident #3's blood sugar on 11/05/24 These deficient practices could place residents at risk for infection due to improper care practices. Findings included: 1.Record review of a face sheet dated 11/06/24 indicated Resident #48 was an [AGE] year-old female admitted on [DATE] with the diagnosis of Dementia (the loss of cognitive functioning) pressure ulcer also known as bedsore (a skin injury caused by constant pressure on an area of the body), high blood pressure, and anxiety (a feeling of fear, dread, and uneasiness that can be a normal reaction to stress). Record review of a significant change in status MDS assessment dated [DATE] indicated Resident #48 was usually understood and usually understood others. The MDS indicated Resident #48 required assistance with bed mobility, dressing, personal hygiene, transfers, toilet use, and supervision with eating. The MDS indicated Resident #48 had a stage 3 pressure ulcer. Record review of the comprehensive care plan dated 09/26/24 indicated Resident #48 had an open stage 3 area to the coccyx. The interventions were for staff to treat as ordered, always tilt her off the coccyx, and use a pillow or a wedge for positioning. Record review of Resident #48's physician's order dated 10/31/24 indicated: Cleanse area to coccyx with normal saline or wound cleanser, pat dry, apply Collagen, cover with silicone dressing daily, and PRN spoilage. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/07/24 at 12:52 p.m., LVN H provided wound treatment for Resident #48. Resident #48 was on enhanced barrier precautions. LVN A washed her hands and applied her gown and gloves. LVN H then cleaned the area of the coccyx and patted the wound dry. LVN H did not change her gloves and then attempted to apply dressing but had forgotten some supplies, so she removed her gloves but not her gown and went outside to her treatment cart and gathered her equipment. LVN H came back into the room applied her gloves without hand hygiene and proceeded with the treatment of applied collagen and the clean dressing on the wound and secured it. LVN H then went outside the room with her gloves and gown on looking for a biohazard bag to put her soiled dressing in. LVN H did not remove her Personal protective equipment or hand hygiene before leaving the room. LVN H then re-entered the room removed the soiled trash, removed her Personal protective equipment, and performed hand hygiene. During an interview on 11/07/24 at 1:15 p.m. with LVN H, she said she realized she had not changed her gloves or performed hand hygiene after cleaning the wound for Resident #48. LVN H said she should have removed her PPE and hand hygiene before leaving Resident #48's room. She said failure to properly hand hygiene or remove PPE before exiting a room could cause infection control issues. 2.Record review of Resident #44's face sheet dated 11/06/24, indicated a [AGE] year-old male who was admitted to the facility on [DATE], with diagnoses which included Liver cancer (a disease that can start in the liver or spread to the liver from another part of the body), Zoster, also known as shingles or herpes zoster (a painful rash caused by the varicella-zoster virus (VZV,) stroke, and type 2 diabetes mellitus (body has trouble controlling blood sugar and using it for energy. Record review of Resident #44's quarterly MDS assessment dated [DATE], indicated Resident #44 was able to be understood and sometimes understood others. The MDS assessment indicated Resident #44 had a BIMS score of 15 which indicated his cognition was intact. The MDS assessment indicated Resident #44 required supervision for his ADL care. Record review of Resident #44's comprehensive care plan dated 11/05/24, indicated Resident #44 had a rash with a diagnosis of shingles. The interventions were for staff to administer medications per ordered, contact precautions with ADL care, and keep his shingles clean and dry as possible. Record review of Resident #44's physician order report dated 11/04/24- 11/11/24, indicated Resident #44 had an order for Valtrex (valacyclovir) tablet; 500 mg; amt: 2 tabs; oral Special Instructions: 1000mg every 8 hours times 7days, for diagnosis of Shingles. During an observation and interview on 11/05/24 at 8:44 a.m., CNA F was coming out of Resident #48's room wearing a gown and gloves. She then placed his tray on the dish cart in the middle of the hallway, walked 2 doors down, and removed her personal protective equipment without hand hygiene. She then walked to Resident #43's room, talked with her, and removed her tray. The surveyor stopped CNA F and asked why she was wearing her gown and gloves in the hallway. She said Resident #48 was on isolation precautions, but since he did not have any boxes or containers in his room, she walked down 2 doors to remove the personal protective equipment. She said she did not wash her hands when she took off her personal protective equipment or before entering Resident #43's room. CNA F said she was supposed to remove her personal protective equipment and hand hygiene before leaving Resident #44's room. She said she would go and do hand hygiene. She said she knew she could cause the spread of infection by not hand hygiene or removing her Personal protective equipment properly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/05/24 at 1:54 p.m., LVN D said Resident #43 was on contact isolation for shingles. She said she had received in report of his shingles from the night nurse. She said the night shift did not get a chance to put the boxes or containers in his room before they left. She said she did not think about the boxes again until the aide came to her. She said she had placed boxes in his room after the aide mentioned it to her. She said she did not expect staff to walk in the hallway with personal protective equipment on or not hand hygiene before leaving a contact isolation room because of the risk of spreading infection. During an interview on 11/07/24 at 10:37 a.m., the DON said she expected wound care to be performed correctly. She said she expected staff to perform hand hygiene before, during, and after providing wound care. She said they should change their gloves when going from dirty to clean, and in between glove changes. The DON said anytime a staff member performed care with a resident that required enhanced barriers or contact isolation should have on a gown and gloves. She said she did not expect any staff member to go into the hallway with Personal protective equipmenton. She said they should remove all PPE and hand hygiene before leaving the room. The DON said wearing Personal protective equipment in the hallway, not providing hand hygiene when needed, and performing wound care incorrectly could lead to infection control issues. During an interview on 11/07/24 at 11:22 a.m., the Administrator said she expected staff to perform wound care and hand hygiene properly. She said residents on enhanced barrier and contact isolation should have a sign outside the room and carts and staff should follow the guidelines for their PPE. She said staff should remove their personal protective equipment and hand hygiene before they leave the room. She said improper wound care, hand hygiene, and not following the enhanced barrier and contact precautions correctly could lead to infection control issues. 46928 3.Record review of Resident #3's face sheet dated 11/06/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included cerebral palsy (movement disorder that appears in early childhood), type 2 diabetes mellitus (body has trouble controlling blood sugar and using it for energy), essential hypertension (high blood pressure), and weakness. Record review of Resident #3's quarterly MDS assessment dated [DATE], indicated Resident #3 was able to be understood and understood others. The MDS assessment indicated Resident #3 had a BIMS score of 15 which indicated her cognition was intact. The MDS assessment indicated Resident #3 received insulin 7 days out of the 7-day look back period. Record review of Resident #3's comprehensive care plan dated 08/15/24, indicated Resident #3 had diabetes mellitus with interventions to administer medications per ordered and received insulin. Record review of Resident #3's physician order report dated 10/06/24- 11/06/24, indicated Resident #3 had an order for insulin lispro 100 unit/ml pen per sliding scale before meals and at bedtime with a start date of 05/20/24. Record review of Resident #3's medication administration record dated 11/01/24-11/06/24, indicated Resident #3 received insulin lispro pen per sliding scale before meals and at bedtime. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 11/05/24 at 11:30 AM, LVN B sanitized her hands and applied gloves. LVN B entered Resident #3's room and obtained Resident #3's blood sugar. LVN B removed her dirty gloves and applied clean gloves. LVN B did not hand sanitize in between glove changes. LVN B then went to the nurse's cart and obtained Resident #3's insulin pen. LVN B proceeded to administer Resident #3 her insulin. LVN B said she should have performed hand hygiene in between glove changes. She said she did not perform hand hygiene because of the loud alarm going off and her brain was fried. LVN B said she was responsible for performing hand hygiene and failure to do so was an infection control issue. During an interview on 11/07/24 at 09:30 AM, the DON said she expected her staff to perform hand hygiene once gloves were removed and prior to donning on clean gloves. The DON said failure to perform hand hygiene after removing dirty gloves placed the residents at risk for infection. The DON said the nurse performing the task was responsible for ensuring hand hygiene was performed. During an interview on 11/07/24 at 09:48 AM, the Administrator said she expected she expected hand hygiene to be performed in between glove changes. The Administrator said there were no risks to the residents because LVN B was dealing with the same resident, and she would have expected her to perform hand hygiene when LVN B went to another resident. Record review of the facility's policy handwashing/hand hygiene revised 01/20/23, indicated . This facility considers hand hygiene the primary means to prevent the spread of infections .1. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 5. Hand hygiene must be performed prior to donning and after doffing gloves . Record review of the facility policy titled, Transmission Precautions, date revised August 2016 indicated, Use Standard Precautions (SP) with transmission-based isolation. Cohort: *the door may remain open, wash hands after every resident contact, wear gloves when in contact with the resident environment, wear gowns if you anticipate that your clothing may become contaminated, wear masks or face shields if you come within 3 feet of the resident and resident wears a mask during transport, dedicate equipment to the infected resident, contain or cover site of infection before resident transport, ensure all environmental surfaces washed at least daily and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled, Wound care, Revised June 2022, indicated Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation:1. Verify that there is a physician's order for this procedure. 3. Assemble the equipment and supplies as needed. Date and initial all bottles and jars upon opening. (Note: This may be performed at the treatment cart.) Equipment and Supplies: The following equipment and supplies will be necessary when performing this procedure. 1. Dressing material, as indicated (i.e., gauze, tape, scissors, etc.);2. Disposable cloths, as indicated;3. Antiseptic (as ordered); and 4. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). Steps in Procedure:4. Put on clean gloves. Loosen the tape and remove the dressing. 5. Pull the glove over the dressing and discard it into an appropriate receptacle. Perform hand hygiene. 6. Put on clean gloves. Gowns will only be necessary if soiling of your skin or clothing with blood, urine, feces, or other body fluids is likely. Masks and eyewear will only be necessary if splashing of blood or other body fluids into your eyes or mouth is likely.10. Apply treatments and dress the wound as ordered by physician 11. [NAME] tape with initials, time, and date and apply to dressing.12. Remove the disposable cloth next to the resident and discard into the designated container. 13. Discard disposable items into the designated container. Discard all soiled laundry, linen, towels, and washcloths into the soiled laundry container. Remove disposable gloves and discard into a designated container. Perform hand hygiene.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 45879 Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for 1 of 3 doors reviewed for a safe environment. The facility failed to ensure the wander guard system operated correctly on the north side door when the Maintenance Supervisor tested the door on 11/07/24. This failure could place residents at risk of elopement, injury, or harm. Findings included: During an observation on 11/07/24 at 9:54 a.m., the Maintenance Supervisor checked the wander guard door on the north side hall and the alarm did not activate. He then checked the other 2 wander guard doors, and they were functioning properly. During an observation on 11/07/24 at 10:08 a.m., LVN D checked 2 different residents' wander guards using their handheld system and they both worked properly. During an interview on 11/07/24 at 10:13 a.m., the Maintenance Supervisor said he checked the door for functionality last week (unknown day). He said the doors were functioning properly during the inspection. He said he checked the doors weekly as part of his duties. He said he would call {name of company} and have them come out to look at the wander guard system. During an observation on 11/07/24 at 10:15 a.m., reflected the Human resource personnel standing by the north side door. During an interview on 11/07/24 at 10:20 a.m., the Administrator said if the wander guard system was not functioning properly, she was supposed to have a staff member on the door watching and making sure no resident left the facility until the doors were fixed. The Administrator said the maintenance Supervisor was responsible for ensuring the wander guard system was always working for the safety of the residents. During an interview on 11/07/24 at 10:25 a.m., the DON said the Maintenance Supervisor was responsible for checking the wander guard system doors. She said if the doors were not functioning properly then a staff member was to be placed at the doors until the doors were fixed for the safety of residents. The DON said they had 6 residents who were at risk of elopement and wore wander guards. During an observation and interview on 11/07/24 at 10:28 a.m., the Maintenance Supervisor said the doors were fixed. He placed a wander guard up to the door and it activated the shutdown system. He said he called {name of company} and they told him to check the batteries first and he did and then the door started working. He said the doors needed to work properly for the safety of the residents. During an interview on 11/07/24 at 11:00 a.m., the Regional Nurse Consultant said they did not have a policy on checking the doors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675788	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Manor of Commerce Nursing and Rehabilitation	2901 Sterling Hart Dr Commerce, TX 75428

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the TELS (a building maintenance Platform that is a leading web-based technology designed to tackle the day-to-day challenges of building operations) logbook on 10/31/24 the north side door was checked and working properly. Record review of the facility policy titled, Wandering and Elopements, dated 09/01/23, indicated Policy Statement: The facility will ensure that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care. 2. For those facilities equipped, each resident that is noted to be a risk per the elopement observation will have a roam alert device placed after: o An order is obtained from a physician. The order will include placement of the device, behavior monitoring q shift, check placement q shift, functionality daily, and monthly check of the expiration date of the sensor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. 43047 Based on observation, interview, and record review, the facility failed to follow established policy regarding smoking areas, and smoking safety for 1 of 1 smoking area. The facility failed to ensure flammable paper products (empty cigarette box, piece of a paper towel, blue sticky note, and a sonic cup) were not discarded in the red metal trash can designed for the disposing of cigarette butts. This failure could place residents who smoke at risk of physical harm and lead to an unsafe smoking environment. Findings Included: During an observation on 11/5/24 at 8:24 a.m., 4 residents were outside in the smoking area smoking with staff present. There was a red smoking can with cigarette butts, an empty cigarette box, piece of a paper towel, blue sticky note, and a sonic cup. During an interview on 11/7/24 at 10:34 a.m., the HR Coordinator stated whoever take the residents out to smoke should check the red smoking can for trash. The HR Coordinator stated the red can should not have any trash inside, only ashes and butts. The HR Coordinator stated it was important to ensure trash was kept out of the red metal trash can to prevent a fire. During an interview on 11/7/24 at 11:11 a.m., the Maintenance Supervisor stated all staff were responsible for ensuring trash was not in the red can. The Maintenance Supervisor stated he check the red can weekly to ensure only ashes and cigarette butts were in there. The Maintenance Supervisor stated this risk could potentially cause a fire. During an interview on 11/7/24 at 11/7/24 at 12:14 p.m., the Administrator stated she expected trash to be put in the correct receptacles. The Administrator stated the Maintenance Supervisor was responsible for checking the red can daily to ensure only ashes and cigarettes butts were in there. The Administrator stated this failure could potentially cause a fire. Record review of a facility's policy titled Smoking Policy-Residents, revised 2019, indicated . this facility shall establish and maintain safe residents smoking practices .