STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675798	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arboretum Nursing and Rehabilitation Center of Win	1215 Highway 124 Winnie, TX 77665

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46892 Based on interviews and record review, the facility failed to ensure prompt efforts were made to resolve grievances for 1 of 24 residents (Resident #64) reviewed for grievances. The facility did not ensure a grievance was filed for Resident #64's black bra and 1 pair of pants when they were not returned from the laundry. This failure could place residents at risk for grievances not being addressed or resolved promptly. Findings included: Record review of a face sheet dated 08/22/24 indicated Resident #64 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety (deterioration of memory, language, and other thinking abilities without behaviors) and chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #64 was able to understand others and was able to make herself understood. The MDS assessment indicated Resident #64 had a BIMS score of 7, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #64 required partial/moderate assistance with dressing and personal hygiene. Record review of the grievances for the months of February 2024 through August 2024 did not indicate a grievance for Resident #64's black bra and pants. During an interview on 08/19/2024 at 10:22 AM, Resident #64 said she had lost a pair of aqua green pants and a black sports bra. Resident #64 said they had been sent to the laundry a couple months ago and were not returned. Resident #64 said she had told the laundry lady (was not able to provide a name) when she went by to leave her clothes. Resident #64 said the laundry lady told her she was still looking for it when Resident #64 asked her about the pants and bra. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/2024 at 8:41 AM, Laundry Staff D said Resident #64 told her a couple months ago that she was missing a black bra, and she had looked for it and could not find it. Laundry Staff D said she was not aware of the missing pants. Laundry Staff D said when a resident reported a missing item, they first looked in the resident's closet, the clothing items with no name, and in the laundry. Laundry Staff D said if she was not able to locate the missing clothing, she would tell the residents I am so sorry, but I could not find it. Laundry Staff D said she was not aware she could file a grievance for missing clothes. Laundry Staff D said it was important for the residents clothing to be returned because it was something valuable to them. During an interview on 08/22/2024 at 2:17 PM, Laundry Staff E said Resident #64 told her she was missing a bra and pants about three weeks ago. Laundry Staff E said she had looked for them but had not found them. Laundry Staff E said when a resident reported missing clothes, they looked for it on the laundry carts and on the carts with clothing that had no names, and other residents' closets. Laundry Staff E said if the clothing was not found she notified the Laundry Supervisor. Laundry Staff E said she had notified the Laundry Supervisor that Resident #64's clothes were missing. Laundry Staff E said it was important for the residents clothing to be returned to them because it was their belongings. During an interview on 08/22/2024 at 2:24 PM, the Laundry Supervisor said when residents reported clothing missing, they searched the laundry, the lost and found, and the residents' rooms. The Laundry Supervisor said when clothing went missing a grievance was filed, and if the clothing was not found it was replaced. The Laundry Supervisor said the laundry staff were supposed to notify her if a resident reported missing clothes to them. The Laundry Supervisor said she was not notified of Resident #64's missing bra and pants. The Laundry Supervisor said it was important for a grievance to be filed so they knew what was missing, and so they could look for the clothes and be aware of if it happened again. The Laundry Supervisor said it was important for the residents clothing to be returned to them because it was their personal stuff and their clothing. During an interview on 08/22/2024 at 6:37 PM, the Administrator said if the residents reported missing clothes to the laundry staff, they were supposed to notify the laundry/housekeeping supervisor, and she notified the Administrator. The Administrator said she would text the CNAs and the laundry staff would check the lost and found and conduct a room to room sweep. The Administrator said if the clothing item was not found and they had proof of the item they would repurchase the missing clothes. The Administrator said she was not aware Resident #64 was missing a bra and pants. The Administrator said a grievance was filed to track the steps and progress. The Administrator said it was important for the residents clothing to be returned to them because it was their stuff, and they had a right to have it. Record review of an undated policy titled, Grievance Forms, indicated, Grievance Policy All residents have the right to voice grievances with respect to treatment or care without fear of discrimination or reprisal. In accordance with state and federal laws, community residents, their family members or any other interested parties have the right to file oral and/or written grievances regarding the community, staff members and other residents . EVERY complainant shall be notified of the actions taken in a timely manner .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interviews and record review, the facility failed to ensure that the comprehensive care plan was reviewed by the interdisciplinary team and that the resident was invited to participate in developing the care plan and making decisions about his or her care for 1 of 24 residents (Resident #64) reviewed for care plan timing and revision. The facility failed to ensure Resident #64 was invited to participate in the development and review of her care plan. This failure could place residents at risk of not being able to attain or maintain their highest practicable level of physical, mental, and psychosocial well-being. Findings included: Record review of a face sheet dated 08/22/24 indicated Resident #64 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety (deterioration of memory, language, and other thinking abilities without behaviors) and chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #64 was able to understand others and was able to make herself understood. The MDS assessment indicated Resident #64 had a BIMS score of 7, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #64 required partial/moderate assistance with dressing and personal hygiene. Record review of Resident #64's care plan last reviewed 08/14/2024, did not address inviting Resident #64 to participate in the development and review of her care plan. During an interview on 08/19/2024 at 10:24 AM, Resident #64 said she had not been invited or attended any care plan meetings. Record review of Resident #64's electronic health record on 08/22/2024 did not indicate any care plan meetings had been completed. During an interview on 08/22/2024 at 10:55 AM, the Social Worker said the care plan meetings were documented in the electronic health record under the assessments as a Care Plan Conference. The Social Worker said the care plan meetings should be completed every three months. The Social Worker said Resident #64 had not had a care plan meeting yet. The Social Worker said Resident #64 should have had one already, but she was trying to catch up from COVID. The Social Worker said it was important for the care plan meetings to be completed with the IDT (IDT team consisted of the RN or hall nurse the dietary manager, MDS nurse, therapy if on therapy, and the activities director) to be able to touch base with the residents and families, to address any issues the residents were having, and to ensure they were all on the same page. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/24 at 6:39 PM, the Administrator said the care plan meetings were offered to the resident and family, and they were completed quarterly. The Administrator said social services was responsible for the care plan meetings. The Administrator said it was important for the care plan meetings to be completed to keep everybody up to date on the plan of care. Record review of an undated policy titled, Comprehensive Care Planning, indicated, .Through the care planning process, facility staff will work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices and goals during their stay at the facility. The facility will establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life . The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions . The facility will provide the resident and resident representative, if applicable with advance notice of care planning conferences to enable resident/resident representative participation .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on observations, interviews, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living receives the necessary services to maintain good hygiene for 1 of 3 residents (Resident #32) reviewed for ADLs. The facility did not ensure Resident #32's fingernails were cleaned. This failure could place residents at risk of not receiving services or care, decreased quality of life, and decreased self-esteem. The findings included: Record review of the face sheet, dated 08/22/2024, revealed Resident #32 was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs) and dementia (group of symptoms affecting memory, thinking and social abilities that interfere with their daily lives). Record review of the quarterly MDS assessment, dated 07/23/2024, revealed Resident #32 had clear speech and was usually understood by others. The MDS revealed Resident #32 was usually able to understand others. The MDS revealed Resident #32 had a BIMS score of 7, which indicated severe cognitive impairment. The MDS revealed Resident #32 had no behaviors or refusal of care. The MDS revealed Resident #32 required substantial/maximal assistance (helper does more than half the effort) with personal hygiene and shower/bathing. Record review of the comprehensive care plan, revised 04/25/2024, revealed Resident #32 required assistance with ADLs and mobility needs. The interventions included: extensive assistance x 1 staff member for bathing and personal hygiene tasks. Record review of the task documentation schedule for August 2024, revealed Resident #32 received bathing assistance on 08/20/2024. During an interview and observation on 08/19/2024 beginning at 3:36 PM, Resident #32 had a thick black gooey substance under his fingernails. Resident #32 said he received a shower regularly by the facility staff. Resident #32 stated the staff would have completed his nail care tomorrow (08/20/2024) with his shower. During an interview and observation on 08/20/2024 beginning at 9:02 AM, Resident #32 had a thick black gooey substance under his fingernails. Resident #32 said the facility staff had not performed nail care yet. During an interview and observation on 08/21/2024 beginning at 8:04 AM, Resident #32 had a thick black gooey substance under his fingernails. Resident #32 said he received his bed bath yesterday (08/20/2024), but the staff could have forgotten to clean his nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/2024 beginning at 2:45 PM, CNA RR stated she assisted Resident #32 with his bed bath on 08/20/2024. CNA RR stated she was helping out on the floor because the facility was short-staffed. CNA RR stated normally nailcare was completed with a bed bath or showers, but she forgot to go back and clean Resident #32's nails because she got busy. CNA RR stated it was important to make sure nail care was performed so the residents did not put their hands in their mouth which could spread or cause infection. CNA RR stated dirty fingernails were unsanitary. During an interview on 08/22/2024 beginning at 5:59 AM, the DON stated CNAs were responsible for cleaning fingernails. The DON stated some residents go to pretty nails (an activity where nails were clean, painted, and trimmed) but most of the time nail care was performed during showers. The DON stated all staff were responsible for monitoring to ensure nail care was completed. The DON said unit managers perform daily champion rounds in which the staff looked for things like that specifically. The DON stated she was unsure who was responsible for completing champion rounds on Resident #32. The DON stated it was mostly administrative staff. The DON said it was important to ensure Resident #32's nails were kept clean to prevent infections from spreading and ensure sanitation. During an interview on 08/22/2024 beginning at 6:14 AM, the Admissions Coordinator UU stated she performed champion rounds on Resident #32. The Admissions Coordinator stated Resident #32's hands were under the covers when she went into his room, so she did not notice his dirty fingernails. The Admissions Coordinator stated nail care was something that was looked at during champion rounds, but she did not ask Resident #32 to look at his fingernails. During an interview on 08/22/24 beginning at 6:51 AM, the Administrator stated she expected nail care to have been completed by the facility staff. The Administrator stated nail care was performed during showers and as needed. The Administrator stated all staff were responsible for monitoring to ensure nails were cleaned. The Administrator stated performing nail care was important for infection control. Record review of the Nail Care policy, undated, revealed Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury form scratching by fingernails or pressure of shoes on toenails .It includes cleansing, trimming, smoothing, and cuticle and is usually done during the bath .When performed at bath time, the nail care can be done following the procedure or as a separate procedure when needed at the convenience of the resident .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on observations, interviews, and record review the facility failed to ensure the resident environment remained free of accident hazards as possible, and each resident received adequate supervision to prevent elopement for 4 of 6 residents (Residents #33, #40, #290, and #1) and prevent coffee burns for 1 of 2 residents (Resident #2) reviewed for accident hazards and supervision. 1. The facility failed to prevent Resident #33 from eloping from the facility on 04/14/2024, 06/20/2024 and 06/21/2024. 2. The facility failed to prevent Resident #40 from eloping from the facility on 08/09/2024. 3. The facility failed to prevent Resident #290 from eloping from the facility on 06/13/2024. 4. The facility failed to prevent Resident #1 from eloping from the facility on 07/13/2024. 5. The facility failed to ensure Resident #2's coffee lid was placed properly which resulted in her spilling it on herself on 04/04/2024. 6. The facility failed to ensure Resident #2 was served coffee in a cup with a lid on it, which resulted in her spilling it on herself on 06/09/2024. An Immediate Jeopardy (IJ) situation was identified on 08/20/2024 at 4:15 p.m. While the IJ was removed on 08/21/2024, the facility remained out of compliance at a scope of pattern and a severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of serious injury or harm. The findings included: 1. Record review of Resident #33's face sheet, dated 08/21/2024, originally admitted to the facility on [DATE] with a diagnosis which included Alzheimer's (progressive disease that destroys memory and other important mental functions). Record review of the quarterly MDS assessment, dated 08/12/2024, indicated Resident #33 made herself understood and understood others. Resident #33's BIMS score was 7, which indicated her cognition was severely impaired. Resident #33 had no behaviors or refusal of care. Record review of the comprehensive care plan, revised on 12/26/2023, indicated Resident #33 was at risk for wandering and elopement. The interventions included: distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, redirect away from entrances and exits, monitor the location frequently and document the wandering behavior and attempted diversional interventions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident # 33's Elopement assessment, dated 04/14/2024, 06/20/2024, and 06/21/2024, reflected Resident #33 was at risk for elopement. Record review of the event nurse's note dated 04/14/2024 at 11:00 a.m., reflected Resident #33 followed another resident outside through the front door. Resident #33 was observed by a staff propelling in the front parking lot of the facility. Record review of the event nurse's note dated 06/20/2024 at 2:10 p.m., reflected Resident #33 was found outside in the front parking lot. Resident #33 stated she really did not know where she was. Record review of the event nurse's note dated 06/21/2024 at 9:00 p.m., reflected Resident #33 was found by a family member outside by vehicles approximately 50 feet from the entrance door. 2. Record review of Resident #40's face sheet, dated 08/21/2024, originally admitted to the facility on [DATE] with a diagnosis which included dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of the quarterly MDS assessment, dated 08/06/2024, indicated Resident #40 made herself understood and usually understood others. Resident #40's BIMS score was 0, which indicated her cognition was severely impaired. Resident #40 had no behaviors or refusal of care. Record review of the comprehensive care plan, revised on 08/09/2024, indicated Resident #40 attempted to elope and was found in the parking lot to the back of building. The interventions included: distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, supervise closely and make regular compliance rounds whenever residents in the room. Record review of Resident # 40's Elopement assessment, dated 08/09/2024, reflected Resident #40 was at risk for elopement. Record review of the event nurse's note dated 08/09/2024 at 8:41 a.m., reflected Resident #40 was observed rolling in her wheelchair outside in the parking lot around the building. Resident #40 stated she was going to see a friend at the hospital. 3. Record review of the face sheet, dated 08/20/2024, revealed Resident #290 was a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses of Traumatic brain injury (head injury causing damage to the brain by external force or mechanism), unspecified dementia with agitation (group of symptoms affecting memory, thinking, and social abilities with excessive verbal or physical aggression that causes emotional distress and excess disability), schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior), and bipolar disorder with psychotic features (serious mental illness characterized by extreme mood swings). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the quarterly MDS assessment, dated 07/23/2024, revealed Resident #290 had clear speech and was usually understood by others. The MDS revealed Resident #290 was able to understand others. The MDS revealed Resident #290 had a BIMS score of 5, which indicated severely impaired cognition. The MDS revealed Resident #290 had disorganized thinking, which fluctuated. The MDS revealed Resident #290 had delusions, but no behaviors, wandering, or refusal of care. The MDS revealed Resident #290 used a manual wheelchair. Record review of the comprehensive care plan, revised on 04/18/2023, revealed Resident #290 was at risk for elopement and wandering because of impaired safety awareness. The goals included: The resident will not leave facility unattended through . and The resident's safety will be maintained . The interventions included: Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes; Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book; Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate; and Monitor location frequently. Document wandering behaviors and attempted diversional interventions. Record review of the elopement risk assessment dated [DATE], 06/12/2024, and 06/13/2024, revealed Resident #290 was at risk for elopement. Record review of the event nurses' note, dated 06/13/2024, revealed Resident #290 exited out the front door of the building and was witnessed in the parking lot by vehicles. Resident #290 told staff she was going to work. 4. Record review of the face sheet, dated 08/20/2024, revealed Resident #1 was a [AGE] year-old male who initially admitted to the facility on [DATE] with a diagnosis of intracranial injury (head injury causing damage to the brain by external force or mechanism). Record review of the quarterly MDS assessment, dated 07/29/2024, revealed Resident #1 had unclear speech and was usually understood by others. The MDS revealed Resident #1 was usually able to understand others. The MDS revealed Resident #1 had a BIMS score of 0, which indicated severe cognitive impairment. The MDS revealed Resident #1 had disorganized thinking, that fluctuated. The MDS revealed Resident #1 had no behaviors, wandering, or refusal of care. The MDS revealed Resident #1 used a wheelchair. Record review of the comprehensive care plan, revised 07/15/2024, revealed Resident #1 was at risk for elopement and wandering. The goals included: The resident will not leave facility unattended . and The resident's safety will be maintained . The interventions included: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book; Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate.; If the resident is exit-seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, etc.; Provide structed activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes.; . Resident redirected back into facility, educated on the dangers of being in parking lot and ongoing monitoring in place. Record review of the elopement risk assessments dated 12/28/2023, 03/29/2024, 06/29/2024, and 07/13/2024 revealed Resident #1 was at risk for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the event nurses' note, dated 07/13/2024, revealed Resident #1 exited out the front door and was found, by a family member, sitting in his wheelchair behind an employee vehicle. Resident #1 stated he was enjoying the sunshine. Record review of the facility's policy titled, Elopement Prevention, revised 10/27/2010 indicated, .every effort will be made to prevent elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement .2. All residents who are at risk for harm because of wandering (elopement) will be assessed by the interdisciplinary care planning team . Physical Plant .1. All facility exits that residents have access to will have a device in place to alert staff of possible elopement attempts .2. All others exit not considered fire exits will be locked when not occupied by staff members .3. All exit devices will be maintained by the manufacture's recommendations and function of each door device will be verified weekly and a log maintained . During an observation on 08/19/2024 at 8:15 a.m., the front door had an automatic sliding door and no alarm had sounded upon entrance to the building. The facility was located on a busy highway. During an interview on 08/19/2024 at 4:12 PM, LVN K said if a resident was a high risk for elopement, they redirected them. LVN K said interventions for residents at risk for elopement were redirecting them, and they had the two double doors before the door to exit that acted as an intervention to stop them. The double doors were not locked. LVN K said the door to the exit had a button you had to push for it to open, but it was not locked either. LVN K said it would be hard for a resident to reach the button in a wheelchair. LVN K said the door to the exit did not have an alarm. LVN K said they did not have a wander guard system or anything like it to put on the residents that wandered. LVN K said elopement risk assessments were completed on admission, every three months, and if a resident had an elopement attempt. LVN K said if a resident attempted to elope 1-2 times they would be moved to the secure unit. During an observation on 08/20/2024 at 7:15 a.m., the front door had an automatic sliding door and no alarm had sounded upon entrance to the building. No staff members were observed in the lobby. During an observation on 08/20/2024 beginning at 7:21 a.m., Resident #33 was wheeling herself down the B-Hall during breakfast time. The only staff member on the hallway was a housekeeper, who was in another resident's room cleaning. Resident #33 started from the nurses' station and slowly wheeled herself down to the therapy gym. Resident #33 wheeled herself around the therapy gym, then sat in the doorway wheeling herself back and forth. (continued on next page)

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	675798	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arboretum Nursing and Rehabilitation Center of Win	1215 Highway 124 Winnie, TX 77665

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 08/20/2024 beginning at 9:38 a.m., the DON stated residents at risk for elopement, not on the secured unit, had no special monitoring. The DON stated the direct care staff were made aware of the residents at risk for elopement and were instructed to keep a close eye on them. The DON stated there were no set timeframes for monitoring the residents, they should have been monitored according to their judgment. The DON stated the facility did not use a wander guard system or alarms. The DON stated the facility tried to keep the double doors leading into the lobby closed and a staff member in lobby to slow residents who were at risk for eloping down. The DON stated if residents actually eloped, then the residents were redirected into the building. The DON stated if residents were not easily redirected, they were placed on the secured unit. The DON stated labs were ordered on a case-by-case basis to determine if an acute illness was causing wandering behaviors or if placement on the secured unit was necessary. The DON stated residents were placed on the secured unit pending labs. The DON stated after an elopement, residents were placed on 72-hour monitoring. The DON stated the IDT usually met after an elopement to discuss and update the care plan. The DON stated Resident #40 started wandering during the evening times. The DON stated Resident #40 was able to go outside without staff supervision as long as a staff member was sitting in the lobby. The DON stated Resident #40 was easily redirected into the building and 72-hour monitoring was performed. The DON stated she did not believe Resident #40 had been evaluated for the secured unit. The DON stated Resident #290 and Resident #33 had been on the secured unit previously but had to be taken out of the secured unit because they were having combative behaviors with other residents. The DON said there was no special monitoring in place for Resident #290 or Resident #33. The DON stated Resident #33 wandered constantly around the building and have instructed staff to ensure she was watched. The DON stated after Resident #290 and Resident #33 eloped they were placed on 72-hour monitoring. The DON was unsure if labs had been completed. The DON stated Resident #1 was able to wheel himself around the facility. The DON stated Resident #1 was probably at risk for elopement related to past attempts. The DON stated Resident #1 was placed on 72-hour monitoring and reeducated on the dangers of wandering outside. The DON stated the risk for residents eloping would depend on the time of the day, but they were at an increased risk for injury or elopement. During an interview on 08/20/2024 beginning at 2:03 p.m., The Administrator stated the preventative measures put in place currently for residents at risk for elopement who do not reside on the secured unit included: staff monitoring and closing the double doors in the front lobby to slow the residents down. The Administrator stated she had been asking corporate to get the facility a locked keypad for the front door and it was supposed to have been a work in progress. The Administrator stated the facility did not have a wander guard system or alarms for the front door. The Administrator stated if a resident eloped the facility implemented 72-hour monitoring. The Administrator stated incident and accidents were reviewed regularly but she was unsure if any trends had been identified. The Administrator stated she asked for the door keypad around the time the resident elopements had started. Record review of a printed screen shot, provided on 08/20/2024 with a time of 2:31 p.m., revealed the Administrator had asked the corporate office for a keypad entry and exit for the front door on 05/07/2024. Record review of a printed copy, provided on 08/20/2024, revealed a submitted proposal on 05/23/2024 for a keypad entry and exit for the front door. The owner had not signed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5. Record review of a face sheet dated 08/20/2024 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety (deterioration of memory, language, and other thinking abilities without behaviors), cerebral infarction (stroke), and glaucoma (eye disease that can cause vision loss or blindness). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #2 usually understood others and was usually able to make herself understood. Record review of the MDS assessment indicated Resident #2 had a BIMS score of 4, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #2 required supervision or touching assistance with eating, substantial/maximal assistance with toileting hygiene, and was dependent for showering/bathing and personal hygiene. Record review of Resident #2's care plan last reviewed 07/25/2024 indicated Resident #2 was at risk of burns due to hot liquids with interventions which included coffee and other hot liquids should not be served if over 140 degrees, educational in-service was given to staff about making sure cup lid was on properly to prevent spillage, if hot liquid was spilled on self, staff should pour room temperature or lower temp liquid on the affected area of the resident, resident to use spill proof cup with lid for coffee, should be seated in upright position with table or overbed table when hot liquids were being consumed, and staff to provide observation and verbal assistance when resident had hot liquids. Record review of the Order Summary Report dated 08/21/2024, indicated Resident #2 had an order for a fortified/enhanced diet, mechanical ground texture, regular consistency, and liquids by straw. Record review of an Event Nurses' Note - Burn dated 04/04/2024 indicated Resident #2 was in the dining room and had a burn caused by coffee, tea, or other hot liquid to the left abdomen and left lower breast. Details of injury indicated she had an 8x9 cm red area, no blistering, slight pain to touch. Nursing Description of the event indicated, CNA stated she was bringing another resident to the dining room and resident was saying help me, when CNA went to her, she noted that her shirt was wet and the resident stated she spilled her coffee. Resident had her personal cup with lid. Unknown who fixed coffee for resident as she is not able. Resident Statement indicated, Resident stated that she did not know who got her coffee but the lid was not on it like it was supposed to be and she spilled it. Initial treatment/new orders indicated, No treatment at this time, will monitor and offered pain med and was refused. Interventions initiated by nurse indicated, Lid on cup/mug/glass. Signed by Treatment Nurse H. Record review of an Injury Nurses' Note 12 hr dated 04/05/2024 12:09 AM, indicated Resident #2 had no injury. Record review of an Event Nurses' Note - Burn dated 06/09/2024 indicated Resident #2 was in the dining room and had a burn caused by coffee, tea, or other hot liquid to the left breast and under left breast. Details of injury indicated she had a burn injury slightly red, approximately 4 cmx2 cm to under left breast and 6 cmx5 cm to left breast. Nursing Description of the event indicated, CNA observed residents blouse being wet, and when she checked she seen the redness underneath. Resident Statement indicated, Resident stated leave me alone. Initial treatment/new orders indicated Zinc oxide (ointment used for skin) BID x 3 days. Interventions initiated by nurse indicated, Lid on cup/mug/glass. Signed by LVN P. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of an Injury Nurses' Note 12 hr dated 06/10/2024 12:43 PM, indicated Resident #2's redness related to the burn was gone. During an observation on 08/20/2024 at 7:20 AM, Resident #2 was observed sitting in the dining room drinking coffee from a covered cup with a straw. During an interview on 08/20/2024 at 7:44 AM, the Food Service Supervisor said Resident #2 was the only one who had spilled coffee on herself that she could think of, and she believed it was only once. The Food Service Supervisor said there had not been any further incidents after June 2024. The Food Service Supervisor said if the residents needed therapy ordered a spill proof cup, and Resident #2 required a spill proof cup for her coffee. The Food Service Supervisor said Resident #2 had to be served her coffee, but the residents that were able to, served themselves coffee. The Food Service Supervisor said they checked the coffee temperature daily and ensured it was at 140 degrees to prevent burns. The Food Service Supervisor said she monitored coffee was available during the day while kitchen staff were present. During an interview on 08/20/2024 at 9:32 AM, LVN L said residents had access to coffee in the dining room all day. LVN L said residents were allowed to get coffee on their own. LVN L said Resident #2 required a special cup because she had spilled coffee on herself a couple of times, and the cup was needed to prevent future burns. LVN L said if she noticed a resident was having issues holding a cup, she would let the nurse manager know and they would get with therapy to get the devices the residents needed. During an interview on 08/20/2024 at 9:56 AM, CNA O said the residents usually had coffee available to them all day. CNA O said the residents were able to get it themselves. CNA O said Resident #2 had a special cup for coffee that had a lid on it, and she was the only one that she knew of. CNA O said Resident #2 required the cup because her grip was not good, and to prevent her from spilling the coffee on herself and getting burned. During an interview on 08/20/2024 at 10:01 AM, the DON said on 04/04/2024 when Resident #2 spilled coffee on herself Resident #2 said the lid was not on tight enough. The DON said Resident #2 was supposed to be using the cup with the lid on it at that point. The DON said she educated the staff to make sure the lid was properly secured to prevent spillage. The DON said she provided an in-service. The DON said they were unable to determine what degree burn she had gotten from the spilled coffee but there was redness, no blister, and had resolved by the next day. The DON said on 06/09/2024 when Resident #2 spilled coffee on herself Resident #2 did not have the coffee cup with the lid on it. The DON said Resident #2 was unable to get coffee herself that somebody had given it to her. The DON said the staff was reeducated again on ensuring Resident #2 had her special cup. The DON said the education was provided verbally and she did not have documentation of it. The DON said they were doing the coffee logs to ensure the coffee was at safe temperatures. The DON said there was not anything implemented to see if any of the other residents were at risk for burning themselves with hot liquids. The DON said they did not complete hot liquid assessments. During an attempted phone interview on 08/20/2024 at 10:31 AM, LVN P did not answer the phone. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 08/20/2024 at 2:04 PM, the Director of Rehab said they did not have a particular screen to assess residents for their abilities to handle hot liquids. The Director of Rehab said if they noticed or were told by the staff a resident was having issues feeding themselves or required adaptive equipment therapy would evaluate and address the need. The Director of Rehab said she believed when Resident #2 was burned she was already receiving occupational therapy and they ordered a cup with a lid for her. During an interview on 08/20/2024 at 2:14 PM, the DON said the nurses should be assessing the residents needs for their abilities to feed themselves and on admission therapy screened the residents for any special needs. During an interview on 08/22/2024 at 6:48 PM, the Administrator said Resident #2 did not want to sit still with her coffee, and they discussed getting her a cup that would assist with spills. The Administrator said residents were assessed by the nurses on a resident-by-resident case for their abilities to handle hot liquids. The Administrator said anytime there was a change of status the residents were supposed to be assessed. The Administrator said there was always a risk for an accident to happen. Record review of the Coffee Temperature log for February 2024, March 2024, April 2024, June 2024, indicated the coffee temperature was 140 daily. Record review of a Record of Inservice Education dated 04/04/2024 with a subject of Coffee cup for Resident #2 indicated, Resident #2 has a cup for coffee with a lid to help prevent spills. It is very important that you make sure lid is on correctly why you make her coffee. Record review of the undated Guidelines on Serving Coffee in the Nursing Facility indicated, .3. Any residents who have risk factors for coffee burns, such as significant cognitive impairment or extreme shaking may be evaluated for additional safety precautions using a hot beverage risk assessment. Safety precautions may include but are not limited to additional supervision when consuming coffee, insulated or non-insulated coffee mugs with sippy lids, coffee service at lower temperatures, or restricted coffee availability . This was determined to be an Immediate Jeopardy (IJ) on 08/20/2024 at 4:15 p.m. The Administrator was notified. The Administrator was provided with the IJ template on 08/20/2024 at 4:19 p.m. During an observation on 08/20/2024 at 5:00 p.m., the speed limit sign in front of the facility changes from 45 to 55 miles per hour. During an observation on 08/21/2024 at 7:15 a.m., the front door had an automatic sliding door and no alarm had sounded upon entrance to the building. During an interview and observation on 08/21/2024 beginning at 9:18 a.m., the Administrator was standing at the front door with a technician. The Administrator stated she had not realized the alarm system had not been functioning. The Administrator stated the technician had disabled the alarm system the last time he worked on it. The Administrator stated the technician was working on the system and adding another contact alarm that would alarm when the front door was opened. The doors had automatically slid open and the alarm had sounded. Beeping was heard at the nurse's station. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The following plan of removal submitted by the facility was accepted on 08/21/2024 at 4:27 p.m. and included the following: Interventions: 1. On 8/20/24, Residents #33, Resident #1 and Resident #290 will be transferred to a sister facility for appropriate supervision. All 3 residents will be placed on 1:1 supervision until transferred. Both residents have been screened and do not meet the criteria to be placed on the secure unit. Other interventions such as alarms, increased staff, wander guards have been reviewed. All doors and alarms have been tested and are functioning properly. All doors with existing alarms were tested and in operation 8/20/24. Front door had an alarm installed the morning of 8/21/24 and will be monitored every shift. 2. On 8/20/24, Resident #40 will be transferred to the secure unit inside the facility. 3. Elopement risk assessments for all residents in the facility were completed and reviewed by the DON/ADON/Designee on 8/20/24. No additional concerns were identified. 4. All elopement risk care plan interventions were reviewed on 8/20/24 by the Regional Compliance Nurse, DON, and ADON. All interventions are in place and care planned. 5. The Administrator, DON, and ADON were in-serviced 1:1 by the ADO and Regional Compliance Nurse on 8/20/24 on the following: A. Elopement Prevention Policy- This in-service includes implementing interventions for residents at risk for elopement. - Completing the elopement risk assessment to determine at risk residents. This in-service also includes reporting to the Charge Nurse, Administrator, or DON any resident who is attempting to elope. The policy includes interventions to assist in preventing elopements, environmental modifications, and staff training. B. Elopement Response Policy- Nursing personnel must report and investigate all residents who attempt to elope. This includes when a resident is observed leaving the premises. A response plan will be implemented immediately. The resident's care plan will be modified to include interventions to prevent further elopement attempts. C. Abuse and Neglect- Neglect includes the failure to prevent, supervise, monitor, and/or intervene when a resident has eloped from the facility. Every effort will be made to prevent elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o The Elopement Risk Assessment will be completed upon admission by the charge nurse. The assessment will be completed by reviewing the resident's medical history and social history. Information may be obtained by reviewing current medical records, if available, interview with resident/family, or conference with the interdisciplinary team member. The Elopement Risk Assessment is to be completed at least quarterly, after an elopement attempt, upon new exit seeking behavior, and upon change of condition. The Elopement Risk Assessment will be completed by the charge nurse or designee. The DON will be responsible for ensuring the completion and review of the assessment. This will begin 8/20/24. o All residents who are at risk for elopement will be assessed by the interdisciplinary team. This will begin 8/20/24. o The resident's care plan will be modified by the DON, MDS Coordinator, or designee to indicate the resident is at risk for elopement with appropriate interventions to prevent elopement attempts. This will begin 8/20/24. 6. Medical Director notified of the immediate jeopardy on 8/20/24. 7. An ADHOC QAPI meeting was conducted on 8/20/24 to discuss the immediate jeopardy citation and subsequent plan of correction. In-services: The Regional Compliance Nurse, Administrator, DON, and ADON will in-service all staff on the following topics below. All staff not present for the in-services will not be allowed to work their next shift until the in-services are complete. All new hires will be in-serviced during orientation prior to working their shift. All agency staff will be in-serviced prior to assuming scheduled shift. A. All staff were in-serviced on the Elopement Response Policy by the Compliance Nurse, Administrator and DON on 8/20/24. Nursing personnel must report and investigate all residents who attempt to elope. This includes when a resident is observed leaving the premises. A response plan will be implemented immediately. The resident's care plan will be modified to include interventions to prevent further elopement attempts. B. All staff were in-serviced on Elopement Prevention by Compliance Nurse, Administrator and DON on 8/20/24. This in-service includes implementing interventions for residents at risk for elopement. - Completing the elopement risk assessment to determine at risk residents. This in-service also includes reporting to the Charge Nurse, Administrator, or DON any resident who is attempting to elope. The policy includes interventions to assist in preventing elopements, environmental modifications, and staff training. C. All staff were in-serviced on Abuse and Neglect by the Compliance Nurse, Administrator, and DON on 8/20/24. Neglect includes the failure to prevent, supervise, monitor, and/or intervene when a resident has eloped from the facility. On 08/21/2024 the survey team confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. During an observation and interview on 08/21/2024 beginning at 4:49 p.m., Resident #33, Resident #1, and Resident #290 were no longer in the facility. The Administrator stated the residents were transferred to a sister facility for appropriate supervision. The Administrator stated the residents were unable to have been placed on the secu [TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on observations, interviews, and record review the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 1 resident (Resident #40) reviewed for incontinent care. The facility failed to ensure Resident #40 was provided proper incontinent care. These failures could place residents at risk for urinary tract infections and a decreased quality of life. Findings included: Record review of Resident #40's face sheet, dated 08/21/2024, originally admitted to the facility on [DATE] with diagnoses which included dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life. Record review of the quarterly MDS assessment, dated 08/06/2024, indicated Resident #40 made herself understood and usually understood others. Resident #40's BIMS score was 0, which indicated her cognition was severely impaired. Resident #40 was always incontinent of urine and bowel. Resident #40 required substantial/maximal assistance with toileting and partial/moderate assistance with personal hygiene. Record review of the comprehensive care plan, revised on 08/20/2024, indicated Resident #40 had a urinary tract infection. The interventions included: encourage adequate fluid intake, and give antibiotic therapy as ordered. Record review of the order summary report dated 08/21/2024 indicated Macrobid 100 mg give 1 capsule by mouth two times a day for UTI for 10 days with a start date 08/18/2024. During an observation and interview on 08/19/2024 at 3:15 p.m., CNA NN provided incontinent care to Resident #40. CNA NN did not provide hand hygiene or apply hand sanitizer prior to donning (put on) gloves. CNA NN donned gloves and wiped Resident #40 peri area once without separating the inner labia (peri area). CNA NN continued providing incontinent care. CNA NN stated she should have performed hand hygiene before donning her gloves. CNA NN stated she should have wiped Resident #40's peri area once and got another wipe and wipe her again. CNA NN stated, I get nervous when someone watches me. CNA NN stated this failure put Resident #40 at risk for a UTI. (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 08/22/2024 at 2:58 p.m., ADON Y stated she was the Infection Control Preventionist for the facility. ADON Y stated she expected CNAs to perform hand hygiene prior to donning gloves. ADON Y stated she expected her to open her peri area and wipe front to back with a clean wipe each time until clear of soilage. ADON Y stated she monitored by monthly in-services, performance of skill check offs, and random checks while performing incontinent care on a resident. ADON Y stated she never had an issue with CNA NN providing incontinent care in the past. ADON Y stated this failure put Resident #40 at risk for a UTI. During an interview on 08/22/2024 at 6:26 p.m., the Administrator stated she expected staff to perform hand hygiene prior to donning gloves to prevent the spread of germs. The Administrator stated she expected staff to clean the peri area correctly. The Administrator stated ADON Y was responsible for monitoring and overseeing appropriate peri care. Record review of a CNA Proficiency Audit dated 4/11/2024 indicated CNA NN was assessed in the area of hand washing, perineal care; female, and infection control awareness scoring a satisfactory in skill level. Record review of the facility's policy titled, Perineal Care Female, revised 12/08/2009 indicated, .H. Wash hands and put on clean gloves for perineal care .Ib. separate inner labia (peri area) and using a different surface, wash down the center and over the urethral area, wiping downward from front toward back . c. continue to wash the rest of the perineal area Change the washcloth or pre-moistened cleaning wipe surface or use a new washcloth or pre-moistened cleaning wipe with each wipe .

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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 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** 46892 Based on observations, interviews, and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 1 of 2 residents (Resident # 5) reviewed for respiratory care. The facility did not ensure Resident #5's oxygen concentrator was set at 2-4 liters per nasal cannula as ordered by the physician. These failures could place residents requiring respiratory care at risk for shortness of breath, respiratory distress, or complications. Findings included: Record review of a face sheet dated 08/20/2024 indicated Resident #5 was an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #5 understood others and was able to make herself understood. The MDS assessment indicated Resident #5 had a BIMS score of 10, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #5 required substantial/maximal assistance with toileting, dressing, and personal hygiene. The MDS assessment indicated Resident #5 received oxygen therapy while a resident at the facility. Record review of Resident #5's care plan last reviewed on 05/26/2024 indicated she had chronic obstructive pulmonary disease with recurrent exacerbation and increase shortness of breath and coughing to give oxygen therapy as ordered by the physician. Record review of the Order Summary Report dated 08/20/2024 indicated Resident #5 had an order for oxygen at 2-4 liters per nasal cannula every day and night shift with a start date of 11/25/2022. During an observation and interview beginning on 08/19/2024 at 3:35 PM, Resident #5 was sitting in the dining room wearing oxygen via nasal cannula with her oxygen concentrator at her side. Resident #5 said she wore the oxygen all the time and it was supposed to be at 2 liters. Resident #5's oxygen concentrator was set at 1 liter. Resident #5 did not appear to be in respiratory distress. Resident #5 said CNA M had put the oxygen on her. The State Surveyor asked LVN K to check Resident #5's oxygen settings. LVN K said Resident #5's oxygen should be set at 2-4 liters. LVN K checked Resident #5's oxygen concentrator and said it was set incorrectly at 1 liter. LVN K adjusted the settings. LVN K said she did not know who had put the oxygen on Resident #5. LVN K said a nurse should put the oxygen on and set it correctly. LVN K said if the oxygen was not set per the physician's order Resident #5's oxygen level could get too low, or she could get short of breath. (continued on next page)

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	675798	A. Building B. Wing	08/22/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/19/2024 at 4:04 PM, CNA M said she had not applied the oxygen on Resident #5. CNA M said she had brought the oxygen concentrator to the dining room and Resident #5 had put it on herself. CNA M said the CNAs were allowed to help them put it on, but they could not adjust the settings. CNA M said she should have gotten the nurse to check the settings to ensure they were set properly. CNA M said it was her mistake, but she was in a rush. CNA M said Resident #5's oxygen being set below what was ordered could make it harder for Resident #5 to breathe. During an interview on 08/22/2024 at 6:05 PM, the DON said the nurses were responsible for ensuring the residents oxygen was set per the physician's order. The DON said the CNA should have let the nurse know that Resident #5 needed oxygen so the nurse could have made sure that the settings were correct. The DON said Resident #5's oxygen being set lower than prescribed placed her at risk for not getting enough oxygen and suffocating. During an interview on 08/22/2024 at 6:41 PM, the Administrator said she expected for the nurses to set the oxygen properly. The Administrator said CNA M had pushed the oxygen concentrator down to Resident #5 and had bumped it and had forgotten to tell the nurse to check the settings. The Administrator said the CNA should have told the nurse. The Administrator said the physician ordered the oxygen to be set at a specific level for a reason, so it needed to be set at the appropriate level. Record review of the policy titled, Oxygen Administration, revised 03/21/2023, indicated, Oxygen therapy includes the administration of oxygen (O2) in liters/minute (l/min) by cannula or face mask to treat hypoxemic conditions caused by pulmonary or cardiac diseases. O2 therapy is also prescribed to ensure oxygenation of all body organs and systems. The amount of oxygen by percent of concentration or L/min, and the method of administration, is ordered by the physician. The administration, monitoring of responses, and safety precautions associated with it are performed by the nurse .

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on interviews and record review, the facility failed to ensure residents were seen by a physician at least once every 30 days for the first 90 days after admission for 3 of 26 residents (Resident's #29, #37, and #64) reviewed for physician services. The facility failed to ensure Resident's #29, #37, and #64 were seen by a physician within the first 30 days of their skilled admission to the facility. This failure could place the residents at risk for medical conditions not being identified, care needs not being met, and a decline in health status. The findings included: 1. Record review of the face sheet, dated 08/22/2024, revealed Resident #29 was a [AGE] year-old male who admitted to the facility for skilled services on 05/26/2024 with a diagnosis of pneumonitis due to inhalation of food and vomit (aspiration pneumonia or lung infection). The face further revealed the Medical Director was Resident #29's primary physician and his primary payor was Medicare A. Record review of the quarterly MDS assessment, dated 08/04/2024, revealed Resident #29's start date for the most recent Medicare stay was 05/26/2024 with no end date documented. The MDS revealed Resident #29 had clear speech and was understood by others. The MDS revealed Resident #29 was able to understand others. The MDS revealed Resident #29 had a BIMS score of 09, which indicated moderately impaired cognition. Record review of the progress notes, dated between 05/26/2024 and 08/22/2024, revealed no progress note from the Medical Director had been completed for Resident #29. Record review of the PA notes, dated between 05/26/2024 and 08/22/2024, revealed the PA completed visits for Resident #29 on 05/27/2024, 05/29/2024, 06/03/2024, 06/05/2024, 06/10/2024, 06/12/2024, 06/25/2024, 07/01/2024, 07/09/2024, 07/15/2024, 07/22/2024, 07/27/2024, 07/29/2024, 07/31/2024, 08/05/2024, 08/12/2024, and 08/19/2024. During an interview on 08/22/2024 beginning at 10:53 AM, Resident #29 stated he was unsure if he had seen the Medical Director or the physician since he had admitted to the facility. Resident #29 stated he knew he had seen the PA. 2. Record review of the face sheet, dated 08/22/2024, revealed Resident #37 was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of peritoneal abscess (infection of peritoneal cavity (inner wall of the abdomen)). The face sheet further revealed the Medical Director was her primary care physician and her primary payor source was Medicare A. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the quarterly MDS assessment, dated 07/09/2024, revealed Resident #37' start date of her most recent Medicare stay was 07/05/2024 with no end date documented. The MDS revealed Resident #37 had clear speech and was understood by others. The MDS revealed Resident #37 was able to understand others. The MDS revealed Resident #37 had a BIMS score of 09, which indicated moderately impaired cognition. Record review of the progress notes, dated between 07/05/2024 and 08/22/2024, revealed no progress note from the Medical Director had been completed for Resident #37. Record review of the PA notes, dated between 07/05/2024 and 08/22/2024, revealed the PA completed visits for Resident #37 on 07/09/2024, 07/11/2024, 07/15/2024, 07/17/2024, 07/22/2024, 07/24/2024, 07/29/2024, 07/31/2024, 08/05/2024, 08/12/2024, and 08/19/2024. During an interview on 08/22/2024 at 2:33 PM, Resident #37 stated she did not remember if the Medical Director had made a visit. 3. Record review of the face sheet, dated 08/22/2024, revealed Resident #64 was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of gastrointestinal bleed (bleeding inside the gastrointestinal tract). The face sheet further revealed the Medical Director was her primary care physician and her primary payor source was Medicare A. Record review of the quarterly MDS assessment, dated 07/04/2024, revealed Resident #64's most recent Medicare stay started on 07/02/2024 and no end date was documented. The MDS revealed Resident #64 had clear speech and was understood by others. The MDS revealed Resident #64 was able to understand others. The MDS revealed Resident #64 had a BIMS score of 7, which indicated severely impaired cognition. Record review of the progress notes, dated between 07/04/2024 and 08/22/2024, revealed no progress note from the Medical Director had been completed for Resident #64. Record review of the PA notes, dated between 07/05/2024 and 08/22/2024, revealed the PA completed visits for Resident #64 on 07/09/2024, 07/15/2024, 07/22/2024, 07/29/2024, 08/05/2024, 08/12/2024, and 08/19/2024. During an attempted interview on 08/21/2024 at 5:23 PM, the Medical Director did not answer the telephone. A brief message was left with a call back number. During an interview on 08/22/2024 at 9:27 AM, the PA stated he completed all the visits for patients at the facility. The PA stated the Medical Director only saw patients if she was requested directly. During an attempted interview on 08/22/2024 at 10:31 AM, the Medical Director did not answer the telephone. A brief message was left with a call back number. No return call upon exit of the facility. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/22/2024 at 11:10 AM, LVN F stated the PA primarily handled the direct care of all the residents. LVN F stated the Medical Director only handled residents on hospice or if residents directly requested to see her. LVN F stated the Medical Director did not answer the phone well but if you sent her a text message, she would have responded timely. During an interview on 08/22/2024 at 11:53 AM, the DON stated Medical Records were responsible for monitoring to ensure the Medical Director was performing the initial visits for skilled patients. The DON stated the physician visit notes would have been documented under the progress notes tab in the electronic medical records. The DON stated it was important to ensure the physician completed the initial visits for skilled residents, so the Medical Director knew what was going on with the residents and was involved with their care. During an interview on 08/22/2024 beginning at 6:51 PM, the Administrator stated the Medical Director should have completed the initial assessment for skilled residents and then as requested. The Administrated stated the Medical Director left all other care to her PA. The Administrator stated she was unaware the PA was completing the initial visit and assessment for skilled residents. The Administrator stated Medical Records usually alerted staff if the initial visit was not being completed by the Medical Director. The Administrator stated the Medical Records were responsible for monitoring to ensure the Medical Director completed the initial visit for skilled patients. The Administrator stated it was important to ensure the physician was completing the initial visit on skilled patients to ensure she was kept in the loop and included in the care of her patients. Record review of the Physician Services Guidelines, undated, revealed Frequency: A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required .

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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 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** 46892 Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 1 of 24 residents (Residents #24) and 1 of 1 facility reviewed for pharmacy services. 1. The facility failed to keep a record of receipt of controlled medications awaiting disposition to allow accurate and periodic reconciliation. 2. The facility failed to ensure Resident #24 medications were administered during the scheduled time. These failures could place the residents at risk of not having medications available for use, drug diversion, not receiving their medications as ordered, and exacerbation of their disease processes. Findings included: 1. During an observation and interview on 08/22/2024 starting at 2:58 PM, an observation was made of the controlled medications awaiting disposal. The controlled medications awaiting disposal were in a locked file cabinet in the DON's office. There were approximately 10 different controlled medications awaiting disposal in the DON's locked file cabinet in her office. The DON said controlled medications that needed to be disposed of were brought to her. The DON said when a controlled medication that needed to be disposed was brought to her, she made a copy of the narcotic count sheet and gave it to the Administrator. The DON said she was not keeping a log of the controlled medications awaiting disposal as they were brought to her. The DON said it was important to keep accurate reconciliation of the controlled medications awaiting disposal because they could get stolen or something. During an interview on 08/22/2024 at 6:42 PM, the Administrator said the DON was responsible for ensuring the controlled medications awaiting disposal were reconciliated periodically. The Administrator said it was important to reconcile the controlled medications to ensure they were disposed of properly. 43047 2. Record review of Resident #24's face sheet, dated 08/21/2024, originally admitted to the facility on [DATE] with a diagnosis which included hypothyroidism (thyroid gland does not produce enough thyroid hormone), hypertensive heart disease (high blood pressure that affect the heart) without heart failure, and unspecified protein-calorie malnutrition. Record review of the order summary report dated 08/21/2024 indicated Resident #24 was ordered: Pantoprazole 20 mg 1 tablet by mouth QD at 7:00 a.m. Levothyroxine 100 mcg 1 tablet by mouth QD at 7:00 a.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hydrochlorothiazide 12.5 mg 1 tablet by mouth QD at 8:00 a.m. Refresh Tears Ophthalmic Solution Instill 2 drops in both eyes TID at 8:00 a.m. Aspirin EC 81 mg 1 tablet by mouth QD at 8:00 a.m. Multivitamin 1 tablet by mouth QD at 8:00 a.m. Vitamin B12 1000 mcg 1 tablet by mouth QD at 8:00 a.m. Lisinopril 20 mg 1 tablet QD at 8:00 a.m. Metoprolol Succinate ER 24-hour 25 mg 1 tablet by QD at 8:00 a.m. Procardia XL ER 24-hour 30 mg 1 tablet by mouth QD at 8:00 a.m. MiraLAX Powder 3350 17 grams by mouth QD every 3 days at 8:00 a.m. Record review of the Medication Administration Audit Report dated 08/21/2024 indicated Resident #24 received her medications on 08/18/2024 by LVN B as listed: Pantoprazole 20 mg 1 tablet at 9:48 a.m. Levothyroxine 100 mcg 1 tablet at 9:48 a.m. Hydrochlorothiazide 12.5 mg 1 tablet at 9:48 a.m. Refresh Tears Ophthalmic Solution at 9:48 a.m. Aspirin EC 81 mg 1 tablet at 9:48 a.m. Multivitamin 1 tablet at 9:48 a.m. Vitamin B12 1000 mcg 1 tablet at 9:48 a.m. Lisinopril 20 mg 1 tablet at 10:08 a.m. Metoprolol Succinate ER 24-hour 25 mg 1 tablet at 10:08 a.m. Procardia XL ER 24-hour 30 mg 1 tablet at 10:09 a.m. Record review of the Medication Administration Audit Report dated 08/21/2024 indicated Resident #24 received her medications on 08/19/2024 by RN C as listed: Pantoprazole 20 mg 1 tablet at 9:41 a.m. Levothyroxine 100 mcg 1 tablet at 9:41 a.m. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hydrochlorothiazide 12.5 mg 1 tablet at 9:41 a.m. Refresh Tears Ophthalmic Solution at 9:42 a.m. Aspirin EC 81 mg 1 tablet at 9:41 a.m. Multivitamin 1 tablet at 9:42 a.m. Vitamin B12 1000 mcg 1 tablet at 9:42 a.m. Lisinopril 20 mg 1 tablet at 9:41 a.m. Metoprolol Succinate ER 24-hour 25 mg 1 tablet at 9:41 a.m. Procardia XL ER 24-hour 30 mg 1 tablet at 9:42 a.m. MiraLAX Powder 3350 17 grams by mouth at 9:42 a.m. During an interview on 08/20/2024 at 11:08 a.m., Resident #24 stated her medications were not always given on time. Resident #24 stated she preferred her medications to be given before or during breakfast. Resident #24 stated she noticed it only occurred with certain nurses but could not recall the names. During an interview on 08/22/2024 at 10:04 a.m., LVN B stated medications that were scheduled at 7:00 a.m. should have been given between 6:00 a.m.-8:00 a.m. and the medications scheduled at 8:00 a.m. should have been given between 7:00 a.m.-9:00 a.m. LVN B stated, it's impossible to administer medications to 35 residents in a timely manner. LVN B stated this failure could potentially cause an accumulation of medications or adverse effect. During a telephone interview on 08/22/2024 at 11:03 a.m., RN C stated medications that were scheduled at 7:00 a.m. should have been given between 6:00 a.m.-8:00 a.m. and the medications scheduled at 8:00 a.m. should have been given between 7:00 a.m.-9:00 a.m. When asked why the medications were not administered on time, RN C stated, I can't tell you, don't know if I got sidetrack or I charted late. RN C stated this failure could potentially cause an adverse effect. During an interview on 08/22/2024 beginning at 5:41 p.m., the DON stated she expected medications to be administered one hour before or one hour after the scheduled time. The DON stated when a medication was given late the MD should have been notified. The DON stated was unaware of the medication administration audit report until the state surveyor intervention. The DON stated her and LVN F reviewed the dashboard on PCC daily to see if there was a green dot which indicated medications were administered or missed. The DON stated the dashboard did not indicate if the medications were administered late. The DON stated the failure of not administering medications on time were not following the physician's order and could cause interactions with other medications. During an interview on 08/22/2024 at 6:26 p.m., the Administrator stated she expected the medications to be administered according to the schedule. The Administrator stated the DON, the ADONs, and the charge nurses were responsible for overseeing and monitoring. The Administrator stated this failure could potentially cause an adverse effect. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled, Medication Administration Procedures, revised 10/25/2017 indicated, . 9. Defining the schedules for administering medications to maximize the effectiveness of the medication, prevent potential significant medication interactions such as medication-medication 20. The 10 rights of medication should always be adhered to . right time Record review of the facility's policy from the Pharmacy Policy & Procedure Manual 2003 titled, Storage of Controlled Substance, did not address the storage, logging, or reconciliation of controlled substances awaiting disposal.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observations, interviews, and record review the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 2 of 24 residents (Resident #24 and Resident #82) and 1 of 5 medication carts (D-hall medication cart) reviewed for drugs and biologicals. 1. The facility failed to ensure LVN L secured the D-hall medication cart and keys during medication administration and while the D-hall medication cart was not in use. 2. The facility failed to ensure LVN N secured the D-hall medication cart during medication administration. 3. The facility failed to ensure the controlled medications awaiting disposal were under a double lock. 4. The facility failed to ensure Resident #82's Carbidopa-Levodopa (medication used to treat Parkinson's Disease) medication label matched her physician order. 5. The facility did not ensure Resident #12's Preparation H (medication used to temporarily relieve swelling, burning pain and itching caused by hemorrhoids) was properly safe and secured. These failures could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse, and drug diversion. Findings included: 1. During an observation of medication administration on 08/20/2024 starting at 8:46 AM, LVN L gathered supplies to administer medications and went into the resident's bathroom. The D-hall medication cart was left in the hallway across from where the room was located. LVN L did not lock her medication cart and left the keys on top of the medication cart. During an interview on 08/20/2024 at 9:27 AM, LVN L said she was supposed to lock the medication cart every time she walked away from it. LVN L said she did not realize she had left the medication cart unlocked and the keys on top of the medication cart. LVN L said leaving the medication cart unlocked and the keys to the medication cart on top of the medication cart could result in a resident or any staff getting into the medication cart. During an observation and interview on 08/20/2024 at 4:22 PM, the D-hall medication cart was at the nurses' station unlocked. LVN L was observed down the hall on the opposite side. LVN L noticed the State Surveyor standing at the medication cart and approached it. LVN L said she forgot to lock the medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation and interview of medication administration on 08/21/2024 starting at 8:19 AM, LVN N went into a resident's room to check a blood sugar. LVN N left the D-hall medication cart unlocked and out of her view. LVN N said she thought she had locked the medication cart. LVN N said the medication cart should be locked every time she stepped away from the medication cart. LVN N said it was important to lock the medication cart so the residents and no one could get into the medication cart. LVN N said if the medication cart was unlocked the residents could get a hold of the medications. 3. During an observation on 8/21/2024 at 3:00 p.m., the regional nurse was sitting in the DON's office alone. The DON's office door was not locked. During an observation and interview on 08/22/2024 starting at 2:58 PM, an observation was made of where the DON kept controlled medications awaiting disposal. The DON's door to her office was open and unlocked upon entering. The DON opened the single locked file cabinet located in her office. There were approximately 10 different controlled medications awaiting disposal. The medications were not stored under two locks. The DON said she was responsible for keeping the controlled medications awaiting disposal. The DON said the controlled medications should be stored under two locks. The DON said the lock on her door was one lock and the lock on the cabinet was the second lock. The DON said she was normally in her office. The DON said it was important to store the controlled medications under a double lock to ensure nobody could go in and get them. During an interview on 08/22/2024 at 6:47 PM, the Administrator said the controlled medications awaiting disposal should be under two locks. The Administrator said the DON was responsible for keeping the controlled medications awaiting disposal. The Administrator said it was important for them to be stored under two locks to ensure nobody could take the medications. 4. Record review of a face sheet dated 08/21/2024 indicated Resident #82 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Parkinson's Disease without dyskinesia, without mention of fluctuations (progressive disorder that affects the nervous system and the parts of the body controlled by the nerves causes unintended or uncontrollable movements). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #82 was able to make herself understood and understood others. The MDS assessment indicated Resident #82 had a BIMS score of 9, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #82 required substantial/maximal assistance with toileting hygiene, set-up or clean up assistance for eating, oral hygiene, and upper body dressing, and partial to moderate assistance with showering/bathing and lower body dressing. Record review of Resident #82's care plan dated 07/22/2024 indicated she had Parkinson's to administer medications as ordered by the physician and to monitor/document side effects and effectiveness. Record review of the Order Summary Report dated 08/21/2024 indicated Resident #82 had an order for Carbidopa-Levodopa 25-250 MG (Carbidopa-Levodopa) Give 1 tablet by mouth three times a day with a start date of 07/19/2024. (continued on next page)

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	675798	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arboretum Nursing and Rehabilitation Center of Win	1215 Highway 124 Winnie, TX 77665

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of medication administration and interview on 08/21/2024 starting at 8:19 AM, LVN N administered medications to Resident #82. Resident #82's medication label instructions indicated Carbidopa-Levodopa 25 mg/250 mg take 1.5 tablets by mouth four times a day. LVN N said she was administering 1 tablet because that was what the order indicated. LVN N said the medication labels on the resident's medication should match their orders. LVN N said she did not regularly administer medications to Resident #82. LVN N said the nurse that noticed the discrepancy was responsible for notifying the pharmacy of the discrepancy. LVN N said a sticker should be placed on the label to alert staff the directions had changed. LVN N said it was important for the orders to match the medication label because the dosage could be wrong, and this could lead to a medication error. During an interview on 08/22/2024 starting at 6:07 PM, the DON said the charge nurses were responsible to ensuring the resident's medication label matched the order. The DON said the hall managers were supposed to monitor the medication carts monthly to ensure the residents' medication labels matched their orders. The DON said a change of direction label should have been placed on the medication. The DON said the medication label not matching the resident's order placed the resident at risk of not getting the correct dose. The DON said this also placed the resident at risk of what they were getting treated for not getting managed properly. The DON said it was the nurses' responsibility to ensure the medication carts were locked and they kept the keys on themselves at all times. The DON said the medication carts should be locked anytime the nurses walked away from the cart. The DON said she made rounds twice a day and looked at the medication carts to make sure they were locked. The DON said in the past she had noticed medication carts not locked and she would tell the nurses to lock them. During an interview on 08/22/2024 at 6:22 PM, ADON Q said the nurses were responsible for checking the medication labels when they were received from the pharmacy to ensure they matched the residents' orders. ADON Q said she had looked at Resident #82's Carbidopa-Levodopa during medication administration before, and she had not noticed the discrepancy between Resident #82's order and the medication label. ADON Q said she guessed she missed it. ADON Q said it was important for the residents' medication labels to match their orders to ensure they received the correct dosage. ADON Q said the medication labels not matching the residents' orders placed them at risk for being under or over medicated. During an interview on 08/22/2024 starting at 6:43 PM, the Administrator said she expected for the nurses or whoever received the medication order to follow through and ensure the medication label matched the order. The Administrator said the ADON/hall nurse should be reviewing the medications to ensure they matched. The Administrator said it was important for the medication label to match the order to ensure the residents received the correct dose. The Administrator said she expected for the nurses to lock the medication carts when thy walked away from them. The Administrator said the DON and the hall managers were responsible for monitoring the nurses. The Administrator said if the medication carts were not locked the residents could access stuff that they should not have access to. 43047 5. Record review of Resident #12's face sheet, dated 08/21/2024, originally admitted to the facility on [DATE] with diagnoses which included hypertensive heart disease (high blood pressure that affect the heart) without heart failure and unspecified protein-calorie malnutrition. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the quarterly MDS assessment, dated 07/23/2024, indicated Resident #12 usually made herself understood and usually understood others. Resident #12 BIMS score was 8, which indicated her cognition was moderately impaired. Resident #12 had no behaviors or refusal of care. Record review of the comprehensive care plan, revised on 07/26/2022, indicated Resident #12 required staff assist with ADL and mobility tasks. The interventions included: limited staff assist x1 for personal hygiene, oral care task, and continent of bowel with occasional incontinent episodes of bladder. Record review of the order summary report dated 08/21/2024 did not address the use of Preparation H. During an observation on 08/19/2024 at 2:56 p.m., Resident #12 was sitting in her recliner. There were 2 tubes of Preparation H cream located in a 4-drawer clear storage container in Resident #12's bathroom. During an observation and interview on 08/20/2024 at 11:08 a.m., Resident #12 was sitting in her recliner visiting family members. When asked if the state surveyor could look in her clear storage container, she stated yes. The State Surveyor asked Resident #12 what the 2 tubes that were in the storage container were used for, she stated, I use it for my bottom. Resident #12 stated a family member brought the medication to her. Resident #12 stated I don't use it often. During an interview and observation on 08/21/2024 at 1:58 p.m., RN G stated Resident #12 had not been checked off for self-administration. RN G stated if a resident was able to self-administer an assessment must be completed and an order obtained prior to administration. RN G observed the 2 tubes of Preparation H in Resident #12's clear storage container. RN G stated it was important that medications were not left in the room because others could ingest the medication or cause toxicity. During an interview on 08/22/2024 at beginning at 5:41 p.m., the DON stated nurses were responsible for ensuring medications were stored appropriately. The DON stated before a resident could keep medications at bedside a self-administer assessment must be completed. The DON stated the MD must be notified and orders would be obtained. The DON stated she monitored by routine checks to ensure compliance. The DON stated she has had issues in the past with medications being stored at bedside. The DON stated if there was an issue it was corrected immediately by removing the medication and educating the resident and the family. The DON stated champion rounds were done every morning by the Admission Coordinator. The DON stated it was important to ensure medications were not left at bedside for resident safety and to prevent harm. During an interview on 08/22/2024 at 6:02 p.m., the Admission Coordinator stated she was responsible for champion rounds for Resident #12. The Admission Coordinator stated during rounds she checked to see if the residents have any concerns, questions, or issues. The Admission Coordinator stated she also looked around the room and bathroom to see if there was anything that needed to be addressed. The Admission Coordinator stated, I would assume those tubes were toothpaste or polydent (denture cream). The Admission Coordinator stated it was important that medications were not left in room to prevent an adverse reaction to another medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/22/2024 at 6:26 p.m., the Administrator stated that if the resident did not have an order to self-administer, she expected medications to be stored on the medication cart. The Administrator stated the DON, the ADONs, and the charge nurses were responsible for monitoring and overseeing that medications were not left out. The Administrator stated it was important to ensure medications were not let at bedside to prevent an adverse reaction. Record review of the facility's policy titled, Self-Administration of Drugs, revised 01/09/2006 indicated, . 1. Only medication permitted (ordered) for self-administration shall be left in residents' room . Record review of the facility's policy from the Pharmacy Policy & Procedure Manual 2003 titled, Medication Administration Procedures, indicated, .After the medication administration process is completed, the medication cart must be completely locked, or otherwise secured . Record review of the facility's policy from the Pharmacy Policy & Procedure Manual 2003 titled, Order Changes, indicated, .Medication orders for which changes have been made are to be completely re-written in the medication administration record as a new order. The previous order is to be discontinued. The nurse may apply a Label Change, Check Med-Sheet@, or a similar accessory label to the medication package for continued use of the medication. This will alert subsequent staff that the directions have been changed . Record review of the Texas Administrative Code Texas Administrative Code (state.tx.us) accessed on 08/28/2024 indicated, .Store medication covered by Schedule II of the Texas Controlled Substances Act under double lock in a separate container. For example, a double lock can include a lock on the cabinet or filing cabinet and the door to the closet where medications are stored .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on observations, interviews, and record review the facility failed ensure each resident receives and the facility provides food that accommodates residents' food preferences for 1 (Resident #290) of 27 residents reviewed for food preferences and the accommodation of resident's meal choices. The facility failed to honor Resident #290's preference for meat to be chopped at table/bedside. This failure could result in a decrease in resident choices, diminished interest in meals, and weight loss. Findings included: Record review of a face sheet, dated 08/21/2024, indicated Resident #290 was a [AGE] year-old female, originally admitted 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 #290's quarterly MDS assessment, dated 07/23/2024, indicated Resident #290 usually made herself understood and understood others. Resident #290 had a BIMS score of 5, which indicated her cognition was severely impaired. Resident #290 required set up or clean up assistance for eating. Record review of the comprehensive care plan, revised 08/21/2024, indicated Resident #290 had an ADL self-care performance deficit related to dementia. The interventions included: resident was independent with eating after set up. Record review of the order summary report did not address Resident #290's preference regarding meat to be cut at table/bedside. Record review of the lunch meal ticket dated 08/19/2024 for Resident #290 indicated Resident #290 was on a regular diet and meat should be cut up at bedside/table. During an observation and interview on 08/19/2024 at 12:21 p.m., Resident #290 lunch meal ticket stated, cut up meat at table/bedside. Resident #290 received a slice of meatloaf. The DON did not cut the meat after she delivered Resident #290 tray. An attempted interview with Resident #290, indicated she was non-interview able. During an interview on 08/22/2024 beginning at 5:41 p.m., the DON stated she was responsible for checking the trays to ensure the proper diet has been served. The DON stated she was not aware that Resident #290's meat should be cut until the state surveyor intervention. The DON stated, state in the building threw all of us off. The DON stated Resident #290 had issues in the past with cutting her meat. The DON stated it was her preference for staff to assist her with cutting her meat at mealtimes. The DON stated it was important for Resident #290's food preference to be followed to prevent an injury. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/2024 at 6:26 p.m., the Administrator stated he expected for the meal tickets and for food preferences to be followed. The Administrator stated the nurse should be checking the meal tickets for accuracy. The Administrator stated it was important for their food preferences and meal tickets to be followed because it was their right and prevent injury. Record review of the facility's policy, titled Nursing Responsibilities at Meal Service, dated 2012, indicated, 6. Assist in preparing food after the tray has been delivered to the resident, if necessary. This includes unwrapping food, cutting meat Record review of the facility's undated policy, titled Resident Meal Service and HS snack, indicated .3. resident preference will be honored .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. The facility did not ensure: 1. Food items were labeled and dated. 2. Hair restraints were worn. 3. The prepared green beans were not stored beside dirty dishes. 4. Volunteer XX wore a hair net and performed hand hygiene while assisting with preparing the appetizers prior to the lunch meal on 08/19/2024. These failures could place residents at risk for foodborne illness. Findings included: During the initial tour observation and interview with the Dietary Manager on 08/19/2024 beginning at 8:28 a.m., the following was revealed: 1. The Dietary Manager, [NAME] R, Dietary Aide S hairnets were not covering their entire head. There was loose hair sticking out for all 3 of them. 2. The Dietary Dishwasher was in the kitchen without wearing a hair restraint. 3. Plastic storage bag that was identified by the Dietary Manager as bacon undated and unlabeled. 4. Plastic bag that was identified by the Dietary Manager as cherries unlabeled. 5. Plastic bag that was identified by the Dietary Manager as shrimp undated and unlabeled. 6. A bag of okra undated and unlabeled. 7. A bag of cherry pies unlabeled. 8. A bag of guacamole unlabeled. 9. A bag of Italian breaded zucchini sticks undated. 10. 2 bags of macaroni elbow pasta undated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. 1 bag of spaghetti undated. 12. A large pan of frozen green beans were stored on the prepping table by dirty dishes. During an interview on 08/22/2024 at 2:50 p.m., Dietary Aide S stated all kitchen staff were responsible for labeling and dating food products. Dietary Aide S stated hairnets should always be worn while in the kitchen and hairnets were supposed to cover the entire head without loose hair sticking out. Dietary Aide S stated the cook was responsible for ensuring the food was stored correctly. Dietary Aide S stated these failures could put residents at risk for food borne illness and contamination. During an interview on 08/22/2024 at 3:15 p.m., [NAME] U stated all kitchen staff were responsible for labeling and dating food products. [NAME] U stated hairnets should always be worn while in the kitchen and hairnets were supposed to cover the entire head without loose hair sticking out. [NAME] U stated the green beans should have been placed on the stove after prepping them. [NAME] U stated these failures could put residents at risk for food borne illness and contamination. During an interview on 08/22/2024 at 3:40 p.m., the Dietary Manager stated cleanliness was important in the kitchen, so her staff were not spreading germs or contaminating anything. The Dietary Manager stated she was responsible for making sure the kitchen was cleaned appropriately. The Dietary Manager stated all food should be labeled and dated with the date received and the date it was opened. The Dietary Manager stated hairnets should be worn while in the kitchen and covering the entire head without loose hair sticking out. The Dietary Manager stated the cook should have placed the green beans on the stove after she prepped them. The Dietary Manager stated she was responsible for monitoring and overseeing by daily walk throughs and when there was an issue staff were verbally in serviced immediately. The Dietary Manager stated she had to address these issues in the past. The Dietary Manager stated these failures could potentially put residents at risk for cross contamination and food borne illness. During an interview on 08/22/2024 at 6:26 p.m., the Administrator stated she expected all food to be labeled and dated. The Administrator stated she expected hairnets to always be worn and covering the entire head. The Administrator stated after the cook prepped the green beans, she should have placed them on the stove. The Administrator stated the Dietary Manager was responsible for monitoring and overseeing the kitchen. The Dietary Manager stated these failures could potentially put residents at risk for cross contamination. 47006 4. During an observation on 08/19/24 beginning at 11:39 a.m., Volunteer XX was helping to prepare the appetizer in the main dining room. Volunteer XX was pouring ranch dressing into cups. Volunteer XX had no hair net and applied gloves without washing her hands or using alcohol-based hand sanitizer. Volunteer XX pulled the appetizer out of the oven and then placed more in the oven. Volunteer XX took her gloves off and did not perform hand hygiene. During an observation on 08/19/2024 beginning at 11:46 a.m., Volunteer XX applied gloves without performing hand hygiene. Volunteer XX was holding her cell phone with gloved hands. Volunteer XX put the cell phone on the table with her gloved hands then took food out of the oven. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/22/2024 beginning at 5:00 p.m., Volunteer XX stated she had been volunteering at the facility since 2015. Volunteer XX stated she was instructed by the facility to perform hand hygiene prior to applying gloves and applying a hair net prior to handling food. Volunteer XX stated she knew better she just did not do better. Volunteer XX stated she had taken food handler classes several times per year. Volunteer XX stated when she was asked to help, she just jumped in without thinking. Volunteer XX stated it was important to ensure hand hygiene was performed prior to putting on gloves or taking off gloves and putting on a hair net prior to handling the food to maintain food sanitation. Volunteer XX stated not wearing a hair net or washing hands was unsanitary. During an interview on 08/22/2024 beginning at 5:59 p.m., the DON stated she expected the facility staff and volunteers to ensure a hair net was used when handling food and hand hygiene was performed prior to applying gloves. The DON stated activity and dietary staff were responsible for monitoring to ensure hair nets were used and hand hygiene was performed prior to handling food. The DON stated it was important to ensure a hair net was worn and hand hygiene was performed to prevent food contamination and maintain sanitation of the food. During an interview on 08/22/2024 beginning at 6:51 p.m. the Administrator stated she expected volunteers to ensure hair nets were worn and hand hygiene was performed while preparing food. The Administrator stated the staff member in the dining room was responsible for monitoring to ensure a hair net was used and hand hygiene was performed. The Administrator stated it was important to ensure a hair net was worn and hand hygiene was performed to prevent cross-contamination and maintain food sanitation practices. Record review of the facility's policy titled, Food Safety, dated 2012 indicated, .2. Opened food shall be labeled, dated, and stored properly . Record review of the facility's policy titled, Infection Control, dated 2012 indicated, .1b. Clean hair is required. It is to be covered with an effective hair restraint . Record review of the Texas Food establishment Rules, dated August 2021 indicated .TFER S228.43 states that food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. It does not apply to food employees such as counter staff who only serve TEXAS DEPARTMENT OF STATE HEALTH SERVICES DIVISION FOR REGULATORY SERVICES ENVIRONMENTAL AND CONSUMER SAFETY SECTION POLICY, STANDARDS, AND QUALITY ASSURANCE UNIT PUBLIC SANITATION AND RETAIL FOOD SAFETY GROUP PSRFSGRC - No.19 Hair Restraints April 1, 2016 (Revised February 21, 2017) Page 2 Public Sanitation and Retail Food Safety Group ? PO Box 149347, Mail Code 1987 ? [NAME], Texas 78714-9347 (512) [PHONE NUMBER] ? Facsimile: (512) [PHONE NUMBER] ? http://www.dshs.texas.gov/foodestablishments/ Pub #23 -14843 Rev. 02/21/2017 beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles Record review of the Texas Food establishment Rules, dated August 2021 indicated the container of ready-to-eat food shall be marked to indicate the date by which food shall be consumed on the premises, sold or discarded. The ready-to-eat food if held at 41 F can only be held for a maximum of 7 days, with day of preparation being day 1. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of FDA 2-402.11, dated 2022, revealed FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE SERVICE and SINGLE-USE ARTICLES. The FDA further revealed in 5-501.17, Based on a predictive growth curve modeling program for Listeria monocytogenes, ready-to-eat, time/temperature control for safety food may be kept at 5oC (41oF) a total of 7 days. Food which is prepared and held, or prepared, frozen, and thawed must be controlled by date marking to ensure its safety based on the total amount of time it was held at refrigeration temperature, and the opportunity for Listeria monocytogenes to multiply, before freezing and after thawing. Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46892 Based on observation, 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 3 of 3 residents (Resident #11, Resident #15, and Resident #35) reviewed for hospice services. The facility did not ensure Resident #11 and Resident #35 had the most current hospice plan of care. The facility failed to obtain Resident #15's most current hospice certification and plan of care, nurse visit notes, and aide visit notes. These deficient practices 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. Findings included: 1. Record review of Resident #11's face sheet dated 08/21/2024 indicated she was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system). Record review of Resident #11's Quarterly MDS assessment dated [DATE] indicated she sometimes was able to make herself understood and sometimes understood others. The MDS assessment indicated Resident #11 had a BIMS score of 7, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #11 received hospice care while a resident at the facility. Record review of Resident #11's care plan last reviewed 07/25/2024 indicated she had a terminal prognosis and was receiving hospice services, and if receiving hospice services, to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs were met. Record review of the Order Summary Report dated 08/21/2024 indicated Resident #11 had an order to admit to hospice for diagnosis of chronic obstructive pulmonary disease with a start date of 01/23/2024. Record review of Resident #11's hospice Facility Document delivery indicated hospice documents were delivered 06/25/2024, and the last hospice Plan of Care in the documents was dated 06/18/2024. There were no plans of care for the month of July 2024 and August 2024. (continued on next page)

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Arboretum Nursing and Rehabilitation Center of Win	1215 Highway 124 Winnie, TX 77665

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of a face sheet dated 08/21/2024 indicated Resident #35 was an 87- year-old male initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Alzheimer's Disease (progressive disease that destroys memory and other important mental functions). Record review of the Comprehensive MDS assessment dated [DATE], indicated Resident #35 was understood by others and was able to understand others. The MDS assessment indicated Resident #35 had a BIMS score of 08, which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #35 received hospice care while a resident at the facility. Record review of Resident #35's care plan last reviewed 07/10/2024 indicated he had a terminal prognosis and was receiving hospice services, and if receiving hospice services, to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. Record review of the Order Summary Report dated 08/21/2024 indicated Resident #35 had an order to admit to hospice for diagnosis of Alzheimer's disease with a start date of 06/17/2024. Record review of Resident #35's hospice Facility Document delivery indicated hospice documents were delivered 07/25/2024, and the last hospice Plan of Care in the documents was dated 07/23/2024. There were no plans of care for the month of August 2024. During an interview on 08/21/2024 at 4:26 PM, the hospice nurse said the facility had requested for the hospice documents to be sent to them electronically. The hospice nurse said the hospice office was responsible for sending the residents hospice documents to the facility, and they were sent monthly. The hospice nurse said it was important for the facility to have the hospice documents for the facility to be up to date on the hospice plan of care. During an interview on 08/22/2024 at 3:53 PM, LVN K said Resident #11 and Resident #35 received hospice services from the same company. LVN K said she was not able to view any of the hospice records. LVN K said she was able to communicate with the hospice nurse almost daily regarding the residents' care. LVN K said it was important for the facility to have access to the hospice records so they could give the correct medications and for continuation of care. 33249 3. Record review of a face sheet dated 8/22/2024 indicated Resident #15 was a [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnoses of hypertensive heart disease (heart damage from high blood pressure over time) and dementia (memory loss disease). Record review of the Annual MDS dated [DATE] indicated Resident #15 was understood and understands others. The MDS indicated Resident #15's BIMS score was a 6 indicating severe cognitive impairment. Section O- Special Treatment, Procedures, and Programs indicted Resident #15 received hospice services while a resident of the facility. Record review of the comprehensive care plan revised on 12/29/2022 indicated Resident #15 had a terminal prognosis of hypertensive heart disease. The goal of the care plan was Resident #15 would be comfortable. The care plan interventions included to work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the consolidated physician's orders dated August 22, 2024, indicated Resident #15 was ordered on 12/29/2022 to admit to hospice care with the diagnosis of hypertensive heart disease. Record review of the comprehensive care plan revised on 12/29/2022 indicated Resident #15 had a terminal prognosis of hypertensive heart disease. The goal of the care plan was Resident #15 would be comfortable. The care plan interventions included to work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. Record review of the Annual MDS dated [DATE] indicated Resident #15 was understood and understands others. The MDS indicated Resident #15's BIMS score was a 6 indicating severe cognitive impairment. Section O- Special Treatment, Procedures, and Programs indicted Resident #15 received hospice services while a resident of the facility. During an observation on 8/19/2024 at 8:52 a.m., Resident #15 was lying on her bed, awake, and oriented to herself only. During an observation and interview on 8/19/2024 at 1:40 p.m., RN A said Resident #15 had hospice services. RN A said Resident #15's nurse visited twice weekly, and the hospice aide 3 times weekly, and was unsure of the social worker or chaplain. RN A reviewed in the miscellaneous section of the EMR and indicated the last upload hospice records was delivered on 6/25/2024 and included the signed recertification of Terminal Illness for the benefit period of 5/24/2024 - 6/23/2024. The contents of this delivery included a demographics page, a medication regimen, nurse notes dated 5/24/2024, 5/28/2024, 5/29/2024, 6/04/2024, 6/06/2024, 6/11/2024, 6/13/2024, 6/17/2024, 6/20/2024, a medical social worker hospice visit note dated 5/29/2024 and 6/11/2024, a chaplain note dated 6/04/2024 and 6/18/2024, nurse aide care plan reports dated 5/24/2024, and a missed visit note dated 5/31/2024, 6/03/2024, 6/06/2024, 6/10/2024, 6/13/2024, 6/17/2024. The hospice packet also included a Hospice Interdisciplinary Group Comprehensive Assessment and Plan of Care Update Report indicated the benefit period was 4/05/2024 - 6/03/2024 (the hospice certification was not current) and another Interdisciplinary Group Comprehensive Assessment and Plan of Care with the benefit period on 6/04/2024 - 8/02/2024. The Hospice Interdisciplinary Group Comprehensive Assessment indicated the nurse would have weekly assessments. Record review of a Facility Document Delivery form indicated on 7/25/2024 the hospice delivered Resident #15's signed recertification of Terminal illness for benefit period 6/24/2024 to 7/23/2024. The contents of this delivered package were a patient information sheet, medication record, and nurse visit notes dated 6/25/2024, 6/27/2024, 7/02/2024, 7/10/2024, 7/11/2024, 7/18/2024, 7/19/2024, and 7/22/2024. The packet included a Medical Social Worker Hospice Visit note dated 6/26/2024 and 7/15/2024. The packet included two chaplain visits dated for 7/01/2024 and 7/18/2024. The packet included nurse aide visit reports for 6/28/2024, 7/01/2024, 7/05/2024, 7/12/2024, 7/15/2024, and 7/18/2024. The packet had a missed visit notification for the nurse on 7/05/2024 and an aide missed visit on 7/08/2024. The packet included the Hospice IDG (Interdisciplinary Group) comprehensive Assessment and Plan of Care update Report with the benefit dates of 6/04/2024 - 8/02/2024. The IDG report indicated the skilled nurse would visit 1 time weekly and prn, the chaplain would visit 2 times monthly, the aide visit plan was not documented. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/20/2024 at 11:30 a.m., Medical Records said she had not requested the medical records from Resident #15's hospice provider. The Medical Records staff member said she had found in the medical records department a packet delivered on 7/25/2024 and had uploaded this in the EMR. The Medical Records said the hospice provider delivers a month at a time of hospice records. The Medical Records staff member said she would have to call the hospice and request records after 7/25/2024. During an interview on 8/21/2024 at 3:55 p.m., the Hospice Nurse said the hospice office staff send the residents medical records over electronically per the facility's request. The Hospice Nurses said sending the hospice visit notes and certifications timely would ensure the staff would be knowledgeable of any changes and updates. The Hospice Nurse said she visits all the hospice residents 2 times weekly, the nurse aide was scheduled two times weekly, and the chaplain and social worker were once monthly. The hospice nurse said the risk to the resident was the facility staff would not be updated on the current hospice plan of care. During an interview on 8/21/2024 at 4:14 p.m., the Hospice Administrator said the hospice sent the resident medical records to the facility monthly unless the facility requests something different. The Hospice Administrator said with the hospice plan of care not being current she could see how the facility nursing staff would not be aware of the current plan of care. During an interview on 08/22/2024 at 5:53 PM, the DON said medical records wereas responsible for uploading the hospice records into the residents' electronic health record. The DON said she was not aware the residents' hospice records were not up to date. The DON said it was important for the hospice records to be up to date to ensure they had the most recent plan of care, and they were doing what they needed to do. During an interview on 08/22/2024 at 6:18 PM, the Administrator said she expected for the hospice records to be current in the residents' electronic health record. The Administrator said the hospice usually scanned them to the facility towards the end of the month. The Administrator said they received the hospice records monthly. The Administrator said she expected for the nurses to know they had the hospice records available to them, and LVN K probably did not know because she was new. The Administrator said the DON and the ADONs checked the hospice records to ensure they were kept up to date. Record review of the Hospice Services policy dated 2/13/2007 indicated as an end-of-life measure, the resident or responsible family member may choose to use hospice services within the facility. Goals: 1. The resident and/or responsible party will verbalize wishes for end-of-life measures. 2. The resident and/or responsible party will receive comfort care. 3. The family will verbalize feelings about end-of-life measures Procedures .11. The DON or designee will be responsible for ensuring that documentation is a part of the current clinical record Hospice Plan of Care. 12. The nursing facility and hospice provider must ensure that a coordinated plan of care reflects the participation of the hospice, nursing facility, the recipient, and legal representative to the extent possible. 13. The plan of care must include directives for managing pain and other uncomfortable symptoms. The plan must be revised and updated as necessary to reflect the resident's current status. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Amendment to Nursing Facility Hospice Services Agreement effective July 26, 2019, indicated, .Review and Revision of Plan of Care. The IDT, in consultation with Nursing Facility representatives and the Nursing Facility Attending Physician, shall review and revise the individualized Plan of Care as frequently as the Resident Patient's condition requires, but no less frequently than every fifteen (15) calendar days .2.7 Patient Care Information Provided. Hospice shall provide the Nursing Facility Designee with the following: (a) A copy of the most recent Plan of Care specific to each Resident Patient; (b) A copy of the Hospice election form and any advance directives specific to each Resident Patient; (c) A copy of the physician certification and recertification of the terminal illness specific to each Resident Patient; (d) Names and contact information for Hospice personnel involved in the hospice care of each Resident Patient; (e) Instructions on how to access the Hospice's twenty-four (24) hour on-call system; (f) A copy of Hospice medication information specific to each Resident Patient; and (g) A copy of Hospice physician and Attending Physician (if any) orders specific 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** 43047 Based on observations, interviews, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 24 residents (Resident #40) and 2 of 2 staff (CNA NN and CNA YY) reviewed for infection control practices and transmission-based precautions. 1. The facility did not ensure Resident #40 was provided proper incontinent care. 2. The facility did not ensure EBP were put in place for Resident #40 These failures could place residents at increased risk for serious complications from a communicable disease that could diminish the resident's quality of life. Findings included: Record review of Resident #40's face sheet, dated 08/21/2024, originally admitted to the facility on [DATE] with diagnoses which included dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of the order summary report dated 08/21/2024 indicated Macrobid 100 mg give 1 capsule by mouth two times a day for UTI for 10 days with a start date 08/18/2024. Record review of the quarterly MDS assessment, dated 08/06/2024, indicated Resident #40 made herself understood and usually understood others. Resident #40's BIMS score was 0, which indicated her cognition was severely impaired. Resident #40 was always incontinent of urine and bowel. Resident #40 required substantial/maximal assistance with toileting and partial/moderate assistance with personal hygiene. Record review of the comprehensive care plan, revised on 08/20/2024, indicated Resident #40 had a urinary tract infection. The interventions included: encourage adequate fluid intake, and give antibiotic therapy as ordered. Record review of the urine culture dated 08/12/2024 indicated Resident #40 was positive for a UTI with the organism Klebsiella pneumoniae (urinary tract bacteria). During an observation on 08/19/2024 at 10:16 a.m., revealed Resident #40 had no enhanced barrier precautions in place outside of her room. During an observation on 08/19/2024 at 3:10 p.m., revealed Resident #40 had no enhanced barrier precautions in place outside of her room. During an observation on 08/20/2024 at 07:30 a.m., revealed Resident #40 had no enhanced barrier precautions in place outside of her room. (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 08/19/2024 at 3:15 p.m., CNA NN provided incontinent care to Resident #40 without donning any PPE. CNA NN did not provide hand hygiene or apply hand sanitizer prior to donning (put on) gloves. CNA NN donned gloves and wiped Resident #40 peri area once without separating the inner labia (peri area). CNA NN continued providing incontinent care. CNA NN stated she should have performed hand hygiene before donning her gloves. CNA NN stated she should have wiped Resident #40's peri area once and got another wipe and wiped her again. CNA NN stated, I get nervous when someone watches me. CNA NN stated this failure put Resident #40 at risk for a UTI. When asked if PPE should be worn while providing care, CNA NN stated, no ma'am. During an observation on 08/20/2024 at 9:45 a.m., CNA YY was getting Resident #40 out of the bed to give her a shower without donning any PPE. During an interview on 08/21/2024 at 2:17 p.m. CNA YY stated she had performed incontinent care and given Resident #40 a shower. CNA YY stated she was not aware gown and gloves should be worn while providing care to Resident #40. CNA YY stated she was not informed that PPE should be worn. CNA YY this failure put residents at risk for spread of infection. During an interview on 08/22/2024 at 2:58 p.m., ADON Y stated she was the Infection Control Preventionist for the facility. ADON Y stated she expected CNAs to perform hand hygiene prior to donning gloves. ADON Y stated she expected her to open her peri area and wiped front to back with a clean wipe each time until clear of soilage. ADON Y stated she monitored by monthly in-services, performance of skill check offs, and random checks while performing incontinent care on a resident. ADON Y stated she never had an issue with CNA NN providing incontinent care in the past. ADON Y stated this failure put Resident #40 at risk for a UTI. ADON Y stated Resident #40 should have had EBP in place when her labs showed positive for MDROs. ADON Y stated she was responsible for ensuring infection control measures were put in place for all residents. ADON Y stated she reviewed the lab results every morning to determine if they need to be on EBP precautions. ADON Y stated, I overlook the page that contained the MDROs positives. ADON Y stated this failure could place the residents at risk for an infection. During an interview on 08/22/2024 at 6:26 p.m., the Administrator stated she expected staff to perform hand hygiene prior to donning gloves to prevent the spread of germs. The Administrator stated she expected staff to clean the peri area correctly. The Administrator stated ADON Y was responsible for monitoring and overseeing infection control practices. Record review of a CNA Proficiency Audit dated 4/11/2024 indicated CNA NN was assessed in the area of hand washing, perineal care; female, and infection control awareness scoring a satisfactory in skill level. Record review of the facility's policy titled, Perineal Care Female, revised 12/08/2009 indicated, .H. Wash hands and put on clean gloves for perineal care .Ib. separate inner labia (peri area) and using a different surface, wash down the center and over the urethral area, wiping downward from front toward back . c. continue to wash the rest of the perineal area Change the wash cloth or pre-moistened cleaning wipe surface or use a new washcloth or pre-moistened cleaning wipe with each wipe . (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's policy titled, Enhanced Barrier Precautions, effective 04/01/2024 indicated, . EBP is used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing .