STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675802	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kemp Care Center	1351 South Elm Street Kemp, TX 75143

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. (continued on next page)

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

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility failed to consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life and failed to demonstrate their response and rationale for such response for 3 of 3 confidential resident council meetings reviewed (04/18/25, 05/13/25, and 06/10/25) for grievances. The facility failed to ensure there was documentation of the facility's efforts to resolve concerns collected at the resident council meetings on 04/18/25, 05/13/25, and 06/10/25. This failure could place residents at risk of not having their concerns and grievances followed through, and a diminished quality of life. Findings included: Record review of the Resident Advisory Council Minutes for 04/18/25 indicated the call lights were not being answered timely and were worse over the weekend, the residents were not receiving scheduled showers, and they had no towels for bathing, and the residents' beds were not being made timely, and they did not have clean sheets. Record review of the Resident Advisory Council Minutes for 05/13/25 indicated the call lights were not being answered timely, the residents were not always receiving scheduled showers, and the residents' beds were not being made timely. Record review of the Resident Advisory Council Minutes for 06/10/25 indicated the call lights were not being answered timely, the residents were not always receiving scheduled showers, and the residents' beds were not being made timely. Record review of the grievances from April 2025 to June 2025 revealed they did not indicate grievances to address the resident councils' concerns. During a confidential group interview with 9 residents on 06/30/25 starting at 10:08 a.m., the resident group said the facility was shorthanded, people were not getting showers, people's beds were not being made on shower days, people were not getting changed promptly, and call lights were not answered timely. The resident group said that every meeting, they discussed the call lights not being answered timely. The resident group said they had invited some of the department heads, including the DON, to the meetings, and they were aware of the call lights not being answered in a timely manner, showers not being given, and beds not being changed timely. The resident group said they were told they would look into it, or we would investigate it. The resident group said they did not get back with them on a resolution and had not given them an explanation as to why the call lights were not being answered timely as that was their greatest concern. During an interview on 07/01/25 at 5:39 p.m., the Activities Director said, after the resident council meeting, she made three copies of the results of the meeting with the residents' concerns and gave one to the DON, one to the Administrator, and one for the resident council meeting book. The Activities Director said every month, the residents complained about the call lights not being answered, and the Administrator and DON had been told about it. She said she was not aware of what to do about the resident concerns since it had been voiced so many times in the resident council meeting, so she invited the DON to the resident council meeting. She said the residents told the DON about the call lights, showers, and beds not being made in the resident council on 06/10/25. The Activities Director said the DON said she would handle it. The Activities Director said she did not know how to file a grievance. The Activities Director said it was important for the residents' concerns/complaints to be addressed so they felt safe and were taken care of. During an interview on 07/01/25 at 5:38 p.m., the Social Worker said he was responsible for the grievances. The Social Worker said he received the minutes from the resident council, but never really looked at them as far as a grievance. He said he was not aware he needed to fill out the grievance forms from the resident council minutes. He said the Activity Director was supposed to fill out the grievance form and give it to him, and then he would put it into their computer software system. He said they would discuss any grievance in the morning meeting, come up with a resolution (by talking to the resident or investigating the situation), and mark the grievance as completed. The Social Worker said it was important for grievances to be filed so they could be documented and to ensure they were managed appropriately, so it would not happen again. During an interview on 07/02/25 at 10:50 a.m., NA P said the residents complained about their call lights not being answered promptly or not receiving their assigned showers. She said they had a challenging time answering lights and giving showers due to the staffing shortage. She said management was aware of the call lights and showers concerns. During an interview on 07/02/25 at 3:20 p.m., the DON said the Social Worker was responsible for the grievances. She said the Activity Director had given her the resident council minutes, but she had not read thoroughly through them. She said she had been invited to the resident council meeting this month (June 2025) but did not remember anything specific from the meeting about call lights, showers, or beds not being made. She said she had never filled out a grievance form since starting as the DON. She

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken for 1 of 7 residents (Resident #1) reviewed for abuse and neglect. The facility failed to ensure the provider investigation report was turned into the state survey agency (HHSC) within 5 working days of the reported incident for Resident #1 This failure could place residents at risk for abuse and neglect. Findings Included: Record review of Resident #1's face sheet, dated 06/30/25, indicated he was a [AGE] year-old male, initially admitted to the facility on [DATE] and most recently re-admitted on [DATE]. His diagnoses included heart failure (a condition where the heart can't pump enough blood to meet the body's needs), brief psychotic disorder (mental health condition characterized by the sudden onset of psychotic symptoms, such as delusions, hallucinations, or disorganized speech, that last for at least one day but less than one month, with a full return to the person's previous level of functioning), and major depressive disorder (a serious mental illness characterized by persistent sadness, loss of interest in activities, and other symptoms that significantly interfere with daily life). Record review of Resident #1's quarterly MDS assessment, dated 04/09/25, indicated he had a BIMS score of 15, which indicated intact cognition. Record review of the facility's provider investigation report for the reported incident for Resident #1, dated 03/15/25, indicated Resident #1 reported that the PASRR representative that took Resident #1 to the store had placed an item on the check out belt and Resident #1 paid for it. The facility notified the local health authority that the representative that he would no longer be allowed in the facility. There were no witnesses to the incident. Ultimately the facility's investigation concluded that the allegation was unconfirmed. The allegation was reported to the state survey agency on 03/11/25. Record review of the TULIP website, accessed on 07/02/25 at 7:58AM, indicated on the page for intake #570206 that a 5-day report or provider investigation report had not been turned into the state survey agency. During an interview on 06/30/25 at 3:00PM, the Area Director of Operations for the facility said they were unable to reach the previous administrator that was responsible for turning in the 5-day report for this intake. She said they were unable to provide proof that the provider investigation report was turned into the state survey agency. On 07/01/25 at 4:25PM, the surveyor attempted to call the phone number that was provided by the facility for the previous administrator. The number was disconnected and no longer in service. Record review of the facility's policy, Abuse/Neglect, last revised 05/09/17, stated: .F. Investigation.3. A report to the appropriate agency will include the following: .The written report must be sent to HHSC no later than the fifth working day after the initial report. The facility will use the designated state reporting form.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident status for 1 of 24 residents (Resident #1) reviewed for MDS assessment accuracy. The facility incorrectly coded Resident #1's discharge MDS assessment dated [DATE] as return not anticipated instead of return anticipated. This failure could place residents at risk for not receiving care and services to meet their needs. Findings included:Record review of Resident #1's face sheet, reflected Resident #1 was a [AGE] year-old male, readmitted to the facility on [DATE] with diagnoses which included chronic combined heart failure (the heart has a long-term problem with effectively pumping blood, affecting both its ability to contract and relax). Record review of Resident #1's discharge MDS assessment, dated 04/14/25, reflected discharge assessment-return not anticipated. Record review of an admission progress note dated 04/16/25 completed by RN A reflected Resident #1 was readmitted to the facility from the hospital. During an interview on 07/01/25 at 9:10 a.m., the MDS Coordinator stated she was responsible for Resident #1's discharge MDS assessment. The MDS Coordinator stated if a discharge assessment-return not anticipated was completed that reflected the resident was discharged home or to another facility. After reviewing Resident #1's electronic medical records, the MDS Coordinator stated a discharge assessment-return anticipated should have been completed because the return from the hospital on [DATE]. The MDS Coordinator stated a new admission assessment did not have to be done because the MD assessments schedule continued from Resident #1 last MDS assessment. The MDS Coordinator stated she should have modified the assessment to reflect return anticipated. The MDS Coordinator stated it was important to ensure the correct assessment was completed for accuracy. During a telephone interview on 07/0/25 at 9:59 a.m., the Regional Reimbursement Nurse stated the MDS Coordinator should have completed discharge assessment-return anticipated. The Regional Reimbursement Nurse stated the MDS Coordinator should have notified the support line to let them know that she did an incorrect assessment, and they would have reviewed it and gave her the ok to modify. The Regional Reimbursement Nurse stated a new admission assessment did not have to be completed because the resident was not out for more than 30 days. The Regional Reimbursement Nurse stated it was important to ensure the correct assessment was completed for continuity of care. During an interview on 07/02/25 at 2:14 p.m., the Administrator stated she expected the MDS Coordinator to complete the correct assessment when a resident return from a hospital. The Administrator stated it was important the correct assessment was completed to ensure when the resident returned, they would receive the proper plan of care. During an interview on 07/01/25 at 4:39 p.m., the Regional Compliance Nurse stated there was no policy and procedures regarding MDS assessment accuracy. The Regional Compliance Nurse stated the facility followed the RAI manual. Record review of the Resident Assessment Instrument 3.0 User's Manual, last revised October 2023, reflected. A1900: admission Date. A1900 (admission Date) . if the resident returns after a discharge return not anticipated or after a gap of more than 30 days outside of the facility, a new episode would begin, and a new admission would be required.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to coordinate assessments with the PASARR program to the maximum extent practicable to avoid duplicative testing and effort for 1 of 6 residents (Resident #32) reviewed for PASARR. The facility failed to ensure a Form 1012 Mental Illness/Dementia Resident Review was completed for Resident #32 after he was initially admitted to the facility on [DATE] to determine if he required further evaluation due to his mental illnesses. This failure could place residents at risk of not receiving specialized services which would enhance their highest level of functioning and could contribute to residents decline in physical, mental, and psychosocial well-being.Findings included: Record review of a face sheet dated 07/02/2025 indicated Resident #32 was initially 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), major depressive disorder recurrent (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks), and schizoaffective disorder (mood disorder that can include depression, delusions, hallucinations, disorganized thoughts, speech and behavior). Record review of Resident #32's Comprehensive MDS assessment dated [DATE] indicated he was not considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. The MDS assessment indicated Resident #32 was usually understood by others and usually understood others. The MDS assessment indicated Resident #32 had a BIMS score of 10, which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #32 had depression, anxiety disorder, and schizophrenia (for example schizoaffective and schizophreniform disorders). The MDS assessment indicated Resident #32 received antipsychotic, antianxiety, and antidepressant medications. Record review of Resident #32's PASRR Level 1 Screening date of screening 10/22/2024, indicated there was evidence that dementia was the primary diagnosis. The PASRR Level 1 Screening indicated there was no evidence or indicator that Resident #32 had a mental illness. Record review of Resident #32's Order Summary Report dated 07/02/2025 indicated he had the following orders: Depakote (medication used to stabilize mood) 250 mg give 1 tablet by mouth three times a day related to schizoaffective disorder with a start date of 10/24/2024. Fluoxetine (medication used to treat depression) 20 mg 1 capsule one time a day for depression with a start date of 10/24/2024. Fluoxetine 40 mg 1 capsule one time a day for depression with a start date of 10/24/2024. Risperidone (medication used to treat mood disorders) 1 mg give 1 tablet by mouth two times a day for anxiety related to schizoaffective disorder with a start date of 10/24/2024. Record review of Resident #32's care plan last reviewed 05/08/2025 indicated he required medications for depression and schizoaffective disorder to administer medications as ordered and monitor/record occurrence of target behavior symptoms. Record review of Resident #32's electronic health record on 07/02/2025 did not indicate a PASRR Evaluation or Form 1012 had been completed. During an interview on 07/02/2025 at 11:55 AM, the MDS Coordinator said she was responsible for the PASRR Level 1 screenings and coordinating PASRR services. The MDS Coordinator said when a resident had a primary diagnosis of dementia, they were unable to indicate on the PASRR Level 1 Screening that the resident had mental illness. The MDS Coordinator said if the resident had a primary diagnosis of dementia, like Resident #32 did, they did not qualify for PASRR services. During an interview on 07/02/2025 at 12:02 PM, the PASRR Manager said if a resident had a primary diagnosis of dementia, they were unable to put yes on the mental illness option on the PASRR Level 1 Screening. The PASRR Manager said because they could not put yes on the mental illness option on the PASRR Level 1 Screening, the facility should complete a Form 1012. The PASRR Manager said the Form 1012 was the facility's justification to show that the resident had a primary diagnosis of dementia. During an interview on 07/02/2025 at 12:12 PM, the MDS Coordinator said she did not know what Form 1012 was that she had not been provided information regarding it. The MDS Coordinator said it was important to ensure the PASRR process was completed properly so the residents who qualified for services received what they needed. During an interview on 07/02/2025 at 2:14 PM, the Regional Reimbursement Nurse said the MDS Coordinator was responsible for PASRR in the facility. The Regional Reimbursement Nurse said she monitored the MDS Coordinator by reviewing the residents' diagnoses and psychiatric notes for new admissions to ensure the PASRR process was being followed. The Regional Reimbursement Nurse said on the PASRR Level 1 Screening when they indicated the resident had a primary diagnosis of dementia, they

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs, for 1 of 4 (Resident #44) residents reviewed. The facility failed to care plan Resident #44's oxygen (which is vital for the human body as it is used by cells to produce energy) therapy. This failure could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. The findings included: Record review of Resident #44's face sheet, dated 07/02/25, revealed an [AGE] year-old female who was re-admitted to the facility on [DATE] with diagnoses to include other nonspecific abnormal finding of lung field (when an abnormality is detected on diagnostic imaging of the lung, but the specific cause or nature of the abnormality is not yet determined), Neuromuscular dysfunction of the bladder(occur when the nerves controlling the bladder are damaged or don't function properly, leading to issues with storage and/or emptying of urine), stroke and diabetes (high blood sugars). Record review of Resident #44's quarterly MDS assessment, dated 04/22/25, indicated Resident #44 usually understood others and was usually understood by others. Resident #44's BIMS score was 08, which indicated her cognition was moderately impaired. The MDS indicated Resident #44 used oxygen. Record review of Resident #44's care plan, revised date of 04/22/25, did not indicate she had an oxygen care plan. Record review of Resident #44 ‘s physician orders dated 01/06/24 indicated to use oxygen at 2-3 liters per minute via nasal canula every shift for hypoxia (lack of oxygen). During an observation on 06/29/25 at 1:00 p.m., Resident #44 had an oxygen sign outside her door. Resident #44 had oxygen in her room, but it was not on. During an observation and attempted interview on 06/30/25 at 8:33 a.m., Resident #44 was in her bed without any oxygen on. Resident #44 did not answer when asked if she wore oxygen. During an observation and interview on 07/02/25 at 9:33 a.m., the MDS Coordinator looked at Resident 44's care plan and said she did not see the care plan for her oxygen. The MDS Coordinator said she and the IDT worked together to do the care plans, but she was responsible for ensuring the care plans were done. She said it was important to care plan the residents' care so they would receive quality care. During an interview on 07/02/25 at 3:20 p.m., the DON said the MDS Coordinator was responsible for completing the care plans. She said each IDT member was responsible for the acute care plans (IE, the treatment nurse updated wounds, dietary manager updated nutrition, etc.). The DON said she was unaware that Resident #44's oxygen-use was not care planned. She said if Resident #44 had a routine order for oxygen, then she should be wearing her oxygen, and it should be care planned. She said the care plan was generated to guide staff and others in the care the resident should receive. During an interview on 07/02/25 at 3:48 p.m., the Administrator said all disciplines should work together to complete a resident's care plan, but the MDS Coordinator was the overseer. She said care plans were generated to provide each resident with proper care based on their needs and diagnosis. Record review of the facility's policy titled, Comprehensive Care planning, dated 03/2018, indicated Policy Statement: the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's right that includes measurable objective and time frame to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following: the services that are to be furnished to obtain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and the right to refuse treatment. Each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her needs, other purposes, and goals, which will address the resident's medical, physical, mental, and psychosocial needs. A comprehensive care plan will be developed within seven days after completion of the comprehensive assessment. The facility will ensure that services are provided, arranged, or delivered by individuals who have the skills, experience, and knowledge to do a particular task or activity. Residents' preferences and goals may change throughout their stay, so the facility should have ongoing discussions to ensure that changes are reflected in the comprehensive care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming, and personal and oral hygiene were provided for 3 of 24 residents (Resident #53, Resident #40 and Resident #29) reviewed for ADL care. 1. The facility failed to ensure Resident #53 was showered or offered a shower as scheduled for June 2025. 2. The facility did not ensure Resident #40 received her shower as scheduled for June 2025. 3. The facility failed to provide Resident #29's showers as scheduled for June 2025. These failures could place residents at risk of not receiving care/services, decreased quality of life, and loss of dignity. Findings included: 1. Record review of Resident #53's face sheet, dated 01/29/25, indicated a [AGE] year-old female who was re-admitted to the facility on [DATE] with diagnoses which included Atrial fibrillation, also known as AFib (a heart condition characterized by an irregular and often rapid heartbeat), Dementia (a general term for the loss of thinking, remembering, and reasoning abilities), and Gastroesophageal Reflux Disease, also known as GERD (is a digestive disorder where stomach acid flows back into the esophagus, causing symptoms like heartburn and regurgitation). Record review of Resident #53's quarterly MDS assessment, dated 05/01/25, indicated Resident #53 understood others and was understood by others. Her BIMS score was a 12, which indicated her cognition was moderately impaired. The MDS indicated she required limited assistance for bathing, bed mobility, dressing, and transferring. Record review of the care plan dated 07/24/24 indicated Resident #53 had an ADL self-care performance deficit requiring assistance with bathing. Resident #53 also refused showers at times, revised 06/11/25. The interventions were for staff to assist with bathing, negotiate a time for ADLs, so that the resident participates in the decision-making process. Return at the agreed-upon time, and if the resident resists with ADLs, reassure and return 5-10 minutes later, and try again. Record review of Resident #53’s Documentation Survey Report dated 06/01/25-06/30/25, indicated Resident #53 was to be bathed on the 10 am-6 pm shift, but it did not indicate what days. It appears the days marked for Resident #53 showers were on Monday, Wednesday, and Friday. It showed Resident #53 was bathed on 06/09/25 and 06/11/25 and refused a shower on 06/06/25, 06/16/25, and 06/25/25. During an interview on 07/02/25 at 10:24 p.m., Resident #53 said she was not getting her showers 3 times a week. She said she was lucky to get a shower 1 time a week. She said when she did get a shower, she had to ask several times before she received it. She said she did receive her shower yesterday (07/01/25) after asking several times. During an interview on 07/02/25 at 10:50 a.m., MA O said Resident #53 received her shower late yesterday (07/01/25). She said Resident #53 had to ask the aides several times before they gave it to her. She said she thought Resident #53 was to receive night showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/25/25 at 11:00 a.m., NA P said residents did complain about not receiving their baths. She said they were not always able to give the residents showers because of time and all the duties they had to complete. She said she reported to the oncoming shift if a shower was not given. She said they were mostly behind on giving showers because the night aides were not giving their showers. She said she reported to the ADONs and the DON (unknown times) about them not being able to complete their showers, but nothing had changed. 2. Record review of Resident #40’s face sheet, dated 07/01/25, reflected Resident #40 was a [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypercapnia (abnormal high levels of carbon dioxide in the blood). Record review of Resident #40’s quarterly MDS, dated [DATE], reflected Resident #40 made herself understood, and understood others. Resident #40’s BIMS score was 15, which reflected her cognition was intact. Resident #40 required partial/moderate assistance with showering and supervision or touching assistance with toileting, upper/lower body dressing, and putting on/taking off footwear. Resident #20 did not have behaviors or refused care. Record review of Resident #40’s comprehensive care plan revised 02/08/24, reflected Resident #40 had an ADL self-care performance deficit. The care plan interventions included assist with personal hygiene as required: hair, shaving, oral care as needed, and bathing required staff x1 for assistance. Record review of Resident #40’s documentation survey report for the month of June 2025, reflected Resident #40 was scheduled to receive a shower/bed bath on Monday, Wednesday, and Friday between 6:00 AM-2:00 PM. The report reflected Resident #40 did not received a shower/bed bath on 06/02/25, 06/23/25, 06/27/25 and 06/30/25. During an interview on 06/29/25 at 1:26 p.m., Resident #40 was in her bed. Resident #40 stated she had only been receiving her shower once a week and would like to receive them at least 3 times a week. Resident #40 stated, “I feel nasty and dirty” when she did not receive a shower regularly. 3. Record review of Resident #29’s face sheet dated 07/02/2025 indicated he was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included Parkinson’s disease with dyskinesia (progressive disorder that affects the nervous system and the parts of the body controlled by the nerves causes unintended or uncontrollable movements with involuntary muscle movements) and atherosclerotic heart disease of native coronary artery without angina pectoris (buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow without chest pain). Record review of Resident #29’s Comprehensive MDS assessment dated [DATE] indicated he was understood by others and understood others. The MDS assessment indicated Resident #29 had a BIMS score of 9, which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #29 required substantial/maximal assistance with showering/bathing and lower body dressing, and partial/moderate assistance with toileting hygiene, upper body dressing, and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #29’s care plan last reviewed 04/14/2025 indicated he had an ADL self-care performance deficit to assist him with personal hygiene as required, and he required the assistance of one staff member for bathing. Record review of Resident #29’s Documentation Survey Report for June 2025 indicated he received one bath in the month of June 2025 on 06/17/2025. Record review of Resident #29’s shower sheets for the month of June 2025 indicated he was scheduled to receive showers Tuesday, Thursday, and Friday from 2 PM to 10 PM. The shower sheets indicated he received a shower on 06/22/2025. During an observation and interview on 06/29/2025 at 2:18 PM, Resident #29 said he was not receiving his showers like he wanted. Resident #29 said, “They may give me one on Monday and the next one is Thursday.” Resident #29 said he thought his last shower was Thursday (06/26/2025) or Friday (06/27/2025), but he had no idea of the time, so he was not sure. Resident #29 said he told the staff he needed a bath, and they told him they would get to it, but they did not. Resident #29 said it was normal for them to tell him that. Resident #29 was wearing a white t-shirt with multiple brown stains down the front of it. During an observation and interview on 06/30/2025 at 3:56 PM, Resident #29 had a white t-shirt with multiple brown stains down the front of it. Resident #29 said he thought they had put on a clean shirt on him last night, but he was not sure. Resident #29 said he had not received a shower yet. During an interview on 06/30/2025 at 10:34 PM, LVN E said she worked the night shift from 6 PM-6 AM. LVN E said she thought all the showers were completed prior to the start of her shift since there were more staff available. LVN E said she had not observed any showers being given on her shift. During an interview on 07/01/2025 at 2:23 PM, CNA D said the CNAs turned in the shower sheets to her and she placed them in a file, and then put them in the ADONs’ office. CNA D said the showers were completed on the 6 AM-6 PM shift that there were no showers completed on the 6 PM-6 AM shift. CNA D said she had told the ADONs and the DON that the residents had been missing showers because they were unable to complete all the showers. CNA D said if they were unable to complete a shower/bath during the day shift they left a note for the night shift for them to complete it. CNA D said the residents complained to her that they were not receiving their showers as scheduled. CNA D said if the residents did not receive their showers, it could affect their dignity, and the residents needed to be cleaned. During an interview on 07/01/2025 at 2:49 PM, CNA F said they had missed showers a few times. CNA F said she did not give Resident #29’s showers because he was scheduled to receive his shower on the night shift. CNA F said if the residents did not receive their showers, they could feel neglected and dirty. During an interview on 07/01/2025 at 3:11 PM, ADON H said she had only been the ADON for about a week. ADON H said the staff had not reported to her that they were not able to give all the showers as scheduled. ADON H said the CNAs were supposed to complete shower sheets. ADON H said if the residents did not receive their showers as scheduled, they could have skin breakdown, get infections and odor. ADON H said the residents needed their showers so they could have a general feeling of well-being. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/01/2025 at 3:15 PM, ADON B said she had been the ADON for about a month. ADON B said the staff had not reported to her they were not able to complete all the showers. ADON B said CNA D collected the shower sheets, and the nurses were supposed to review the shower sheets to ensure the residents wee receiving their baths. ADON B said if the residents did not receive their showers, it could affect their skin and self-esteem. During an interview on 07/01/2025 at 3:41 PM, CNA C said she worked the 6 PM-6 AM shift. CNA C said she did not give showers on her shift because she did not have time. CNA C said when she started her shift they had to help with dinner and pick-up trays, then do her rounds, and by the time she finished her rounds it was too late. CNA C said as far as she knew there were showers scheduled but she did not have the time to get to them. CNA C said if the residents did not receive their showers it could result in odors and infections. During an interview on 07/01/2025 at 4:06 PM, LVN G said she worked the 6 PM-6 AM shift. LVN G said the night CNAs were supposed to be giving showers, but by the time they finished dinner and got all the patients changed it was too late to give showers. LVN G said one CNA and two nurses for the building was not enough to provide care for the residents. LVN G said they were supposed to have 3 CNAs at night, but they had a lot of people call in. LVN G said she had talked to CNA D, who scheduled the showers, and told her the CNAs were not able to complete the showers at night. LVN G said the ADONs and DON were aware the residents were not receiving their showers as scheduled. LVN G said she had not been able to find a way to fix the missed showers. LVN G said the residents not getting their baths was neglect. During an interview on 07/02/2025 at 3:05 PM, the DON said the showers were documented on the bathing sheets and the electronic health record. The DON said the CNAs were supposed to turn in the shower sheets to the ADONs for them to review. The DON said the staff had not reported to her that they were unable to complete the showers as scheduled. The DON said if the residents did not receive their showers, it could affect the residents’ personal hygiene. The DON said it was important for the residents to receive their showers to keep them from being sent out to the hospital and to the doctor. During an interview on 07/02/2025 at 3:27 PM, the Administrator said the residents should be placed on the shower schedule, and they should be getting their showers as scheduled. The Administrator said if the resident requested, they could also have a shower in between their scheduled days. The Administrator said nursing was responsible for ensuring the showers were completed. The Administrator said the residents not receiving their showers as scheduled could affect their hygiene. Record review of the facility’s undated policy titled, “Bath, Tub/Shower”, from the Nursing Policy & Procedure manual indicated, “Bathing by tub bath or shower is done to remove soil, dead epithelial cells, microorganisms from the skin, and body odor to promote comfort, cleanliness, circulation, and relaxation…The frequency and type of bathing depends on resident preference, skin condition, tolerance and energy level…The resident will receive assistance with bathing according to their resident centered plan of care…”.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 (Resident #51) of 1 resident reviewed for enteral nutrition. The facility failed to follow physician orders for Resident #51's enteral feeding tube to be administered at 53 ml/hr. This failure could place residents who had gastrostomy tube at risk for fluid overload.Findings included: Record review of Resident #51's face sheet, dated 07/01/25, reflected Resident #51 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included severe protein-calorie malnutrition. Record review of Resident #51's quarterly MDS assessment, dated 04/15/25, reflected Resident #51 made herself understood, and usually understood others. Resident #51's BIMS score was 13, which reflected her cognition was intact. Resident #51 had a feeding tube that she received 51% total calories through the feeding tube. Record review of Resident #51's comprehensive care plan revised on 12/31/24 reflected Resident #51 required a feeding tube for nutrition. The care plan interventions included: check for tube placement and gastric contents/residual volume per facility protocol and record. Record review of Resident #51's physician order summary report, dated 07/01/25 reflected an active physician order for enteral feeding at bedtime start continuous: Isosource 1.5 calorie (formula): rate 53 ml/hr with a start date 02/06/25. Record review of a progress note dated 06/30/25 completed by LVN K reflected Resident #51 had significant residual (something that remains or was left behind after a process, treatment, or event has occurred) noted. Nurse Practitioner notified, new order hold feeding for 2 hrs. and recheck residual. During an observation on 06/29/25 at 1:42 p.m., Resident #51 was lying in bed. The feeding tube machine reflected, Isosource 1.5 calorie at a continuous rate of 55 ml/hr. During an observation and interview on 06/30/25 at 09:29 AM, LVN K checked Resident #51's room to administer her routine morning medications via her peg tube. LVN K stopped the feeding pump, checked for peg tube placement and residual. Resident #51 had 60 mL of residual. After LVN K administered Resident #51's medication she said she was not restarting the feeding because Resident #51 had quite a bit of residual and had to notify the physician. During an observation on 06/30/25 at 2:50 p.m., Resident #51 was lying in bed. The feeding tube machine reflected, Isosource 1.5 calorie at a continuous rate of 55 ml/hr. During an observation and interview on 06/30/25 at 2:52 p.m., after reviewing Resident #51's electronic medical records, LVN K stated Resident #51 tube feeding formula rate should be 53 ml/hr. LVN K observed the rate with the state surveyor at 55 ml/hr. LVN K stated the charge nurses were responsible for verifying each order, every shift, every time the resident's feeding was administered. LVN K stated receiving 55 ml/hr instead of 53 ml/hr of feeding formula would result in overload. During an interview on 07/02/25 at 10:09 a.m. , the DON stated she expected the nurses to follow the physician order. The DON stated her and the ADONs were responsible for monitoring accuracy by daily champion rounds and random checks throughout the day. The DON stated, It was missed. The DON stated it was important for the resident to receive the correct rate for their safety. During an interview on 07/02/25 at 2:14 p.m., the Administrator stated she expected the nurses to ensure the correct rate was set per the physician order. The Administrator stated the DON/ADONs were responsible for monitoring. The Administrator stated it was important for the resident to receive the correct rate to prevent overload. Record review of the undated facility's policy titled Enteral Nutrition reflected. We will provide nutritionally complete enteral or parenteral feedings as ordered by the physician for the nourishment of residents who are unable to eat by mouth. 1. The Nursing Services Department is responsible for all feeding equipment and the administration of tube feedings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 1 of 3 residents (Resident #48) reviewed for respiratory care. The facility failed to ensure Resident #48's CPAP (a device that keeps breathing airways open while sleeping) mask was stored properly. This failure 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 07/02/2025 indicated Resident #48 was an [AGE] year-old female initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed air flow in the lungs). Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #48 understood others and was understood by others. The MDS assessment indicated Resident #48 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #48 was dependent on staff for eating, oral hygiene, dressing, and required partial/moderate assistance with personal hygiene and eating. The MDS assessment did not address the use of a CPAP. Record review of Resident #48's Order Summary Report dated 07/02/2025 indicated she had an order for may use CPAP at bedtime with a start date of 05/29/2025. Record review of Resident #48's care plan last reviewed 05/28/2025 indicated she required the use of a CPAP, and she would use the device as ordered. During an observation and interview on 06/29/2025 at 12:44 PM, Resident #48's CPAP mask was on top of a bubble gum container that was on top of her nightstand, and it was not in a bag, it was exposed. Resident #48 said the staff usually kept it that way and did not store it in a bag. Resident #48 said the staff had to assist her with putting it on and taking it off because she was unable to do it on her own. Resident #48 said she could not reach her CPAP mask due to her limited mobility. During an interview on 07/02/2025 at 2:46 PM, ADON B said the CPAP masks should be placed in a bag when not in use. ADON B said she conducted rounds daily in the mornings to ensure they were stored properly. ADON B said the night nurses were responsible for ensuring the CPAP masks were stored in a bag. ADON B said it was important for the CPAP masks to be stored in a bag when not in use for them to be kept sanitary. During an interview on 07/02/2025 at 2:59 PM, the DON said the CPAP masks should be stored in a bag when not in use. The DON said ultimately, she was responsible for ensuring they were stored properly. The DON said they conducted champion rounds during the week and the RN supervisor on the weekend ensured the masks and cannulas were stored in a bag. The DON said the CPAP mask not being stored properly could result in it not being clean and could cause an infection. During an interview on 07/02/2025 at 3:24 PM, the Administrator said the CPAP masks should be stored in a bag when not in use. The Administrator said the nurses were responsible for ensuring this occurred. The Administrator said it was important for them to be stored in a bag for infections reasons and to keep them clean. During an interview on 07/02/2025 at 3:39 PM, RN A said the CPAP masks should be stored in a bag when not in use. RN A said she did not know why Resident #48's CPAP mask was not stored in a bag. RN A said she tried to check in the mornings when she went into the residents' rooms to ensure the CPAP masks and nasal cannulas were stored properly. RN A said it was important for the CPAP masks to be stored in a bag to protect them from dust and germs. Record review of the facility's policy titled, Oxygen Administration, revised March 21, 2023, did not address the storage of CPAP masks.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interviews, and record reviews, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 1 of 5 residents (Resident #6) reviewed for pharmacy services. The facility failed to ensure ADON H administered Resident #6's Magdelay (magnesium chloride, combination medication used as a supplement for minerals lacking in diet) as ordered on 06/30/25. This failure could place the residents at risk of not receiving the intended therapeutic benefits of prescribed medications. Findings included: Record review of Resident #6's face sheet dated 07/01/25, indicated a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses which included dementia (memory loss), essential hypertension (high blood pressure), muscle weakness, and osteoporosis (disease that weakens the bones and increases the risk of fractures). Record review of Resident #6's quarterly MDS assessment dated [DATE], indicated she was understood and understood others. Resident #6 had a BIMS score of 14, which indicated her cognition was intact. Record review of Resident #6's comprehensive care plan revised 01/16/24, indicated she had impaired cognitive function/dementia or impaired thought processes. The care plan interventions indicated to administer medications as ordered. Record review of Resident #6's order summary report dated 07/01/25, indicated she had an order for MagDelay 64mg give one tablet one time a day for supplement with an order started date of 06/01/25. During an observation on 06/30/25 at 08:45 AM, ADON H prepared Resident #6's routine morning medications. ADON H obtained one tablet of sloMg and placed it in the medicine cup. The bottle of sloMg indicated it contained the following ingredients: magnesium 143mg, calcium 238mg, and chloride 416mg. ADON H then administered Resident #6 her medications. Resident #6 took all medications including the sloMg tablet. Record review of Resident #6's medication administration record dated 06/01/25-06/30/25, indicated she had received one tablet of Magdelay 64mg on 06/30/25 in the morning and had been administered by ADON H. Record review of the website on 07/01/25, https://hargravesotc.com/products/magdelay-64-mg-delayed-release-60-tablets-by-major?variant=32392354562131, indicated the active ingredients for Magdelay included: calcium 212mg, magnesium 128mg, and chloride 375mg. During an interview on 07/01/25 at 2:32 PM, ADON H reviewed the bottle of sloMg she administered and said it was not the correct dosage, and she should have not administered the medication to Resident #6 until she had clarified the order with the physician. ADON H said she had given the medication because it had handwritten on the top of the bottle magnesium delay. She said she had only administered one tablet although the bottle had indicated a dose was 2 tablets because she assumed she had calculated the magnesium correctly and obviously she did not. She said she was responsible for ensuring the medications were being administered as ordered. ADON H said not administering the correct medication was a medication error and Resident #6 was at risk for receiving more than the prescribed dose which could cause cardiac related adverse reactions. During an interview on 07/01/25 at 3:16 PM, the DON said she expected medications to be administered as ordered. The DON said the nurse was responsible for clarifying the order with the physician. The DON said not giving the correct dose of medication was a medication error and the resident could have ill effects depending on their diagnoses. During an interview on 07/01/25 at 3:19 PM, the Administrator said she expected medications to be administered following the medication rights. She said ADON H should have had called the physician to get clarification if the medication could be administered. She said failure to administer medications as ordered could cause the resident not to get the therapeutic level of the ordered supplement. Record review of the facility's undated policy Medication Administration and General Guidelines indicated. Medications are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and only by persons legally authorized themselves with the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel for 1 of 24 residents (Resident #20) reviewed for medications at their bedside. The facility did not ensure Resident #20's Ayr Nasal Solution (nasal spray), and biotene dry mouth moisturizing spray were not left on his bedside table. This failure could place residents at risk for misuse of medication, overdose, drug diversions, adverse reactions of medications, and not receiving the therapeutic benefit of medications.Findings included: Record review of Resident #20's face sheet, dated 07/01/25, reflected Resident #20 was an [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included diastolic (congestive) heart failure (occurs when the heart's lower left chamber becomes stiff and cannot relax and fill with blood properly between beats). Record review of Resident #20's quarterly MDS, dated [DATE], reflected Resident #20 sometimes made himself understood and usually understood others. Resident #20's BIMS score was 14, which reflected his cognition was intact. Record review of Resident #20's comprehensive care plan revised on 11/11/24 reflected discharge from the facility was not feasible as evidenced by resident unable to safely self-medicate and required 24 hr. nursing care. The care plan interventions included respect resident's right to view nursing facility as his home. Record review of Resident #20's order summary report dated 06/01/25 reflected an active physician order for Ayr Nasal Solution: 2 sprays in both nostrils every 4 hours as needed for nasal irritation with a start date 06/29/25. Record review of Resident #20's order summary report dated 06/01/25 reflected an active physician order for biotene dry mouth moisturizing spray: 1 spray by mouth every 4 hours as needed for dry mouth with a start date 06/29/25. During an observation and attempted interview on 06/29/25 at 1:58 p.m., A bottle of Ayr Nasal Solution (nasal spray) and biotene dry mouth moisturizing Spray were observed on Resident#20's bedside table. Resident #20 had a communication problem related to unclear speech. During an observation and interview on 06/29/25 at 2:00 p.m., the DON was coming out of the room next door to Resident #20 when the state surveyor asked her if anyone on the hall was able to self-medicate. The DON stated there was no one in the building able to self-medicate. The state surveyor asked the DON if the nasal spray and the mouth moisturizing spray should be on Resident #20's bedside table. The DON removed the medication from the table and told Resident #20 the medication should be stored in the nurse's cart. During an interview on 06/29/25 at 2:03 p.m., ADON H stated Resident #20 had not been evaluated for self-administration of medications. ADON H stated if a resident was able to self-administer, he/she must be assessed for competence. ADON H stated once the resident was safe to self-medicate an order must be obtained. ADON H stated she did not see the medication on his bedside table when she went into his room. ADON H stated, he has so much stuff on that table. ADON H stated it was important to ensure medications were not left at bedside for resident safety. During an interview on 07/02/25 at 10:09 a.m., the DON stated she expected that if Resident #20 was able to self-administer that the resident be assessed, obtain an order for the resident to self-administer and store the medications on the nurse's cart. The DON stated all staff should be ensuring medications were not left at bedside. The DON stated she was responsible for monitoring medications at bedside by daily champion rounds. The DON stated she was not aware if a round was made that morning prior to surveyor intervention. The DON stated it was important to ensure medications were not left at bedside for resident safety. During an interview on 07/02/25 at 2:14 p.m., the Administrator stated medications should be locked/secured in the nurse's cart and administered by the nurse or MA. The Administrator stated the DON was responsible for monitoring and overseeing medication storage by daily rounds. The Administrator stated it was important to ensure medications were not left at bedside for resident safety. Record review of the undated facility's policy titled Medication Storage in the Facility reflected. 2. Medication rooms, carts, and medication supplies are locked or attended to by persons with authorized access.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675802	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kemp Care Center	1351 South Elm Street Kemp, TX 75143

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

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all residents were provided a nourishing, palatable, well-balanced diet that meets daily nutritional and special dietary needs for 1 of 2 residents (Resident #19) reviewed for dietary needs and preferences. The facility failed to ensure Resident #19 received small, frequent meals as recommended by her physician. This failure placed residents at risk for altered nutritional status and decreased quality of life. Findings included: Record review of Resident #19's face sheet dated 07/02/2025 indicated she was a [AGE] year-old female initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included type 2 diabetes mellitus with other circulatory complications (insulin resistance leading to high blood sugars resulting in complications with circulation), gastro-esophageal reflux disease without esophagitis (a long-term condition in which acid from the stomach comes up into the esophagus without inflammation of the esophagus), and irritable bowel syndrome (condition that affects the digestive system and can cause abdominal pain, cramping, bloating, gas, constipation, and diarrhea). Record review of Resident #19's Quarterly MDS assessment dated [DATE] indicated she understood others and was understood by others. The MDS assessment indicated Resident #19 had a BIMS score of 14, which indicated her cognition was intact. The MDS assessment indicated Resident #19 was independent for eating. The MDS assessment did not indicate Resident #19 required a therapeutic diet. Record review of Resident #19's Order Summary Report dated 07/01/2025 indicated she had an order for a regular diet with regular texture and consistency with a start date of 11/19/2024. Record review of Resident #19's care plan last reviewed 04/14/2025 indicated she had a potential nutritional problem related to diabetes mellitus to provide and serve diet as ordered. Record review of Resident #19's Physician's Orders in her After Visit Summary from the gastroenterology lab (specialized area where procedures and tests related to the digestive system are performed) dated 05/29/2025 indicated, gastroparesis (condition where the stomach empties its contents too slowly) with solid food in stomach likely diabetic gastroparesis (condition in people with diabetes that causes delayed emptying of the stomach). should be on small frequent meals 4-5 times daily. Record review of Resident #19's electronic health record indicated the last Dietary Profile completed was on 04/16/2025, and it did not address Resident #19's requirement of small frequent meals. The Dietary Profile was signed completed by the Dietary Manager on 04/16/2025. During an interview on 06/29/2025 at 2:30 PM, Resident #19 said she had diabetic gastroparesis and was told by the doctor she was supposed to have little meals. Resident #19 said she was supposed to eat every 2 hours, and the facility could not accommodate that for her. Resident #19 said she did the best she could to eat small meals by saving food from the meals she was served to eat throughout the day. Resident #19 said she talked to the kitchen manager, and they flat out say they cannot do it. Resident #19 said the kitchen manager told her everybody received the same diet. During an interview on 07/01/2025 at 4:47 PM, the Dietary Manager said if a resident required a special diet the nursing staff notified dietary, and they tried to accommodate the diet. The Dietary Manager said a diet order should be completed and given to the kitchen. The Dietary Manager said she tried to visit the residents monthly and completed dietary profiles to get the residents' dietary preferences. The Dietary Manager said she was not aware Resident #19 required small, frequent meals, and she was not provided a diet order. The Dietary Manager said she tried to visit with Resident #19 every couple of weeks, and Resident #19 had not informed her she wanted small, frequent meals. The Dietary Manager said it was important to accommodate the residents' dietary needs and preferences for their dignity and because they should have as much control as possible over their meals. During an interview on 07/02/2025 at 2:49 PM, ADON B said Resident #19 had gastroparesis, and was instructed to eat small meals. ADON B said when a resident went to the doctor the nurses should review the orders upon the residents return to the facility. ADON B said she thought she may have been the charge nurse the day Resident #19 returned with the order for the small meals, but she did not remember. ADON B said she did not complete a dietary communication sheet, and it should have been completed. ADON B said she did not put an order in because she guessed in her mind she did not because Resident #19 controlled her meals. ADON B said if the residents' dietary needs and preferences were not followed it could cause adverse reactions and have a bad outcome. During an interview on 07/02/2025 at 3:02 PM, the DON said the nurses were responsible for reviewing the physician's orders when the residents returned from a doctor's appointment. The DON said the ADONs and herself reviewed the orders after the

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide food that was palatable and served at an appetizing temperature for 5 of 24 residents (Residents #1, #10, #29, #48, and #53) and 1 of 1 lunch meal reviewed for palatability. The facility did not provide palatable food served at an appetizing temperature or taste to residents who complained the food was cold and not seasoned. This failure could place residents who ate food from the kitchen at risk of weight loss, altered nutritional status, and diminished quality of life. Findings include: Record review of Resident #53's grievance dated 05/08/25, indicated Resident #53 had stated .food was ‘always ice cold'. Record review of the Resident Council Minutes dated 06/10/25 indicated . hall food cold, coffee cold. During an interview on 06/29/25 at 12:36 PM, Resident #1 stated he ate in his room and the food was served lukewarm and needed to be seasoned more. During an interview on 06/29/2025 at 12:44 PM, Resident #48 said the food was cold. During an interview on 06/29/2025 at 1:25 PM, Resident #10 said the food was not good, most of the time it was not seasoned, the meat was too hard, and sometimes the food was cold. During an interview on 06/29/2025 at 2:28 PM, Resident #29 said sometimes the food was cold, but then sometimes the food was too hot to eat. During an observation and interview on 06/30/25 at 1:07 PM, a lunch tray was sampled by the Dietary Manager, the Area Director of Operations and 5 surveyors. The sample tray consisted of meatloaf, red potato wedges, brussels au gratin, roll, and strawberry banana cake. The meatloaf was not sampled as the meat had red tinged areas. The Area Director of Operations said she could see the redness in the meat. She said overall the meal was good. The surveyors observed the redness of the meat, and the potato wedges were lukewarm. During an interview on 07/01/25 at 2:54 PM, the Dietary Manager said there was nothing wrong with the test tray meal. She said the meat loaf was made from ground beef and ground beef was safe to eat at any color if the temperature was correct. She said the potatoes were fine as well and that the Area Director of Operations had agreed there was nothing wrong with the meal. She said she had not received any complaints of cold food. She said residents had even voiced to her that they were happy she was in the kitchen because the food was tasting so much better. During an interview on 07/01/25 at 3:19 PM, the Administrator said if the residents did not like what was being served then they would most likely not eat. She said an alternate meal would have been offered. She said she had received one food complaint that she was aware of for cold food. During an interview on 07/01/25 at 3:25 PM, the Area Director of Operations said she thought the test tray was okay and was aware of the concerns of the surveyors regarding the red meat. She said the ground meat could be served if the temperature was correct, and it had been because the temperature was 197 degrees Fahrenheit. She said there were no concerns from the residents regarding the meal. She said she had not received any food complaints when she had visited the facility. The Area Director of Operations said she visited the facility twice a month and obtained a test tray each time with no issues noted with the meals. Record review of the facility's policy Menu Approval and Honoring Resident Special Requests, and Food Brought to the Facility from Unapproved Sources dated 2012, indicated . 4. Every attempt will be made to honor resident food preferences. The policy did not address the facility providing food that was palatable, attractive, and at a safe and appetizing temperature.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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. The ham was discarded after the use by date of 06/26/25.2. The potatoes were labeled and dated. These failures could place residents at risk for foodborne illness.Findings included: During the initial tour observation of the kitchen on 06/29/25 beginning at 11:20 AM, the following was revealed in the fridge: Ham had a use by date of 06/26/25. Potatoes were found in a container with no label or date. During an interview on 07/01/25 at 2:54 PM, the Dietary Manager said the ham was unfortunately 1 day out of date. She said the potatoes had just been pulled from the freezer, were labeled, and dated but the label had gotten soggy from the ice. She said a new label should have been placed. The Dietary Manager said the ham should have been pulled on the day it expired and thrown away. She said the fridges were checked daily for expired food and she was unsure how it was missed. The Dietary Manager said the cooks and herself were responsible for ensuring the food was labeled correctly, and expired food was removed. She said failure to remove the expired food items could cause the residents to get sick. During an interview on 07/01/25 at 2:58 PM, Dietary [NAME] M said he checked the fridges daily for expired food. He said the potatoes should have been labeled and dated when they were prepared, and the ham should have been removed the day it expired. Dietary [NAME] M said failure to remove the expired food or not labeling/dating correctly could place a resident at risk for receiving expired food and cause them to get sick. He said the kitchen staff was responsible for ensuring the food was labeled/dated correctly and expired food was removed. During an interview on 07/01/25 at 3:19 PM, the Administrator said she expected all food items to be labeled and dated accordingly and discarded upon the expiration date. The Administrator said the Dietary Manager was responsible for overseeing it was being completed. She said depending on the food itself expired food could case GI discomfort and upset for the residents if used. Record review of the facility's policy Food Storage and Supplies dated 2012 indicated. All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. 4. Open packages of food are stored in closed containers with covers or in sealed bags and dated as to when opened.Perishable items that are refrigerated are dated once opened and used within 7 days.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to establish and 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 4 residents (Resident #44) reviewed for infection control. The facility failed to ensure CNA N performed hand hygiene while providing incontinent care for Resident #44 on 06/29/25. This failure could place any resident at the facility at risk for cross-contamination and the spread of infection.Finding included: Record review of Resident #44's face sheet, dated 07/02/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses to include Neuromuscular dysfunction of the bladder (occurs when the nerves controlling the bladder are damaged or don't function properly, leading to issues with storage and/or emptying of urine), stroke and diabetes (high blood sugars). Record review of Resident #44's quarterly MDS assessment, dated 04/22/25, indicated Resident #44 usually understood and was usually understood by others. Resident #44's BIMS score was 08, which indicated her cognition was moderately impaired. The MDS indicated Resident #44 required assistance with toileting, bed mobility, dressing, personal hygiene, transfers, and eating. The MDS did not indicate she was frequently incontinent of bladder. Record review of Resident #44's comprehensive care plan, revised on 07/27/23, indicated that Resident #44 had an ADL Self Care Performance Deficit. The care plan interventions were for 2 staff to provide toileting. During an observation on 06/29/25 at 1:00 p.m., CNA N provided incontinent care of bowel and bladder for Resident #44. She wiped her front area and then her backside without changing her gloves or performing hand hygiene. She then grabbed a clean brief, applied barrier cream, changed her linen, and then applied her gown, while using the same dirty gloves. CNA N then removed her gloves, gathered her equipment, left the room, and then washed her hands. During an interview on 06/29/25 at 3:02 p.m., CNA N said she did not realize she did not perform hand hygiene or change her gloves after wiping Resident #44, then touching the clean brief, linen, and her gown with dirty gloves. She said she knew that without hand hygiene or removing dirty gloves, she could cause cross-contamination and infection. During an interview on 07/02/25 at 3:20 p.m., the DON said she expected the CNAs to perform incontinent care correctly. She said she expected staff to change their gloves between dirty to clean and use hand hygiene between glove changes. The DON said they went over incontinence care and hand washing at least annually. She said she oversaw the infection control process. She said staff should change gloves and practice hand hygiene to prevent infection and cross-contamination. During an interview on 07/02/25 at 3:48 p.m., the Administrator said she expected all staff to use proper hand hygiene techniques between dirty and clean areas with all care. The Administrator said the DON was responsible for ensuring staff were trained on incontinent care and infection control. She said improper hand hygiene could place residents at risk for cross-contamination. Record review of the facility's policy titled Hand Hygiene, undated, indicated, You may use alcohol-based hand cleaner or soap and water for the following: when hands are visibly soiled, after contact with a residents mucous membrane and body fluids or excretions, after handling soiled or used linens, before and after assisting a resident with personal care, and before and after assisting a resident with toileting. Record review of the facility's policy titled Infection Control, revised 03/23, indicated, The facility will establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. The facility will require staff to wash their hands after each direct resident contact for which hand washing is indicated by acceptable professional practice.