STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675810	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancaster Ltc Partners Inc	1515 N Elm St Lancaster, TX 75134

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 (Resident #21) of 8 resident rooms reviewed for cleanliness. The facility failed to ensure that Resident #21's room was thoroughly cleaned. This failure could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life. Findings included: Review of Resident #21's Face sheet, not dated, reflected he was a [AGE] year-old-male admitted to the facility on [DATE]. His diagnoses included dementia and diabetes. An observation on 10/08/24 at 8:48 AM revealed Resident #21 had a dirty bedside table across his bed. It looked like spilled food and drink. The resident was lying on a torn mattress. There was not a sheet on the mattress and it did not require a sheet because it was a bariatric specialty mattress. An observation and interview on 10/08/24 at 11:54 AM revealed Resident #21 was still lying in bed and was awake. He said the torn mattress with no sheet on it caused his skin to itch. He said he did not have any skin irritations. He said he did not like the bedside table being dirty and that staff did not clean it. He said he did not ask staff to clean it. An interview on 10/10/24 at 1:10 PM with the Housekeeping Director revealed he started working at the facility in August 2024 and Resident #21's mattress had been torn since he started employment, but he had not mentioned it to anyone. He said the staff were supposed to clean off his lap tray table daily. He said failure to clean the room could be an infection control issue for the resident. An interview on 10/10/24 at 3:55 PM with the DON revealed Resident #21's mattress was torn because the resident received bed baths in bed. She said the water damaged the mattress. The DON said they ordered a new mattress for the resident. The DON was asked to show the receipt for the new mattress at that time, but it was not received prior to exit. The DON said she would provide it, but never did. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy, Standard Operation Procedures For Housekeeping, reflected: Purpose: To keep facilities clean and odor free, while providing the residents, their families, and staff with the safest environment possible and projecting a positive image. Frequency: Perform all tasks daily. 2. Resident Room(s) o Each Room (including Closets)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747 Based on observations, interviews, and record review, the facility failed to notify residents or their representatives on how to file a grievance in an anonymous manner, and the information of who the facility named as the Grievance Official for 5 residents out of 5 residents interviewed for grievances. 1.The facility failed to notify Residents or their representatives either individually or through prominent postings throughout the facility on how to file a grievance or complaint in an anonymous manner. 2.The facility failed to follow their grievance policy by providing the correct information as to who the facility identified as the Grievance Official for 5 resident. These failures could affect resident's ability to file a grievance without the fear of discrimination, reprisal, retribution, and their right to request a written decision regarding the resolution of their grievance. Findings Included: Review of the document titled, [Facility Name] Grievance List, dated for 10/08/24 for the time frame of 7/1/24-8/10/24 with one resident listed as filing a grievance. Observation of entries to the facility on [DATE] at 9:25am revealed no grievance forms, or any type of container that held grievances. Interview with five residents during Resident Counsel on 10/10/2024 at 10:30 AM residents revealed they did not know how to file grievances and were unaware where any grievance forms were located. The residents stated that they did not know who to tell if they had a concern or who the grievance official was. Interview with LVN D on 10/10/24 at 11:24am revealed that she worked the 100 hall. LVN D revealed if a resident wanted to file a grievance, she would give them a form to fill out. LVN D did not have a response for what a resident would do if they wanted to fill out a grievance anonymously. LVN D could not locate any grievance forms in entry or the adjacent nursing station where she worked. Interview with the Social Worker on 10/10/24 at 1:30pm revealed if a resident or representative requested to file a grievance, the receiving staff member should document the grievance in the facility's electronic medical record system to alert the necessary department heads to follow-up or complete a facility grievance form. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DON on 10/10/24 at 1:00pm revealed the residents were told to tell someone their concern, then the staff documents the concern and gives it to the department head. The DON did not have an answer as to what a resident would do if a resident wanted to be anonymous in filing their grievance. DON stated she did not know who the grievance official was for the facility, she stated the facility did not have grievance log. In an interview with the facility's DON on 10/10/24 at 3:30pm revealed that there had been no concerns with residents being able to file a grievance or filing a grievance in an anonymous manner. Review of the facility's policy titled, Grievances dated November 2016 revealed that, the The resident has the right to voice grievances to the facility or other agency or entity that hears. grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The facility will notify residents on how to file a grievance orally, in writing, or anonymously, with postings in prominent locations. Review of the Resident's Rights subsection Grievances revealed. The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The facility must make information on how to file a grievance or complaint available to the resident. 47030

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on interviews record reviews the facility failed to ensure residents in the locked memory care unit were free from involuntary seclusion for 1 (Resident #45) of 8 residents reviewed for involuntary seclusion. The facility failed to ensure Resident #45 was free from physical restraints. Facility staff placed Resident #45 in the secure unit for staff convenience. This failure could place residents at risk for a decreased quality of life, a decline in physical functioning, and injury. Findings included: Record review of Resident #45's quarterly MDS assessment dated [DATE] reflected Resident #45 was a [AGE] year-old female admitted to the facility on [DATE]. The MDS reflected Resident #45 had a BIMS score of 01 which indicated severe cognitive impairment. The resident had no behaviors. The resident's diagnoses included Alzheimer's disease and heart failure. The resident had no falls and physical restraints were not used. Record review of Resident #45's care plan , dated 04/15/24, reflected: The resident was at risk for falls. Facility interventions included: Anticipate and meet the resident's needs, keep the call light in reach and remind the resident to use it, educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. The resident is at risk for malnutrition. Facility interventions included: Resident likes to eat in dining room in secure unit. The resident did not have a care plan to be in the secure unit. An observation and interview on 10/08/24 at 10:32 AM revealed Resident #45 was in the memory care unit. She was seated at a table in the day room/dining room. She was not eating. There were other residents scattered around the room. RN D said she was the nurse for the Memory Care Unit and Hall 200. RN D said she moved Resident #45 from Hall 200 to the memory care unit so that she could watch her more closely. RN D said the resident was at risk for falls. An observation on 10/08/24 at 12:04 PM revealed Resident #45 was still seated in the same place in the memory care unit. She was not eating. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 10/08/24 at 12:33 PM with Resident #45 revealed she was eating lunch and said she liked the memory care unit. She said staff was respectful to her. She said she would like to stay in her room on Hall 200, but it did not really matter to her. She said the staff took good care of her. An observation on 10/08/24 at 2:00 PM revealed Resident #45 was still seated in the same place in the memory care unit. The resident was not eating. An observation on 10/09/24 at 10:00 AM revealed Resident #45 was seated in the same chair and the same table as on 10/08/24. She was not eating. An interview on 10/09/24 at 4:37 PM with the family of Resident #45 revealed she did not know the resident was being kept on the memory care unit. The family member said the resident was supposed to be on Hall 200 and she did not want the resident kept in the memory care unit. An interview on 10/09/24 at 12:28 PM with the DON revealed Resident #45 was only supposed to go to the secure unit for meals. She said the resident was not at risk for elopement and keeping her in the secure unit was a physical restraint. She said the resident did not have an order for restraints. The DON said restraining a resident on the secure unit when they were not supposed to be there could lead to behavioral problems including acting out and becoming aggressive. Record review of the facility's Abuse/Neglect policy, dated 03/29/18 reflected: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

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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** 35747 Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 3 residents (Resident #1) reviewed for neglect reporting. The facility failed to report an allegation of neglect to the State Agency when Resident #1 sustained a serious injury. This failure could place residents at risk for not having allegations of neglect reported which could lead to injury or worsening of condition. Findings included: 1. Review of Resident #1 MDS assessment, dated July 31, 2024, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. The resident's cognitive status was severely impaired. His diagnoses included Alzheimer's Disease and Traumatic Brain Injury (TBI). Review of Resident #1's Care Plan, dated 08/07/24, reflected: o Resident has an ADL self-care performance deficit related to debility. o Resident is at moderate risk for falls related to gait/balance problems, psychoactive drug o Resident is a risk for falls, has had an actual fall with minor injury related to poor balance o Resident has laceration, 4 staples to head. Resident hit head on dresser near refrigerator in room. Review of Resident #1's Nurse Note , dated 08/09/2024 at 9:36 PM, reflected: The nurse found resident #1 in his room with head injury and bleeding noted. When asked how the incident happened, resident was unsure on how he hit his head. The note reflected the type of injury as laceration, located back of head, and 3 centimeters in size. The note reflected that resident was oriented and indicated no levels of pain. Vital signs taken. Blood pressure 105/65, temperature 97.7, pulse 89, respirations 18. Physician notified of incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Transfer Form, dated 08/09/2024 at 9:12 PM, reflected: Resident #1 was emergency transferred to the hospital at 8:50 PM due to head laceration. Review of Resident #1's Nurse Note , dated 8/10/2024 at 2:08 PM reflected: Resident returned from Hospital at 2:00 AM on a stretcher accompanied by two transport employees from the Ambulance service. Upon arrival resident's blood pressure was 112/69 pulse 102, respirations 18 and temperature 97.6. Oxygen saturation 92% on room air. Received report from Charge nurse at hospital, Resident had a superficial laceration on scalp with four staples, labs normal and new orders states that staples should be removed in 10 days. Resident denies pain and is up currently. An observation and interview on 10/10/24 at 10:39 AM with Resident #1 revealed Resident was playing Bingo in the dining room. Resident was observed to be well-groomed and in appropriate clean and fitting clothing. Resident was alert and willing to speak to surveyor. Surveyor asked resident if he could tell surveyor how he received staples to the back of his head. Resident said he hurt his head by falling down. He said his head hit the wall. Resident said he went to the doctor for it. An interview on 10/09/2024 at 12:40 PM with the DON revealed she was informed that Resident #1 hit his head on the dresser near his refrigerator. The DON said that there were no witnesses to the fall. She said she was not sure why this incident was not self-reported. The DON said it was determined Resident #1 fell and hit his head on the dresser because there was blood found on the dresser. An interview on 10/10/2024 at 1:00 PM with the Administrator revealed that the incident involving Resident #1 was not self-reported. He said if he had been the administrator during that time, he would have reported the incident. Review of the facility policy Reporting Events; Home Office and State, reflected: The following guidelines will be followed at this facility regarding reporting of incidents and variances that occur within the facility property. The home office, risk management and legal team will assist the facility with appropriate responses to the variance. The team approach and early intervention may prevent an event from becoming a liability for the facility. Reporting Guidelines to Home Office. The following variances will be reported immediately to the facility ADO, facility Compliance Nurse, VP of Clinical Services, VP of Risk Management, and the Chief Operations Officer. Report: 1. All hospitalization s resulting from an injury or an unusual occurrence. 51181

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview and record review, the facility failed to ensure that an alleged violation involving neglect was thoroughly investigated for 1 (Resident #13) of 8 residents reviewed. The facility failed to have evidence of a thorough investigation as there was no documented evidence provided of an investiation, when Resident #13 went to the hospital as a result of an injury of an unknown source that occured on 08/09/24. This failure could place residents at risk of abuse, neglect, and/or exploitation. Findings included: 1. Review of Resident #13's MDS assessment, dated July 31, 2024, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. The resident's cognitive status was severely impaired. His diagnoses included Alzheimer's Disease and Traumatic Brain Injury (TBI). Review of Resident #13's Care Plan, dated 08/07/24, reflected: Resident had an ADL self-care performance deficit related to debility. Resident was at moderate risk for falls related to gait/balance problems, psychoactive drug Resident was at risk for falls and had an actual fall with minor injury related to poor balance Resident had a laceration, 4 staples to head. Resident hit head on dresser near refrigerator in room. Review of Resident #13's Nurse Note, dated 08/09/2024 at 9:36 PM, reflected: The nurse found resident #13 in his room with head injury and bleeding noted. When asked how the incident happened, resident was unsure on how he hit his head. The note reflected the type of injury as laceration, located back of head, and 3 centimeters in size. The note reflected that the resident was oriented and indicated no levels of pain. Vital signs taken. Blood pressure 105/65, temperature 97.7, pulse 89, respirations 18. Physician notified of incident. Review of Resident #13's Transfer Form, dated 08/09/2024 at 9:12 PM, reflected: Resident #13 was emergency transferred to the hospital at 8:50 PM due to head laceration. Review of Nurses' Note, dated 8/10/2024 at 2:08 PM reflected: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident returned from Hospital at 2:00 AM on a stretcher accompanied by two transport employees from the Ambulance service. Upon arrival resident's blood pressure was 112/69, pulse 102, respirations 18, temperature 97.6, and 92% oxygen saturation on room air. Received report from charge nurse at hospital, Resident had a superficial laceration on scalp with four staples, labs normal and new orders states that staples should be removed in 10 days. Resident denies pain and is up currently. An interview on 10/10/24 at 10:39 AM with Resident #13 revealed: Resident was observed playing Bingo in the dining room. Resident was observed to be well-groomed and in appropriate clean and fitting clothing. Resident was alert and willing to speak to surveyor. Surveyor asked resident if he could tell surveyor how he received staples to the back of his head. Resident said he hurt his head by falling down. He said his head hit the wall. Resident said he went to the doctor for it. An interview on 10/09/2024 at 12:40 PM with the DON revealed she was informed that Resident #13 hit his head on the dresser near his refrigerator. The DON said that there were no witnesses to the fall. She said she was not sure why this incident was not self-reported. The DON said it was determined resident #13 fell and hit his head on the dresser was because there was blood found on the dresser. An interview on 10/10/2024 at 1:00 PM with the Administrator, the Surveyor asked the Administrator if an investigation was conducted for Resident #13's head injury. The Administrator said there were times when he could piece together what happened without conducting a full investigation. The Administrator said there was no actual investigation for the incident, only a risk management. The Administrator stated he reported the incident to the state on 10/09/2024 after the Surveyor brought the issue to his attention. Review of the facility policy Reporting Events; Home Office and State, reflected: The following guidelines will be followed at this facility regarding reporting of incidents and variances that occur within the facility property. The home office, risk management and legal team will assist the facility with appropriate responses to the variance. The team approach and early intervention may prevent an event from becoming a liability for the facility. Reporting Guidelines to Home Office. The following variances will be reported immediately to the facility ADO, facility Compliance Nurse, VP of Clinical Services, VP of Risk Management, and the Chief Operations Officer. #26. Complete a thorough investigation. Obtain witness statements if needed as soon as possible. Forward investigation results to the facility ADO, facility Compliance Nurse, VP of Clinical Services, VP of Risk Management and the Chief Operations Officer. 51181

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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** 35747 Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for one (Resident #18) of four residents reviewed for ADLs. The facility failed to provide Resident #18 with his scheduled bathing/hygienic care on 10/08/24. This failure had the potential to affect residents who were dependent on staff for bathing by placing them at risk for poor personal hygiene, odors, embarrassment, low self-worth and a decline in their quality of life. Findings included: Review of Resident #18's Face Sheet, dated 10/10/24, reflected he was an [AGE] year-old male who admitted to the facility on [DATE], with diagnoses including Alzheimer's disease (a brain disorder that causes a gradual decline in memory, thinking, and other cognitive skills) and lack of coordination (a condition that occurs when a person has trouble controlling their muscles, resulting in jerky, unsteady movements). Review of Resident #18's MDS Assessment, dated 09/30/24, reflected his BIMS score was 1, indicating he had severe cognitive impairment. Resident #18 was identified as requiring supervision or touching assistance when showering/bathing (meaning the helper would provide verbal cues and/or touching/steadying and/or contact guard assistance as the resident showered/bathed, with assistance possibly being provided intermittently throughout the activity). Review of Resident #18's Care Plan, dated 10/03/24, reflected he had an ADL self-care deficit and required the assistance of one staff member for bathing. Review of Resident #18's Nurse's Notes, dated 10/08/24, reflected, .Resident refused care offered assistance with a shower and also asked to change resident clothing resident refused care continues . Observation of and interview with Resident #18 on 10/08/24 at 9:45AM revealed he was lying in his bed. He was wearing a white shirt which was soiled with numerous various colored stains. Resident #18 stated he wanted to take a shower. He was unable to disclose the last time he had a shower, or the last time his clothing was changed. Observation of and interview with Resident #18 on 10/09/24 at 9:25AM revealed he was sitting up in his bed. He was wearing the same shirt as the day prior (10/08/24) which was soiled with numerous various colored stains. Resident #18 stated he had not yet received a shower but wanted to have one. During an interview with CNA E on 10/09/24 at 9:33AM, she stated she attempted to assist Resident #18 with a scheduled shower the day prior (10/08/24), but he refused to take one or change his clothing. She then clarified that he told her to wait a minute and she assumed that meant he did not want a shower or his clothing changed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of CNA E on 10/09/24 at 9:38AM revealed she went into Resident #18's room and offered to give him a shower. Resident #18 responded by saying, Wait a minute. CNA E provided no encouragement to Resident #18 but said to the surveyor, See, he [Resident #18] said wait a minute. The surveyor then pointed out that Resident #18 was in the process of using his bedside urinal. CNA E advised she would assist Resident #18 with a shower after he was finished using his bedside urinal. During an interview with the Director of Nursing on 10/09/24 at 9:55AM, she stated facility staff were expected to provide encouragement and alternate approaches, when necessary, to help ensure they participated in ADLs (such as showers). She said if a resident told a staff member to wait a minute when ADL care was offered, the staff member should not consider that a refusal of care. The Director of Nursing stated the risk of a resident not receiving ADL care, such as showers or regular clothing changes, included the possibility of skin breakdown. A policy related to ADLs, including showers, was requested from the Administrator on 10/10/24 at 4:02PM but was not received at the time of exit.

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	675810	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancaster Ltc Partners Inc	1515 N Elm St Lancaster, TX 75134

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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** 37028 Based on observation, interview, and record review 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 each resident for one (Resident #18) of eight residents reviewed for pharmacy services. RN D failed to ensure Resident #18 swallowed his medication after she administered it. This failure placed residents at risk of choking on their medications. Findings included: Record review of Resident #18's quarterly MDS Assessment, dated 09/30/24, reflected he was an [AGE] year-old male admitted to the facility on [DATE], He had a BIMS score of 1 which indicated his cognition was severely impaired. His diagnoses included heart failure, Alzheimer's disease, and dysphagia (difficulty swallowing). Record review of Resident #18's Care Plan dated 05/18/23, reflected, He was on a regular 2-gram sodium mechanical soft diet with thin liquids. Record review of Resident #18's Order Summary Report dated 11/04/23 reflected: May crush meds or open capsules as needed unless contraindicated. An observation and interview on 10/08/24 at 10:09 AM revealed Resident #18 was sitting on the side of the bed, he was leaning back and could not sit himself up. He was not able to speak. The resident had a glass of water in his hand. His mouth was open, and he had three intact white pills in his mouth that he was trying to swallow. He could not swallow the pills. The Surveyor called for the nurse. The resident sat forward and swallowed the pills. RN D walked into the room immediately after the resident swallowed the pills. RN D said she administered his medications but did not know he still had pills in his mouth. She said she was supposed to watch the resident swallow the medications, but this time she did not. She said the risk to the resident was that he could choke if he was not watched to make sure he swallowed his medications. An interview on 10/10/24 at 2:04 PM with the DON revealed the nurse was supposed to watch the resident swallow medications and if they did not watch the resident, then the resident could choke. Record review of the facility's policy titled, Medication Administration Procedures, dated 2003 and revised on 10/25/17, reflected: 1. All medications are administered by licensed medical or nursing personnel . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. After the resident has been identified, administer the medication and immediately chart doses administered on the medication administration record. 51181

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on interview and record review, the facility failed to ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record for one (Resident #13) of eight residents reviewed for unnecessary medications. The facility failed to ensure Resident #13 was not prescribed to take Clonazepam and Lorazepam which are both in the same class of medication (benzodiazepines -medications that work in the central nervous system to treat various medical conditions) This failure could affect residents by placing them at risk for possible adverse side effects, a decreased quality of life and continued use of possible unnecessary medications. Findings included: Review of Resident #13's MDS assessment, dated July 31, 2024, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. The resident's cognitive status was severely impaired. His diagnoses included Alzheimer's Disease and Traumatic Brain Injury (TBI) with loss of consciousness, Unspecified Intracranial Injury Without Loss of Consciousness, Essential (Primary) Hypertension, unsteadiness on feet, Dysphagia, Oropharyngeal Phase Cognitive Communication Deficit, Muscle Wasting and Atrophy; not elsewhere classified, Multiple Sites other lack of coordination, insomnia (unspecified), Candidiasis of skin and nail, Abnormalities of Gait and Mobility, need for assistance with personal care, Mild Protein-Calorie Malnutrition, Muscle Weakness (Generalized), Anxiety Disorder (Unspecified), Personal history of other mental and behavioral disorders, Anemia, Schizoaffective Disorder, Bipolar type unspecified psychosis not due to a substance or known physiological condition, functional intestinal disorder, hypotension (unspecified). Review of Resident #13's Physician Progress Note, with a date of service of September 4, 2024, reflected Resident #13's active medications: Klonopin Oral Tablet 0.5 MG Give 0.5 mg by mouth three times a day Lorazepam Oral Tablet 0.5 MG Give 1 tablet by mouth every 6 hours as needed. Lorazepam Oral Tablet 1 MG Give 1 mg by mouth two times a day. Record review of Resident #13's Psychotropic Medication Utilization Report/Pharmacist Summary, dated 08/30/2024 reflected: o Lorazepam 1 MG, 1 tablet by mouth two times a day ordered on 5/15/2024. o Clonazepam 0.5 MG, 1 tablet by mouth three times a day, ordered on 11/17/2022, last GDR on 4/7/2024, decreased in July 2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #13's Progress Note dated 9/10/2024 reflected that Resident #13 had new order to increase Lorazepam to three times a day. An interview with the Physician on 10/10/24 revealed Resident #13 was taking clonazepam for anxiety and aggression and the resident was also taking lorazepam which also treated anxiety. The Physician said he did not think the resident needed to be taking both medications and he would adjust the resident's orders. Record review of the facility policy titled, Consultant Pharmacist, reflected: The Mediation Regimen Review (MRR) is an important component of the overall management and monitoring of a resident's medication regimen. The pharmacist must review each resident's medication regimen at least once a month to identify irregularities and to identify clinically significant risks and/or actual or potential adverse consequences which may result from or be associated with medications. The pharmacist cannot delegate the medication regimen reviews to other staff that are not pharmacists. The pharmacist's findings are considered part of each resident's medical record and as such are available to the resident/representative upon request. If documentation of the findings is not in the active record, it is maintained within the facility and is readily available for review. Procedure: d. The use of a medication in an excessive dose (including duplicate therapy) or for excessive duration, thereby placing the resident at greater risk for adverse consequences or causing existing adverse consequences; and . 3. Unnecessary drug is defined as any drug used; a. In excessive dose (including duplicate drug therapy); or b. For excessive duration; or c. Without adequate monitoring; or d. Without adequate indications for its use; or e. In the presence of adverse consequences which indicate the dose should be reduced or f. discontinued .

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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** 35747 37028 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 five (Resident #147, Resident #19, Resident #42, Resident #21, and Resident #30) of eight residents observed for infection control. 1. The facility failed to post proper signage and put out PPE for Resident #21 who was on enhanced barrier precautions. 2. LVN A failed to perform hand hygiene and clean the blood pressure cuff between uses for Resident #147 and Resident #19. 3. CNA B failed to perform hand hygiene while performing incontinence care for Resident #30. 4. LVN C failed to don the appropriate PPE prior to providing wound care to Resident #42 These failures could place residents at risk for healthcare associated cross contamination and infections. Findings included: 1. Record review of Resident #21's face sheet, not dated, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included stroke and diabetes. Record review of Resident #21's care plan, dated 08/12/24, reflected the resident was on enhanced barrier precautions because he had a Foley catheter. Facility interventions included: Gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, catheter care, bathing, or other high-contact activity. An observation on 10/08/24 at 8:48 AM of Resident #21 revealed the resident was asleep and laying in his bed. His door was open. The resident had a Foley catheter full of yellow urine. There was not a sign posted for enhanced barrier precautions and there was no PPE outside of the resident's door. 2. Record review of Resident #147's face sheet, not dated, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included end stage renal disease and diabetes. Record review of Resident #19's face sheet, not dated, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included congestive heart failure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 10/09/24 at 9:02 AM revealed LVN A was preparing to administer medications to Resident #147. LVN A put on gloves, removed the blood pressure cuff from the medication cart and took it into Resident #147's room. LVN A took the resident's blood pressure and returned the blood pressure cuff back to the medication cart. LVN A did not clean the blood pressure cuff. LVN A removed his gloves but did not perform hand hygiene. LVN A prepared and administered medications to Resident #147. LVN A did not perform hand hygiene. An observation on 10/09/24 at 9:28 AM revealed LVN A was preparing to give medications to Resident #19. LVN A put on gloves, took the blood pressure cuff off the medication cart, used it on the resident, and returned it back to the medication cart. LVN A did not clean the blood pressure cuff. LVN A removed his gloves but did not perform hand hygiene. LVN A then bagged up the trash from the medication cart and took it to the Housekeeper. LVN A did not put on gloves on perform hand hygiene. LVN A put a new trash liner in the trash can on the medication cart. LVN A then administered medication to Resident #19. After administering Resident #19's medications, LVN A washed his hands. An interview on 10/09/24 at 10:12 AM with LVN A revealed he was supposed to clean the blood pressure cuff between uses and perform hand hygiene before and after administering medications to a resident. LVN A said he thought he did perform hand hygiene when administering medications. He said cleaning equipment and performing hand hygiene was important to prevent the spread of infection. 3. Record review of Resident #30's face sheet, not dated, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Huntington's disease. An observation on 10/09/24 at 10:48 AM revealed CNA B was preparing to perform incontinence care for Resident #30. CNA B washed her hands and put on gloves. CNA B folded down the resident's brief, cleaned her peri-area, removed her gloves, went to find hand sanitizer, used the hand sanitizer, and put on clean gloves. CNA B positioned the resident and cleaned her buttocks which were soiled. CNA B folded the soiled brief underneath the resident. CNA B did not change her gloves or perform hand hygiene. CNA B used the same gloves to get new drawsheet and put down new brief. CNA B positioned the resident, removed the dirty brief with a brown-tan substance on it, and fastened the clean brief. CNA B removed the soiled linen with the same gloves and repositioned the resident's blanket back on her. An interview on 10/09/24 at 10:55 am with CNA B revealed she was supposed to change gloves and perform hand hygiene after cleaning the resident's buttocks and before putting on a clean brief. She said she did not this time, because she did not have hand sanitizer in the room. CNA B said hand hygiene was important because she was going from a dirty area to a clean area. 4. Record review of Resident #42's face sheet, not dated, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included stage IV pressure ulcer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 10/10/24 at 3:13 PM revealed LVN C was preparing to perform wound care on Resident #42. The resident had signage on his door indicating PPE was required to provide care to the resident. PPE was available outside the door. LVN C entered the room without a gown. LVN C washed her hands and put on gloves. LVN C positioned the resident and removed the soiled dressings and cleaned the wounds. LVN C removed her gloves, washed her hands and left the room. LVN C re-entered the room wearing a gown. LVN C said she was supposed to have had a gown on prior to starting wound care for the resident to protect the resident from getting germs from her into his wound. She said he was on enhanced barrier precautions because he had a wound. An interview on 10/09/24 at 4:21 PM with the DON revealed staff had notified her regarding their infection control issues. The DON said Resident #21 should have had enhanced barrier protection signage posted and PPE available because he had a Foley catheter. She said she did not know why it was not posted and said maybe the signage fell . She said nursing staff was responsible for ensuring the signage was posted and the enhanced barrier protection was important to protect the resident from infection. She said staff were responsible for wearing the appropriate PPE prior to walking into a resident's room to provide care. The DON said hand hygiene was important to perform while administering medications and when going from a dirty area to a clean area while performing incontinence care. Record review of the facility policy, Infection Control Plan, dated 2024, reflected: Infection Control 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 establish an Infection Control Program under which it - Investigates, controls, and prevents infections in the facility. Decides what procedures, such as isolation, should be applied to an individual resident . Uses appropriate hand hygiene prior to and after all procedures . Ensures that reusable equipment is appropriately cleaned, disinfected, or reprocessed.