STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675812	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Pines Nursing and Rehab	910 S Beech St Winnsboro, TX 75494

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on observation, interview and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 2 of 22 residents reviewed for dignity. (Residents #14 and #36). The facility did not ensure Resident #14's catheter drainage bag was covered for one day. The facility failed to ensure CNA C did not feed Resident #36 while standing. These failures could place residents at risk of a diminished quality of life, loss of dignity and self-worth. Findings included: 1.Record review of a face sheet dated 05/09/2024 indicated Resident #14 was [AGE] years old, readmitted on [DATE] with diagnoses including encounter for surgical aftercare - surgery on skin and subcutaneous tissue (deepest layer of the skin), urinary tract infection, schizoaffective disorder(mental health disorder that is marked by a combination of schizophrenia symptoms such as hallucinations and delusions) , gastro reflux, dysphagia (difficulty swallowing), gastrostomy status (artificial entrance for the stomach), parkinsonism (disorder of the central nervous system that affects movements, often resulting in tremors), hypertension (condition in which the force of the blood against the artery walls is too high), dementia, mild cognitive impairment (a group of thinking and social symptoms that interferes with daily functioning). Record review of the most recent comprehensive MDS dated [DATE] indicated Resident #14 usually made herself understood and usually understands. Resident #14 had a BIMS (brief interview for mental status) score of 9 which indicated Resident #14 was moderately cognitively impaired. The assessment indicated Resident #14 did not reject care necessary to achieve the resident's goals for health or well-being. The MDS indicated Resident #14 required total dependence with bed mobility, transfers, dressing, toileting, personal hygiene, bathing and eating. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the care plan revised on 05/07/2024 indicated Resident #14 required an indwelling urinary catheter with interventions of assess drainage - record the amount, type, color, and odor. Avoid lying on tubing. Do not allow drainage tube to touch the floor. Position bag below the bladder. Store the collection bag inside a protective dignity cover. Record review of the physician order dated 02/02/2024 indicated Resident #14 has a foley catheter for urinary retention as follows: During an observation on 05/06/2024 at 9:57 a.m., Resident #14 was lying in bed asleep. Resident #14's indwelling catheter did not have a cover over the urinary bag. Resident #14 urinary bag was visible from the hallway. During an observation on 05/06/20241 at 12:00 p.m., Resident #14's indwelling catheter did not have a cover over the urinary bag. Resident #14 urinary bag was visible from hallway. During an observation on 05/06/2024 at 1:47 p.m., Resident #14's indwelling catheter did not have a cover over the urinary bag. Resident #14 urinary bag was visible from the hallway. During an observation on 05/06/2024 at 3:15 p.m., Resident #14's indwelling catheter did not have a cover over the urinary bag. Resident #14 urinary bag was visible from the hallway. During an interview on 05/07/2024 at 2:02 p.m., LVN F said Resident #14 should have had a cover over the urinary bag to preserve dignity. LVN F said Resident #14 was under her care and hall and she had not placed the cover over the urinary bag earlier because she had not noticed. During an interview on 05/07/2024 at 2:15 p.m., LVN A said Resident #14 should have had a cover over the urinary bag for privacy and dignity reasons. 2.Record review of a face sheet dated 05/09/2024 indicated Resident #36 was [AGE] years old, readmitted on [DATE] with diagnoses including complete traumatic amputation at level between knee and ankle, left lower leg, acute respiratory infection, hypertension (high blood pressure), psychotic disorder with hallucinations (a mental disorder characterized with a disconnect from reality), major depressive disorder (persistently low or depressed mood, decreased interest in pleasurable activities, feelings of guilt or worthlessness), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), lack of coordination, dysphagia (difficulty swallowing), vitamin deficiency, anxiety disorder, muscle weakness. Record review of the most recent comprehensive MDS dated [DATE] indicated Resident #36 usually made himself understood and usually understands. Resident #36 had a BIMS (brief interview for mental status) score of 5 which indicated Resident #36 was severely cognitively impaired. The assessment indicated Resident #36 did not reject care necessary to achieve the resident's goals for health or well-being. The MDS indicated Resident #36 required total dependence with bed mobility, transfers, toileting, bathing and maximal assistance with dressing, personal hygiene, and eating. Record review of the care plan revised on 05/06/2024 indicated Resident #36 required assistance with ADL's related to impaired cognition and impaired mobility with the intervention for setup help provided during meals. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/06/2024 at 12:16 p.m., CNA C was standing in front Resident #36's chair in the dining room while feeding his lunch. During an interview on 05/06/2024 at 02:24 p.m., CNA N said she sits down to feed the residents at eye level to make the resident feel better. During an interview on 05/06/2024 at 02:39 p.m., CNA H said she sits with the residents while feeding because she should. Unable to reach CNA C after three attempted telephone calls with requested call back on 05/08/2024 at 12:15 p.m., 05/09/2024 at 10:32 a.m., 05/09/2024 at 04:35 p.m. During an interview 05/09/2024 at 4:07 p.m., the DON said residents' urinary bag to be covered to preserve dignity. The DON said Resident #14 should have had a privacy bag over his urinary drainage bag and she expected staff to ensure it was always covered. The DON said the appropriate thing to do when feeding a resident was to sit at eye level facing the resident. The DON said these failures could be a dignity issue. During an interview on 05/09/2024 at 02:22 PM, the Regional Director said Residents with foley catheters should have had a privacy bag over the urinary drainage bag. The Regional Director said staff should not stand towering over the residents while feeding for dignity purposes. The Regional Director said he expected the Administrator and DON to ensure the staff is educated on the rights of the residents. Record review of a Resident Rights policy dated November of 2021 indicated, be treated with dignity, courtesy, consideration and respect. 45810

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 22 residents (Residents #4) reviewed for reasonable accommodations. The facility failed to ensure Resident #4's call light was accessible. This failure could place residents at risk of injuries, health complications and decreased quality of life. Findings included: Record review of Resident #4's face sheet dated 05/07/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4's diagnoses included dementia (memory loss), depression (persistent depressed mood), and urinary tract infection (an infection in any part of the urinary system). Record review of Resident #4's comprehensive care plan dated 03/18/24, indicated Resident #4 has had an actual fall and has potential for injury related to falls due to unsteady gait, history of previous fall impulsiveness, and decreased safety awareness. The care plan interventions included to place call light within reach. Record review of Resident #4's quarterly MDS assessment dated [DATE], indicated she was sometimes understood and sometimes understood others. The MDS assessment indicated Resident #4 had a BIMS score of 4, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #4 was dependent on staff with oral hygiene, toileting hygiene, showers, dressing, personal hygiene, and chair to bed transfer. The MDS assessment indicated Resident #4 had 2 falls with no injury since the prior MDS assessment. During an observation on 05/06/24 at 10:12 AM, Resident #4 was laying in her bed and her call light was noted to be under the bed and unable to be reached by resident. During an observation on 05/06/24 at 2:44 PM, Resident #4 was sitting on the side of the bed. Resident #4's call light continued to be under her bed and unable to reached by Resident #4. During an interview on 05/06/24 at 3:43 PM, Resident #4's family member was in her room and said she had noted Resident #4's call light not within reach and reported it to the DON. Resident #4's family member said the DON dug it from under her bed. Resident #4's family member said she has had issues with Resident #4's call light not being in reach before. Resident #4's family member said Resident #4 forgets to use it, but she still wanted the call light within reach of Resident #4. Resident #4's family member said she has had to dig it up before but today I went to tell. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24 at 3:23 PM, CNA D said it was everyone's responsibility to ensure the call lights were within reach. CNA D said failure to have the call lights within reach of the resident could cause them to get up and fall trying to get assistance. CNA D said she had never seen Resident #4 remove her call light once it was placed within reach. During an interview on 05/09/24 at 3:26 PM, RN B said the call lights were to be within reach of the resident. RN B said the nurses and aides were responsible of ensuring the call lights were within reach during their rounds. RN B said not having the call light within reach could cause residents to not be able to call for assistance or they could fall. During an interview on 05/09/24 at 3:50 PM, the DON said she expected the call lights to be in place and answered timely. The DON said everyone was responsible for ensuring the call lights were within reach. The DON said not having the call lights within reach could cause resident to not receive the care they needed. The DON said she obtained Resident #4's call light from the floor on 05/06/24, after Resident #4's family member notified her, it was not within reach. The DON said she was 100% sure Resident #4's call light had fallen to the floor. During an interview on 05/09/24 at 04:36 PM, the Regional Director said he expected the call lights to be answered timely and be within reach. The Regional Director said by not having their call light within reach the resident would not be able to call for assistance. The Regional Director said all staff was responsible for ensuring the call lights were within reach. During an interview on 05/09/24 at 09:24 AM, the DON said they did not have a policy on call lights.

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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. 33249 Based on observation, interview, and record review, the facility failed to consider the views of a resident 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 3 of 3 groups. There was no documentation of the facility's effort to resolve grievances concerning beds not being made daily and cold food collected at Resident Council meetings on 2/29/2024, 3/27/2024, and 4/18/2024. This failure placed residents at risk of not having grievances addressed or provided a rational for facility decisions for issues identified Findings included: Record review of a Resident Council Meeting Form dated 2/29/2024 indicated the group council voiced their beds were not made daily and hot foods should be hot. The form failed to address how the grievances would be managed. The AD signed the Resident Council meeting form on 2/29/2024. Record review of a Resident Council Meeting Form dated 3/27/2024 indicated the group council voiced their beds were still not getting made. The form failed to address how the grievance would be managed. The AD signed the Resident Council meeting form on 3/27/2024. Record review of a Resident Council Meeting Form dated 4/18/2024 indicated the group council voiced their beds were not getting made. The response portion of the Resident Council Meeting Form indicated the DON wrote on 4/24/2024 the department heads would make frequent rounds to ensure beds were made. During an observation of medication administration on 5/06/2024 at 10:00 a.m.- 10:45 a.m., 1 confidential resident's bed was not made. The confidential resident had made this concern to management in resident council meetings. During an interview on initial tour on 5/06/2024 9:28 a.m. - 4:00 p.m., 2 confidential residents voiced their meal trays when received were cold. These confidential residents had made these concerns known during resident council meetings. During a confidential group interview on 5/07/2024 at 2:00 p.m., 5 of 5 residents said the food trays served on the halls were cold, and they have had problems for months with their beds not being made. During an observation, and interview, on 5/08/2024 at 12:10 p.m., the Dietary Manager voiced agreeance the test trays chicken taco was cold, and the Mexican corn was warm at best. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/09/2024 at 12:09 p.m., the DON said she expected the grievances to be resolved in its entirety. The DON said the grievance officer was the Administrator, but each department would address the grievance in their area. The DON said she expected beds to be made, and food to be served palatable. The DON said management completed rounds as part of the monitoring process. During an interview on 5/09/2024 at 1:12 p.m., the RDO said he expected grievances to be resolved. The RDO said the Administrator was responsible for ensuring grievances were resolved by delegating to the individual departments to manage a resolution. The RDO said the Administrator was out of town and was not able to be reached for interview. During an interview on 5/09/2024 at 3:20 p.m., the Activity Director said during resident council she writes down the concerns of the residents, then she distributes them to the indicated department to form a resolution within 72 hours. The Activity Director said she had been in her position since February 2024 and had just recently learned how to handle the resident council grievances/concerns. Record review of a Grievance-Voicing and Resolution policy dated 12/2017 indicated the policy of this home was that staff would promptly attempt to resolve grievances the resident may have, including those which involve the behavior of others. They will be able to voice grievances without fear of reprisal or discrimination. Such grievances included those with respect of 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 stay. Record review of the Resident Rights from the Texas Department of Aging and Disability Services dated April 2008 found in the resident council minutes binder revealed in the section, Complaints revealed: a resident had the right to complain about the care or treatment and receive prompt response to resolve the complaint without fear of reprisal or discrimination . Procedure: 1. The home will inform each resident upon admission and at least annually of their right to voice grievances . 2. The Grievance Official will be the Administrator .issuing written grievance decisions to the resident and coordinating with state and federal agencies as necessary . 4. The home will address each grievance in a reasonable time frame and as necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation was being investigated . 7. The home will provide acknowledgment of grievances to the person who filed the complaint. 8. Home will upon resolution of grievance, follow-up in a timely manner to assure that resolution has been successful. Record review of the HUMAN RESOURCES CODE CHAPTER 102. RIGHTS OF THE ELDERLY (texas.gov) accessed on 5/13/2024 revealed: (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sec. 102.003. RIGHTS OF THE ELDERLY. (a) An elderly individual has all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this state and the United States, except where lawfully restricted. The elderly individual has the right to be free of interference, coercion, discrimination, and reprisal in exercising these civil rights. (b) An elderly individual has the right to be treated with dignity and respect for the personal integrity of the individual, without regard to race, religion, national origin, sex, age, disability, marital status, or source of payment. This means that the elderly individual: . (f) An elderly individual may complain about the individual's care or treatment. The complaint may be made anonymously or communicated by a person designated by the elderly individual. The person providing service shall promptly respond to resolve the complaint. The person providing services may not discriminate or take other punitive action against an elderly individual who makes a complaint.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. 33249 Based on interview, and record review, the facility failed to ensure residents received mail delivered to the facility for 5 of 5 confidential residents reviewed for right to communication The facility failed to ensure residents received their mail on the weekend. This failure could affect residents in the facility who receive mail at risk for not receiving mail in a timely manner that could result in a decline in resident's psychosocial well-being and quality of life. Findings included: Record review of a Resident Council Meeting Form dated 2/29/2024 indicated the council was asked, Do you receive mail timely and on weekends?. The resident council answered no. Record review of a Resident Council Meeting Form dated 3/27/2024 indicated the council was asked, Do you receive mail timely and on weekends?. The resident council answered no. Record review of a Resident Council Meeting Form dated 4/18/2024 indicated the council was asked, Do you receive mail timely and on weekends?. The resident council answered no. During a confidential group interview on 5/07/2024 at 2:00 p.m., 5 of 5 residents said mail was not being distributed on Saturdays. They indicated they were unsure why mail was not delivered by the weekend staff. During an interview on 5/09/2024 at 12:06 p.m., the DON said she was new in the facility, but she indicated she believed the Activity Director would be responsible for the delivery of mail. The DON said a resident could get upset if they did not receive their mail timely. During an interview on 5/09/2024 at 1:10 p.m., the RDO said the Administrator was not available during the survey, but he indicated he expected the residents to receive their mail if the mail ran on Saturdays. The RDO said the Administrator was responsible for ensuring the residents received their mail timely. During an interview on 5/09/2024 at 3:00 p.m., RN B said she works the weekends. RN B indicated she had not delivered any weekend mail and was unsure about the mail process. During an interview on 5/09/2024 at 3:13 p.m., the local Postmaster indicated the facility did not receive mail on the weekends. The Postmaster said the business stopped their mail. The Postmaster said the resident mail was included in the mail held for delivery due to the delivery site was considered a business. The Postmaster failed to respond when asked why the individuals residing in the facility mail was stopped. During an interview on 5/09/2024 at 3:30 p.m., the Clinical Director indicated there was not a facility policy regarding mail. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Resident Rights from the Texas Department of Aging and Disability Services dated April 2008 found in the resident council minutes binder revealed in the section Privacy and Confidentiality that a resident had the right to send and receive unopened mail and to receive help in reading or writing correspondences. Record review of the HUMAN RESOURCES CODE CHAPTER 102. RIGHTS OF THE ELDERLY (texas.gov) accessed on 5/13/2024 revealed: An elderly individual has all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this state and the United States, except where lawfully restricted. The elderly individual has the right to be free of interference, coercion, discrimination, and reprisal in exercising these civil rights. (b) An elderly individual has the right to be treated with dignity and respect for the personal integrity of the individual, without regard to race, religion, national origin, sex, age, disability, marital status, or source of payment. This means that the elderly individual: . (g) An elderly individual is entitled to privacy while attending to personal needs and a private place for receiving visitors or associating with other individuals unless providing privacy would infringe on the rights of other individuals. This right applies to medical treatment, written communications, telephone conversations, meeting with family, and access to resident councils. An elderly person may send and receive unopened mail, and the person providing services shall ensure that the individual's mail is sent and delivered promptly. If an elderly individual is married and the spouse is receiving similar services, the couple may share a room.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on record review and interview, the facility failed to ensure residents had the right to formulate an advanced directive for 1 of 22 residents (Resident #10) reviewed for advance directives. The facility failed to accurately update Resident #10's comprehensive care plan with her code status. This failure could affect residents of the facility by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, psychosocial outcome and inaccurate medical records. Findings included: Record review of Resident #10's face sheet dated [DATE], indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included Alzheimer's (a progress disease that destroys memory and other important mental functions), atrial fibrillation (irregular often rapid heart rate that commonly causes poor blood flow), depression (persistent depressed mood), and anxiety. Record review of Resident #10's significant change in status MDS assessment dated [DATE], indicated Resident #10 was usually understood and usually understood others. The MDS assessment indicated Resident #10's BIMS score was a 5, which indicated her cognition was severely impaired. Record review of Resident #10's comprehensive care plan dated [DATE], indicated Resident #10 was a full code CPR order in place. The care plan interventions indicated to review medical record to ensure that proper documents were signed. Record review of Resident #10's physician order report dated [DATE]-[DATE], indicated Resident #10 had an order for code status DNR (do not resuscitate) with a start date of [DATE] . Record review of Resident #10's Out of Hospital Do-Not-Resuscitate (OOH-DNR) order indicated Resident #10's family member had signed the order on [DATE] and was notarized. The OOH-DNR order indicated the physician had signed the order on [DATE]. During an interview on [DATE] at 3:50 PM, the DON said Resident #10 comprehensive care plan should have been updated to indicate her code status had changed from full code to DNR whenever they received the order for DNR. The DON said nurse leadership was responsible for updating the care plans. The DON said failure to update Resident #10's care plan could place Resident #10 at risk for receiving CPR. The DON said that was not something they would have want to happen since Resident #10 had a DNR. During an interview on [DATE] at 05:23 PM, the Regional Clinical Consultant said she expected the care plans to updated timely. The Regional Clinical Consultant said Resident #10's care plan should have reflected the updated code status so plan of care was appropriate. The Regional Clinical Consultant said nursing leadership was responsible for updating the care plans. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Care Plan dated ,d+[DATE], indicated . It is the policy of this home that staff must develop a comprehensive care plan to meet the needs of the resident .10. To update the resident care plan . changes and dated on problems per home policy . if the entry must be changed significantly, the plan will look neater if the entry is lined out and reference made to the new entry .the resident care plan is the tool used to coordinate all care provided to the resident to be sure care is necessary, appropriate and planned to meet the individual needs of the resident consistent with the physicians plan of care for the resident .the resident care plan must be kept current at all times .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Pines Nursing and Rehab	910 S Beech St Winnsboro, TX 75494

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on interview and record review, the facility failed to notify the resident's representative immediately when there was an accident or significant change in the resident's physical, mental, or psychosocial status that is, a deterioration of health, mental, or psychosocial status in either life-threatening conditions or clinical complications for 2 of 9 residents (Resident #9 and Resident #39) reviewed for notification of changes. The facility failed to notify Resident #9's representative when Resident #9 sustained a fall on 02/18/2024. The facility failed to notify Resident #39's representative when Resident #39 sustained a fall on 03/31/2024. This failure placed residents' at risk of not having their representative being aware of any changes in their conditions and could result in delay in treatment and decline in residents' health and well-being. Findings included: 1. Record review of a face sheet dated 05/07/2024 indicated, Resident #9 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included unspecified dementia with other behavioral disturbance (a condition in which a person loses the ability to think, remember, learn and make decisions and solve problems), weakness, vitamin D deficiency, major depressive disorder (mental disorder with persistent sadness and a lack of interest or pleasure in previously enjoyable activities), urinary tract infection, acute respiratory disease (occurs when your lungs cannot release enough oxygen into your blood), hypertension (high blood pressure). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #9 was understood and was able to understand others. The MDS assessment indicated Resident #9 had a BIMS score of 04, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #9 required maximal assistance for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. Record review of the care plan with a target date of 07/31/2024 indicated, Resident #9 required staff assistance with ADL's. Record review of Resident #9's progress note dated 02/18/2024 at 05:15 PM and signed by RN B indicated Resident #9 had an unwitnessed fall and noted a scratched eyebrow and applied hydrocolloid dressing and neurological checks started . Neurological checks was completed for 72 hours. The Skin Assessment was completed. The progress note did not indicate Resident #9's family member had been notified of the fall or new areas of injuries. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a face sheet dated 05/08/2024 indicated, Resident #39 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included unspecified dementia with other behavioral disturbance (a condition in which a person loses the ability to think, remember, learn and make decisions and solve problems), hypertension (high blood pressure), major depressive disorder (mental disorder with persistent sadness and a lack of interest or pleasure in previously enjoyable activities), insomnia (a sleep disorder), cognitive communication deficit (difficulty with thinking and how someone uses language), Alzheimer's disease (a progress disease that destroys memory and other important mental function) with late onset. Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #39 was understood and was able to understand others. The MDS assessment indicated Resident #39 had a BIMS score of 05, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #39 required supervision or touching assistance for bed mobility, transfers, dressing, toilet use, personal hygiene, and maximal assistance for bathing. Record review of the care plan with a target date of 07/31/2024 indicated, Resident #39 had an actual fall had potential for injury related to falls with interventions for physical therapy, occupational therapy, encourage exercise, well-fitting shoes and placing call light in reach. Record review of Resident #39's progress note dated 03/31/2024 at 6:30 AM and signed by RN B indicated Resident #39 had an unwitnessed fall and noted a small bump to left forehead and bruising under eyes with neurological checks started. The Skin Assessment was completed. Neurological checks was completed for 72 hours. The progress note did not indicate Resident #39's family member had been notified of the fall or new areas of injuries. During an interview on 05/06/2024 at 03:43 PM, Resident #9's family member said they were not notified by the facility regarding the unwitnessed fall on 02/18/2024. During an interview on 05/07/2024 at 01:10 PM, Resident #39's family member said they were not notified by the facility regarding the unwitnessed fall on 03/31/2024. During an interview on 05/07/2024 at 3:05 PM, RN B said she failed to notify the family members of Resident #9 and Resident #39 because there was so much to be done with all the paperwork and she forgot. RN B said family should be notified to prevent any issues, delays in treatments and serve as coordination of care. During an interview on 05/08/2024 at 04:00 PM, the DON said Resident #9 and Resident #39's family should have been notified regarding the falls at the time of the occurrence. The DON said the progress note did not indicate Resident #9's family was notified of the fall on 2/18/2024. The DON said the progress note did not indicate Resident #39's family was notified of the fall on 3/31/2024. The DON said the family members of both Residents #9 and #39 should have been notified of the falls because it was a change in condition, and they should have been made aware of new areas of concerns, orders, etc. The DON said it was the responsibility of the charge nurse to notify the family of any changes of condition of the residents. The DON said she gave an inservice regarding notifications to physicians and families when there has been an accident/change in condition. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/2024 at 04:22 PM, the Regional Director said he expected the resident's representatives to be notified of any changes in the resident's care. The Regional Director said he expected the staff to document the notification of the family. The Regional Director said Resident #9 and Resident #39's family should have been notified of the fall and orders because the residents' family could come in, see, and suspect the residents were being abused. The Regional Director said the charge nurse was responsible for notifying the resident's representative. The Regional Director said he was unsure if there was a system in place to monitor if resident's representatives where being notified of any changes in condition or new orders. Record review of the facility's policy Change of Condition - Observing, Reporting and Recording effective December 2018 indicated . 5. Notify resident's responsible party . 3. Document in the clinical software who was notified and when.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review the facility failed to ensure resident rights of confidentiality of medical records for 2 of 23 residents (Resident #'s 1 and 35) reviewed for medical record confidentiality. The facility failed to ensure MA E closed the EMR of Resident #'s 1 and 35's medication regimen prior to her walking away from the medication cart during the passing of medications. This failure could place residents at risk of their medical information being provided to unauthorized personnel, other residents, or visitors. Findings included: 1)Record review of a face sheet dated 5/08/2024 indicated Resident #1 was a [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnoses of heart failure, and keratoconjunctivitis (inflammation of both the cornea and the conjunctiva, which can be infectious or non-infectious causing ocular dryness, burning, and foreign-body sensation and grittiness). Record review of the comprehensive care plan dated 1/19/2024 indicated Resident #1 had a visual function problem with the goal of Resident #1 would maintain current level of visual function. The care plan interventions indicated to administer medications as ordered. The comprehensive care plan also indicated Resident #1 had anxiety with the goal of the care plan being Resident #1 would not have signs or symptoms of anxiety. The interventions of the care plan included to administer medications as ordered and monitor and record abnormal behaviors. Record review of the Quarterly MDS dated [DATE] indicated Resident #1 was usually understood, and usually understood others. The MDS indicated Resident #1 had difficulties with recall and she was severely cognitively impaired with a BIMS of 4. Record review of the consolidated physician's orders dated 5/01/2024 - 5/08/2024 indicated Resident #1 received Systane balance eye drops one drop to each eye at 9:30 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. During an observation and interview on 5/07/2024 at 9:47 a.m., MA E walked away from the medication cart parked in front of room [ROOM NUMBER], walked down the hall to the dayroom/nurse station area looking for Resident #1 while leaving Resident #1's medication regimen open and viewable to others. MA E said leaving Resident #1's EMR open and visible could allow others to view her information and break privacy. 2) Record review of a face sheet dated 5/08/2024 indicated Resident #35 was a [AGE] year-old female who admitted on [DATE] with the diagnosis of major depressive disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure in normal enjoyable activities) and weakness. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the comprehensive care plan dated 3/15/2024 indicated Resident #35 had a diagnosis of depression. The goal of the care plan was Resident #35 would remain free of distress and anxiety. The interventions for Resident #35's care plan included to administer medications as ordered, and discuss any fears, issues regarding her health. Record review of the Annual MDS dated [DATE] indicated Resident #35 was usually understood, and usually understood others. The MDS indicated Resident #35 had problems with recall and had severely impaired cognition. Record review of the consolidated physician's orders dated 5/01/2024- 5/08/2024 indicated Resident #35 received aspirin 81 milligrams daily, buspirone 10 milligrams one three times daily, and Claritin 10 milligrams daily. During an observation and interview on 5/07/2024 at 9:50 a.m., MA E prepared Resident #35's medications, walked away from her medication cart parked in front of room [ROOM NUMBER], to enter room [ROOM NUMBER]. MA E left Resident #35's medication regimen open and viewable to others. MA E said she should have not left Resident #35's medication regimen open and visible. MA E said leaving the computer open to Resident #35's medications could allow for others to view her information. MA E said she was unsure of the last training regarding privacy of records. During an interview on 5/09/2024 at 11:40 a.m., the DON said she expected the staff to protect the resident's personal information. The DON said by leaving the EMR visible it could allow others to have information regarding the resident that was not needed. The DON said everyone was responsible for ensuring resident privacy was protected. The DON said the facility monitors for breach of privacy by observation with walking rounds called scout rounds. During an interview on 5/09/2024 at 1:08 p.m., the RDO said he expected confidentiality to be protected. The RDO said the Administrator was responsible for ensuring privacy was protected. During an interview on 5/09/2024 at 3:00 p.m., RN B said she expected the computer screens to be closed to protect a resident's privacy. Record review of a Resident Rights posting dated April 2008 indicated in the section Privacy and Confidentiality indicated a resident had the right to have facility information about them maintained as confidential. Record review of the HUMAN RESOURCES CODE CHAPTER 102. RIGHTS OF THE ELDERLY (texas.gov) accessed on 5/13/2024 revealed: An elderly individual has all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this state and the United States, except where lawfully restricted. The elderly individual has the right to be free of interference, coercion, discrimination, and reprisal in exercising these civil rights. (b) An elderly individual has the right to be treated with dignity and respect for the personal integrity of the individual, without regard to race, religion, national origin, sex, age, disability, marital status, or source of payment. This means that the elderly individual: . (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(g) An elderly individual is entitled to privacy while attending to personal needs and a private place for receiving visitors or associating with other individuals unless providing privacy would infringe on the rights of other individuals. This right applies to medical treatment, written communications, telephone conversations, meeting with family, and access to resident councils. An elderly person may send and receive unopened mail, and the person providing services shall ensure that the individual's mail is sent and delivered promptly. If an elderly individual is married and the spouse is receiving similar services, the couple may share a room.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 30527 Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable environment for 1 of 9 residents (Resident #9's) and 1 of 1 dining rooms reviewed for a homelike environment. The facility failed to ensure Resident #9's bathroom was free of offensive odors and unbroken and misshaped tiles around the base of the toilet. The facility failed to ensure the dining room did not have plastic, folding tables used as dining tables. This failure could place residents at risk for an uncomfortable, unhomelike environment, and a diminished quality of life. Findings included: 1. Record review of a face sheet dated 05/07/2024 indicated, Resident #9 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included unspecified dementia with other behavioral disturbance (a condition in which a person loses the ability to think, remember, learn and make decisions and solve problems), weakness, vitamin D deficiency, major depressive disorder (mental disorder with persistent sadness and a lack of interest or pleasure in previously enjoyable activities), urinary tract infection, acute respiratory disease , hypertension (high blood pressure). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #9 was understood and was able to understand others. The MDS assessment indicated Resident #9 had a BIMS score of 04, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #9 required maximal assistance for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. Record review of the care plan with a target date of 07/31/2024 indicated, Resident #9 required staff assistance with ADL's. During an observation on 05/06/2024 at 09:20 AM, upon entrance of Resident #9's room a strong odor of urine was detected in the bathroom area. The floor tiles around the base of the toilet were broken and misshaped and exposed large areas of grout. During an observation on 05/06/2024 at 11:30 AM, there was a strong odor of urine in Resident # 9's bathroom. During an observation on 05/06/2024 at 2:35 PM, there was a strong odor of urine in Resident # 9's bathroom . Resident #9 was in the room asleep at this time. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/07/2024 at 1:32 PM., RN G said on occasion he had noticed the urine odor in Resident #9's bathroom. RN G said there had been water leaks around the toilets in a couple of the rooms recently and he had noticed the tile had peeled up and was exposing areas of grout. In Resident #9's bathroom, RN G said the maintenance supervisor was aware of broken and peeled up tiles because they had discussed this on different occasions over the last month or so when there was some plumbing issues in the unit. RN G said he was not aware of the status of repairs. RN G said the urine odor could be absorbed in the exposed grout. RN G said the smell of urine and the broken tiles was not a welcoming environment for the resident's family. During an interview on 05/08/24 at 9:23 AM., Housekeeping Aide O said she smelled urine odor in Resident #9's room. Housekeeping Aide O said she usually cleans the rooms once daily for a deep clean then does a walk through in the evenings. She said she used the chemicals she was able to use when cleaning Resident #9's bathroom. She said she saw the bathroom floor tiles peeling from around the toilet in Resident #9's bathroom. She said she had not placed a work order for maintenance but said she thought the maintenance supervisor was aware . She said she would clean Resident #9's room next. Housekeeping Aide O said she told the Maintenance Supervisor in person at some point weeks ago but she could also put the needed repair in the maintenance work order book. During an interview on 05/08/2024 at 2:24 PM., the Maintenance Supervisor said he was aware of the tiles in Resident #9's bathroom that were broken, misshaped and revealed areas of grout. The Maintenance Supervisor said the facility had experienced some plumbing issues that had been caused by wipes and briefs being flushed and had clogged in the system. The Maintenance Supervisor said all the plumbing repairs had been completed and he did not feel like there was any type of leakage currently that had caused the strong urine odor in Resident #9's bathroom unless it had absorbed in the grout during the recent plumbing issues. The Maintenance Supervisor said there is a written plan to complete the renovation for the peeled-up tiles in the bathroom, but he was awaiting the approval to proceed. The Maintenance Supervisor said it was his responsibility to ensure the facility created a home like environment for the residents. During an interview on 05/08/2024 at 04:00 PM, the DON said she had not noticed the offensive odors or the broken/peeled-up tiles in Resident #9's bathroom and she did not recall being in Resident #9's room lately. The DON said she expected the housekeeping staff to fully clean all resident's bathrooms daily to alleviate odors. The DON said all the staff should be making sure the facility did not have offensive odors. The DON said she expected the Maintenance Supervisor to maintain the facility to create a home-like environment. The DON said she felt like there was a plan of renovation for the flooring repairs, but she would need to verify that with the Maintenance Supervisor and Administrator. The DON said it was important to keep the facility free of offensive odors and it was important to provide the residents with a clean and safe environment. During an interview on 05/09/2024 at 04:22 PM, the Regional Director said all the staff were responsible for making sure there were no offensive odors in the facility. The Regional Director said he expected for the staff to provide a homelike environment for the residents. 2. During an observation on 05/06/2024 at 12:15 PM, approximately 17 residents were seated at the plastic, folding tables in the dining room. The arms of the wheelchair were unable to fit appropriately under the table to allow proper positioning for eating comfortably. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 05/07/2024 at 12:15 PM, approximately 17 residents were seated at plastic, folding tables in the dining room. The arms of the wheelchair were unable to fit appropriately under the table to allow the resident proper positioning for eating comfortably. During an observation on 05/08/2024 at 12:15 PM, approximately 17 residents were seated at plastic, folding tables in the dining room. The arms of the wheelchair were unable to fit appropriately under the table to allow the resident proper positioning for eating comfortably. During an observation on 05/09/2024 at 12:15 PM, approximately 17 residents were seated at plastic, folding tables in the dining room. The arms of the wheelchair were unable to fit appropriately under the table to allow the residents proper positioning for eating comfortably. During an interview on 05/09/2024 at 1:30 PM, LVN A said it had been several months that the dining room was provided with the plastic, folding tables and the other wooden tables had been removed. LVN A said the plastic, folding tables were institutional like and did not enhance the dining experience for the residents due to the cumbersome fit of the wheelchairs at the tables. During an interview on 05/09/2024 at 04:30 PM, the Regional Director said the plastic, folding tables were not homelike. The Regional Director said he had intentions of purchasing better tables for the dining area and the more homelike tables were in his basket of things to do. During an interview on 05/09/2024 at 09:24 AM, the DON said the facility does not have a policy regarding homelike environment. 45810

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review, the facility failed to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility failed to follow their policy on abuse for 2 of 22 residents (Resident #'s 10 and 36) reviewed for abuse. The facility failed to report Resident #10's injury of unknown to HHSC when bruising was found to her perineum. The facility failed to report Resident #36's injury of unknown to HHSC when bruising was found to his bilateral buttocks and left chest. These failures could place residents at risk of being abused and neglected. Findings included: Record review of the facility's policy titled, Abuse/Reportable Events dated 12/1/2018, indicated . All residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation . The facility will provide and ensure the promotion and protection of resident rights. It is everyone's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility . Injury of Unknown Source: any injury to a resident where: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because the extent of the injury or the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidents of injuries over time .Identification: The facility will identify and investigate events that may constitute abuse/neglect. The facility will determine the direction of the investigation based on a thorough examination of events. Opportunities to prevent abuse/neglect will be managed accordingly. Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, and state. State law mandates that citizens report all suspected cases of abuse, neglect, or financial exploitation of the elderly and incapacitated persons. When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist and/or designee will be called .The facility administrator or designee will report the allegation to HHSC. If the allegations involve abuse or result in serious bodily injury, the report is made within 2 hours of the allegation. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation . 1. Record review of Resident #10's face sheet dated 05/07/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included Alzheimer's (a progress disease that destroys memory and other important mental functions), atrial fibrillation (irregular often rapid heart rate that commonly causes poor blood flow), depression (persistent depressed mood), and anxiety. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #10's significant change in status MDS assessment dated [DATE], indicated Resident #10 was usually understood and usually understood others. The MDS assessment indicated Resident #10's BIMS score was a 5, which indicated her cognition was severely impaired. The MDS indicated Resident #10 required substantial/maximal assistance with toileting and toilet transfer and was dependent on staff with personal hygiene and chair to bed transfers. The MDS assessment indicated Resident #10 had 2 falls with no injuries and one fall with injury within since the prior MDS assessment. Record review of Resident #10's physician order report dated 03/01/24-05/07/24, indicated Resident #10 had the following orders with a start date of 03/14/24: *Monitor dry scabbed scratches to the left knee every day until resolved *Monitor daily mid upper back red blanchable area until resolved. The order summary report did not indicate any orders to monitor areas for the bruising noted to the perineum. Record review of Resident #10's comprehensive care plan dated 03/14/24, indicated Resident #10 has had an actual fall and potential for injury related to falls due to history of previous fall. The care plan interventions included to offer to toilet resident upon rising, before and after means, at bedtime and as needed through night. The care plan also indicated to remind/encourage resident to use call light to gain assistance. The care plan indicated Resident #10 was at risk for self-inflicting injury such as skin tears and bruising related to poor safety awareness with interventions for weekly skin assessments. Record review of Resident #10's progress note dated 03/14/24 at 07:38 AM completed by LVN A, indicated . Resident was observed sitting on the floor next to her bed, leaning against the bed. She was sitting in urine and the trash can was turned over and she was leaning back on the trash can. She stated she had gotten up to use the restroom. She denied hitting her head, there were no injuries to the scale (sic). She has a red/blue mark approximately 6 inches in length on the mid back that appears from where she was leaning against the trash can. This was on the only area noted at this time. It was not open, and she denied any pain. She was assisted back to bed, legs were weak, arms strong, neuros started and were normal for resident's ability . Record review of Resident #10's event report dated 03/14/24 completed by LVN A, indicated an unwitnessed fall and Resident # 10 said she had gotten up to go to restroom. The event report under location of injury indicated has a mark on mid back, from where she was resting against her trash can. The event report under evaluation notes indicated . Resident was noted attempting to utilize the restroom and fell to the floor. IDT feels most appropriate to offer scheduling toileting. Care plan reviewed and updated. Record review of Resident #10's progress note dated at 03/15/24 at 07:11 AM, indicated . no delayed injuries noted, the mark on her mid back has diminished. She does have bruising at the top of shoulders. No complaints of pain or discomfort noted to any area . Record review of Resident #10's progress note dated 03/16/24 at 01:30 AM, indicated . no delayed injuries noted from fall . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675812	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Pines Nursing and Rehab	910 S Beech St Winnsboro, TX 75494

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #10's progress note dated 03/17/24 at 01:38 PM, indicated . no delayed injuries from fall . Record review of Resident #10's progress note dated 03/18/24 at 12:08 AM, indicated . no delayed injuries from fall . Record review of Resident #10's event report dated 03/19/24, indicated bruise to perineum and purplish black checked. The event report indicated under activity during bruise occurrence had fall marked. Record review of Resident #10's progress note dated 03/20/24 at 02:40 AM, indicated monitoring bruise to perineum area. Resident is in her bed sleeping at this time and shows no signs or symptoms of distress or discomfort . During an interview on 05/07/24 at 09:55 AM, LVN A said, regarding the bruising to Resident #10's perineum, the prior week they had found Resident #10 on the floor next to her bed, sitting next to the trash can. There was a line to her back and there was urine all over the floor. LVN A said when the aides had found the bruising, they figured Resident #10 had sat down on the trash can the day she fell and then sat on the floor. LVN A said Resident #10 never complained of pain. LVN A said Resident #10's bruise was large and was found on her perineum area towards the back. LVN A said Resident #10 had been going to the bathroom by herself at times and had a bedside commode in her room. LVN A said any signs of abuse or neglect should be reported to the Administrator and DON immediately. LVN A said the Administrator was the abuse coordinator for the facility. During an interview on 05/07/24 at 10:04 AM, CNA C said Resident #10 used to be able to walk to the bathroom by herself. CNA C said the day Resident #10 fell she was trying to pee in the trash can, since Resident #10 was not used to wearing a brief. CNA C said the bruising to Resident #10's perineum was very black and believed it was caused by the trash can. CNA C said she believes she noticed the bruising the day after the fall and reported it to LVN A and the Treatment Nurse. CNA C said Resident #10 did not voice any complaints of someone hurting her. During an interview on 05/07/24 at 10:13 AM, the Treatment Nurse said they had noticed the bruising to Resident #10's perineum a few days after the fall. The Treatment Nurse said they suspected the bruising had been from her fall on 03/14/24. The Treatment Nurse said Resident #10 had not complained of pain or anyone hurting her. The Treatment Nurse said they had gotten Resident #10 a bedside commode after the fall since she tried to get up by herself to use the restroom. The Treatment Nurse said any signs of abuse or neglect should be reported to the Administrator immediately, since he was the abuse coordinator at the facility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24 at 3:50 PM, the DON said they felt confident that Resident #10's bruising to the perineum was from the fall she had on 03/14/24. The DON said if they had felt it was suspicious, they should have reported and investigated but based on staff present and the staff that found the bruising it did not seem suspicious. The DON said since the nurse had reported to her when Resident #10 fell , she was hovering over the trash can and was trying to pee they related the bruising to that. The DON read Resident #10's progress notes and it did not specify Resident #10 fell on the trash can . The DON said the Administrator was responsible for reporting suspicious bruising to the HHSC . The DON said if Resident #10 had not had a fall previously then it would have been different where they should have had reported the bruising then. The DON said if it had been an abuse allegation and it was not reported the residents could have been at risk for harm. The DON said the Administrator was out of the country and was not available for interview. During an interview on 05/09/24 at 4:36 PM, the Regional Director said without knowing about the case thoroughly he chose not to comment. 45810 2.Record review of Resident #36's face sheet dated 05/09/2024 indicated he was an [AGE] year-old male who readmitted to the facility on [DATE] with diagnosis including complete traumatic amputation at level between knee and ankle, left lower leg, acute respiratory infection, hypertension (high blood pressure), psychotic disorder with hallucinations (a mental disorder characterized with a disconnect from reality), major depressive disorder (persistently low or depressed mood, decreased interest in pleasurable activities, feelings of guilt or worthlessness), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), lack of coordination, dysphagia (difficulty swallowing), vitamin deficiency, anxiety disorder, muscle weakness. Record review of Resident #36's most recent comprehensive MDS dated [DATE] indicated he usually made himself understood and usually understands. Resident #36 had a BIMS (brief interview for mental status) score of 5 which indicated Resident #36 was severely cognitively impaired. The assessment indicated Resident #36 did not reject care necessary to achieve the resident's goals for health or well-being. The MDS indicated Resident #36 required total dependence with bed mobility, transfers, toileting, bathing and maximal assistance with dressing, personal hygiene, and eating. Record review of Resident #36's care plan revised on 05/06/2024 indicated he required assistance with ADL's related to impaired cognition and impaired mobility. The care plan also indicated he was at risk for falls related to decreased mobility and use of anti-depressant medication use with no actual falls noted. Record review of Resident #36's event report dated 11/29/23 indicated he had bruising of unknown origin to his bilateral buttocks and his left breast. Record review of Resident #36's progress note dated 11/29/23 at 6:30 PM completed by LVN P indicated the resident was given a shower with family present due to refusal or behaviors and during the shower the bruising was noted to left buttock approximately 12CM X5CM blue discoloration, right buttock 3CM X3CM dark purple/blue discoloration, and left breast 2CM X 2CM greenish/yellow discoloration. The progress note also indicated Resident #36 denied having fallen or any pain. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24 at 5:13 PM, the DON said typically bruises of unknown origins should have been reported but she was not the DON at that time. She said after reviewing the final summary she did not think the bruising was suspicious but would have expected it to be reported due to it having an unknown cause and it was not up to the facility to determine if the incident was reported or not. During an attempt to call the previous DON on 05/09/24 at 5:20 PM there was no answer.

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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** 46928 Based on interviews 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 caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did 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 2 of 22 resident (Residents #'s 10 and 36) reviewed for abuse. The facility failed to report Resident #10's injury of unknown to HHSC when bruising was found to her perineum. The facility failed to report Resident #36's injury of unknown to HHSC when bruising was found to his bilateral buttocks and left chest. This failure could place residents at risk for further potential neglect due to unreported and uninvestigated allegations of abuse and neglect. Findings include: 1. Record review of Resident #10's face sheet dated 05/07/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included Alzheimer's (a progress disease that destroys memory and other important mental functions), atrial fibrillation (irregular often rapid heart rate that commonly causes poor blood flow), depression (persistent depressed mood), and anxiety. Record review of Resident #10's significant change in status MDS assessment dated [DATE], indicated Resident #10 was usually understood and usually understood others. The MDS assessment indicated Resident #10's BIMS score was a 5, which indicated her cognition was severely impaired. The MDS indicated Resident #10 required substantial/maximal assistance with toileting and toilet transfer and was dependent on staff with personal hygiene and chair to bed transfers. The MDS assessment indicated Resident #10 had 2 falls with no injuries and one call with injury within since the prior MDS assessment. Record review of Resident #10's physician order report dated 03/01/24-05/07/24, indicated Resident #10 had the following orders with a start date of 03/14/24: *Monitor dry scabbed scratches to the left knee every day until resolved *Monitor daily mid upper back red blanchable area until resolved. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The order summary report did not indicate any orders to monitor areas for the bruising noted to the perineum. Record review of Resident #10's comprehensive care plan dated 03/14/24, indicated Resident #10 has had an actual fall and potential for injury related to falls due to history of previous fall. The care plan interventions included to offer to toilet resident upon rising, before and after means, at bedtime and as needed through night. The care plan also indicated to remind/encourage resident to use call light to gain assistance. The care plan indicated Resident #10 was at risk for self-inflicting injury such as skin tears and bruising related to poor safety awareness with interventions for weekly skin assessments. Record review of Resident #10's progress note dated 03/14/24 at 07:38 AM completed by LVN A, indicated . Resident was observed sitting on the floor next to her bed, leaning against the bed. She was sitting in urine and the trash can was turned over and she was leaning back on the trash can. She stated she had gotten up to use the restroom. She denied hitting her head, there were no injuries to the scale (sic). She has a red/blue mark approximately 6 inches in length on the mid back that appears from where she was leaning against the trash can. This was on the only area noted at this time. It was not open, and she denied any pain. She was assisted back to bed, legs were weak, arms strong, neuros started and were normal for resident's ability . Record review of Resident #10's event report dated 03/14/24 completed by LVN A, indicated an unwitnessed fall and Resident # 10 said she had gotten up to go to restroom. The event report under location of injury indicated has a mark on mid back, from where she was resting against her trash can. The event report under evaluation notes indicated . Resident was noted attempting to utilize the restroom and fell to the floor. IDT feels most appropriate to offer scheduling toileting. Care plan reviewed and updated. Record review of Resident #10's event report dated 03/19/24, indicated bruise to perineum and purplish black checked. The event report indicated under activity during bruise occurrence had fall marked. Record review of Resident #10's progress note dated 03/20/24 at 02:40 AM, indicated monitoring bruise to perineum area. Resident is in her bed sleeping at this time and shows no signs or symptoms of distress or discomfort . During an interview on 05/07/24 at 09:55 AM, LVN A said, regarding the bruising to Resident #10's perineum, the prior week they had found Resident #10 on the floor next to her bed, sitting next to the trash can. There was a line to her back and there was urine all over the floor. LVN A said when the aides had found the bruising, they figured Resident #10 had sat down on the trash can the day she fell and then sat on the floor. LVN A said Resident #10 never complained of pain. LVN A said Resident #10's bruise was large and was found on her perineum area towards the back. LVN A said Resident #10 had been going to the bathroom by herself at times and had a bedside commode in her room. LVN A said any signs of abuse or neglect should be reported to the Administrator and DON immediately. LVN A said the Administrator was the abuse coordinator for the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/07/24 at 10:04 AM, CNA C said Resident #10 used to be able to walk to the bathroom by herself. CNA C said the day Resident #10 fell she was trying to pee in the trash can, since Resident #10 was not used to wearing a brief. CNA C said the bruising to Resident #10's perineum was very black and believed it was caused by the trash can. CNA C said she believes she noticed the bruising the day after the fall and reported it to LVN A and the Treatment Nurse. CNA C said Resident #10 did not voice any complaints of someone hurting her. During an interview on 05/07/24 at 10:13 AM, the Treatment Nurse said they had noticed the bruising to Resident #10's perineum a few days after the fall. The Treatment Nurse said they suspected the bruising had been from her fall on 03/14/24. The Treatment Nurse said Resident #10 had not complained of pain or anyone hurting her. The Treatment Nurse said they had gotten Resident #10 a bedside commode after the fall since she tried to get up by herself to use the restroom. The Treatment Nurse said any signs of abuse or neglect should be reported to the Administrator immediately, since he was the abuse coordinator at the facility. During an interview on 05/09/24 at 3:50 PM, the DON said they felt confident that Resident #10's bruising to the perineum was from the fall she had on 03/14/24. The DON said if they had felt it was suspicious, they should have reported and investigated but based on staff present and the staff that found the bruising it did not seem suspicious. The DON said since the nurse had reported to her when Resident #10 fell , she was hovering over the trash can and was trying to pee they related the bruising to that. The DON read Resident #10's progress notes and it did not specify Resident #10 fell on the trash can . The DON said the Administrator was responsible for reporting suspicious bruising to the HHSC . The DON said if Resident #10 had not had a fall previously then it would have been different where they should have had reported the bruising then. The DON said if it had been an abuse allegation and it was not reported the residents could have been at risk for harm. The DON said the Administrator was out of the country and was not available for interview. During an interview on 05/09/24 at 4:36 PM, the Regional Director said without knowing about the case thoroughly he chose not to comment. 45810 2. Record review of Resident #36's face sheet dated 05/09/2024 indicated he was an [AGE] year-old male who readmitted to the facility on [DATE] with diagnosis including complete traumatic amputation at level between knee and ankle, left lower leg, acute respiratory infection, hypertension (high blood pressure), psychotic disorder with hallucinations (a mental disorder characterized with a disconnect from reality), major depressive disorder (persistently low or depressed mood, decreased interest in pleasurable activities, feelings of guilt or worthlessness), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), lack of coordination, dysphagia (difficulty swallowing), vitamin deficiency, anxiety disorder, muscle weakness. Record review of Resident #36's most recent comprehensive MDS dated [DATE] indicated he usually made himself understood and usually understands. Resident #36 had a BIMS (brief interview for mental status) score of 5 which indicated Resident #36 was severely cognitively impaired. The assessment indicated Resident #36 did not reject care necessary to achieve the resident's goals for health or well-being. The MDS indicated Resident #36 required total dependence with bed mobility, transfers, toileting, bathing and maximal assistance with dressing, personal hygiene, and eating. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #36's care plan revised on 05/06/2024 indicated he required assistance with ADL's related to impaired cognition and impaired mobility. The care plan also indicate he was at risk for falls related to decreased mobility and use of anti-depressant medication use with no actual falls noted. Record review of Resident #36's event report dated 11/29/23 indicated he had bruising of unknown origin to his bilateral buttocks and his left breast. Record review of Resident #36's progress note dated 11/29/23 at 6:30 PM completed by LVN P indicated the resident was given a shower with family present due to refusal or behaviors and during the shower the bruising was noted to left buttock approximately 12CM X5CM blue discoloration, right buttock 3CM X3CM dark purple/blue discoloration, and left breast 2CM X 2CM greenish/yellow discoloration. The progress note also indicated Resident #36 denied having fallen or any pain. Record review of the facility's policy titled, Abuse/Reportable Events dated 12/1/2018, indicated . All residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation . The facility will provide and ensure the promotion and protection of resident rights. It is everyone's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility . Injury of Unknown Source: any injury to a resident where: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because the extent of the injury or the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidents of injuries over time .Identification: The facility will identify and investigate events that may constitute abuse/neglect. The facility will determine the direction of the investigation based on a thorough examination of events. Opportunities to prevent abuse/neglect will be managed accordingly. Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, and state. State law mandates that citizens report all suspected cases of abuse, neglect, or financial exploitation of the elderly and incapacitated persons. When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist and/or designee will be called .The facility administrator or designee will report the allegation to HHSC. If the allegations involve abuse or result in serious bodily injury, the report is made within 2 hours of the allegation. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation .

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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** 46928 Based on interviews and record reviews the facility failed to ensure assessments accurately reflected the resident status for 1 of 22 residents (Resident #41) reviewed for MDS assessment accuracy. The facility inaccurately coded Resident #41 as having had a weight loss on his quarterly MDS assessment dated [DATE]. This failure could place residents at risk for not receiving care and services to meet their needs. Findings included: Record review of Resident #41's face sheet dated 05/08/24, indicated a [AGE] year old male who admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis that affects all limbs and body from the neck down), dysphagia (difficulty swallowing), anemia (a condition in which the blood does not have enough healthy red blood cells, to carry oxygen all through the body), and neurofibromatosis (a condition that causes tumors to form in the brain, spinal cord, and nerves). Record review of Resident #41's comprehensive care plan dated 01/10/24, indicated Resident #41 had a significant unplanned/unexpected weight gain of 9.3% in the last 60 days. The care plan interventions included to monitor and record food intake at each meal and notify the dietician of the weight gain upon their next visit. Record review of Resident #41's registered dietician progress note dated 01/11/24 indicated . resident has good appetite and PO intake . Resident is underweight but 9.2 lbs weight gain noted since last 30 days-desired . Record review of Resident #41's quarterly MDS assessment dated [DATE], indicated he was able to make himself understood and understood others. The MDS assessment indicated Resident #41 had a BIMS score of 13, indicating his cognition was intact. The MDS assessment indicated Resident #41 was dependent on facility staff for all ADLs. The MDS assessment indicated Resident #41 had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and was not on a physician prescribed weight regimen. During an interview on 05/07/24 at 10:40 AM, Resident #41 said he has had a weight gain. Record review of Resident #41's weights from 09/01/23-05/07/24, indicated the following recorded weights: *11/02/24- 91.2lbs- admission weight *12/05/23- 99 lbs *01/05/24- 108.2 lbs *01/18/24- 110 lbs (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*02/05/24- 110.4 lbs During an interview on 05/09/24 at 2:08 PM, the MDS Coordinator reviewed Resident #41's MDS assessment dated [DATE] and said Resident #41 did not have a weight loss and that he had actually had a weight gain. The MDS Coordinator said she must have clicked the wrong one by mistake and unsure as to why she did that. The MDS Coordinator said the MDS was inaccurate, and it was a human error. The MDS Coordinator said it was her responsibility to ensure the MDS were accurate. During an interview on 05/09/24 at 3:50 PM, the DON said she expected the MDS assessments to be accurate. The DON said the MDS Coordinator was responsible for ensuring the MDS were accurate. The DON said not having an accurate MDS could place the resident at risk for inappropriate interventions. During an interview on 05/09/24 at 04:36 PM, the Regional Director said he expected the MDS assessments to be accurate. The Regional Director said the MDS Coordinator was responsible for ensuring the MDS assessments were accurate. The Regional Director said an inaccurate MDS assessments could affect their quality measures and reimbursement but as far as clinical practice he was unsure. During an interview on 05/09/24 at 09:24 AM, the DON said they did not have a policy on MDS accuracy.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs, for 4 of 6 (Resident #40, Resident #33, Resident #4 and Resident #23) residents reviewed for the care plan. 1. The facility failed to care plan Resident #40 needs to be in the secure unit 2. The facility failed to care plan or write an order for Resident #33's to be in the secure unit. The facility failed to care plan Resident #33 was a smoker. 3. The facility failed to ensure Resident #4's comprehensive care plan addressed she received a prophylactic antibiotic. 4. The facility failed to ensure Resident #23's comprehensive care plan was person-centered to include his diagnosis of PTSD and any triggers he had. These failures could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. The findings included: 1.Record review of Resident #40's face sheet, dated 05/07/24, indicated Resident #40 was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #40 had diagnoses which included Dementia (loss of memory), Depression (sadness), and Paranoid Schizophrenia (a kind of psychosis, which means your mind does not agree with reality). Record review of Resident #40's quarterly MDS assessment, dated 03/14/24, indicated Resident #40 was sometimes understood and sometimes understood by others. Resident #40's BIMS score was 07, which indicated he was moderately cognitively impaired. Resident #40 required extensive assistance with toileting, personal hygiene, transfer, dressing, bed mobility, and supervision with eating. Record review of Resident #40's Elopement/Wandering Observation dated 02/27/24 indicated Resident #40 was at high risk of elopement. Record review of Resident #40's physician orders dated 12/19/22, indicated resident to reside in the secure unit related to wandering and elopement risk. Record review of Resident #40's comprehensive care plan dated 09/22/21 did not indicate any plan of care or interventions for the secure unit. During an observation on 05/06/24 at 10:00 a.m., Resident #40 was sitting at the dining room table in the secure unit. (continued on next page)

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	675812	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Pines Nursing and Rehab	910 S Beech St Winnsboro, TX 75494

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #33's face sheet, dated 05/07/24, indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included stroke, Parkinson's (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), and Paranoid Schizophrenia (a kind of psychosis, which means your mind doesn't agree with reality). Record review of Resident #33's quarterly MDS assessment, dated 03/22/24, indicated Resident #33 was rarely understood and sometimes understood by others and his BIMS was a 04, indicating severe cognition impairment. The MDS assessment indicated he had short and long-term memory problems. Resident #33 required assistance with bathing, dressing, bed mobility, personal hygiene, toileting, and setting up for eating. Record review of Resident #33's Elopement/Wandering Observation dated 02/26/24 indicated Resident was at a low risk of elopement. Record review of Resident #33's Smoking assessment dated [DATE] indicated Resident #33 was a smoker. Record review of Resident #33's physician orders dated 05/07/24, did not indicate an order for the secure unit. Record review of Resident #33's comprehensive care plan, dated 03/24/24, did not indicate any plan of care or interventions for the secure unit. Record review of Resident #33's comprehensive care plan, dated 03/24/24, did not indicate any plan of care or interventions for smoking. During an observation on 05/06/24 at 10:31 a.m., Resident #33 was outside smoking with staff. During an observation on 05/06/24 at 12:15 p.m., Resident #33 was walking down the hallway in the secure unit. During an interview on 05/09/24 at 9:49 a.m., RN G said Resident #33 was a resident who smoked and resided in the unit. RN G said if a resident was on the secure unit, they should have an order indicating they needed to be in the unit and it should be care planned. RN G said the nurses were responsible for writing an order to admit to the secure unit. He said the MDS nurse or nurse management did the care plans. During an observation and interview on 05/09/24 at 6:06 p.m., the MDS nurse said she was responsible for the comprehensive care plans, but all the department heads did their acute care plans. The surveyor observed the MDS nurse look in the electronic records for Resident #40 and Resident #33. She said she did not see a care plan for the secure unit on Resident #40 or Resident #33. She said she did not see a smoking care plan for Resident #33. The MDS nurse said the reason for being in the secure unit and interventions should have been listed on Resident #40's and Resident #33's care plan. She said Resident #33 should have had a smoking care plan because he smoked. The MDS nurse said they discussed orders, changes in the resident's condition in the morning meetings, and any changes that should have been made to their care plan. She said she did not know how she failed to care plan for both residents. She said care plans were done to address concerns, she said it was like a road map for their care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/09/24 at 6:39 p.m., the DON said the MDS nurse was responsible for completing the care plans but all department heads did care plans. She said during morning meetings she would review orders, progress notes, 24-hour reports, and incidents to ensure things had been added or discontinued from the care plan. She said she was the overseer. She said Resident #40 and Resident #33's nurses should have written orders for the secure unit when they were admitted to the unit. The DON said she was not aware that Resident #40 and Resident #33 had missed care plans. She said care plans were done to ensure the residents were getting the appropriate care. 46928 3. Record review of Resident #4's face sheet dated 05/07/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4's diagnoses included dementia (memory loss), depression (persistent depressed mood), and urinary tract infection (an infection in any part of the urinary system). Record review of Resident #4's quarterly MDS assessment dated [DATE], indicated she was sometimes understood and sometimes understood others. The MDS assessment indicated Resident #4 had a BIMS score of 4, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #4 had taking antibiotic within the last 7 days of the look back period. Record review of Resident #4's comprehensive care plan dated 03/20/24 did not indicate Resident #4 was taking Macrodantin or a prophylactic antibiotic daily. Record review of Resident #4's physician order report dated 05/01/24- 05/07/24, indicated Resident #4 had an order for Macrodantin (antibiotic to treat and prevent urinary tract infections) 50mg one tablet daily for prophylaxis (preventative) with a start date of 01/04/23. Record review of Resident #4's medication administration history dated 05/01/24-05/09/24, indicated she had been receiving macrodantin 50mg one capsule daily. 4. Record review of Resident #23's face sheet dated 05/08/23, indicated a [AGE] year-old male who admitted to the facility on [DATE] with diagnosis which included type 2 diabetes mellitus (long-term condition in which the body has trouble controlling blood sugars and using it for energy), post-traumatic stress disorder (disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), hypertensive heart disease (heart condition due to untreated high blood pressure) and paraplegia (leg paralysis). Record review of Resident #23's admission MDS assessment dated [DATE], indicated was usually understood and was able to understand others. The MDS assessment indicated Resident #23's BIMS score was a 9, indicating his cognition was moderately impaired. The MDS assessment indicated Resident #23 had diagnoses of post-traumatic stress disorder. Record review of Resident #23's comprehensive care plan dated 04/05/24, did not indicate Resident #23 had a diagnosis of PTSD or if he had any triggers. During an interview on 05/07/24 at 10:59 AM Resident #23 said he had PTSD from Vietnam and Kuwait wars. Resident #23 said loud noises was his trigger. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/09/24 at 3:50 PM, the DON said Resident #4's prophylactic antibiotic and Resident #23's diagnoses of PTSD should have had been care planned. The DON said they should have been care planned so staff would know Resident #4 was taking an antibiotic long term and Resident #23 had a diagnosis of PTSD with any triggers he had. The DON said the nurse leadership was responsible for ensuring the care plans were updated. The DON said since Resident #4's antibiotic and Resident #23's PTSD diagnoses were not care planned, the care plan was not accurate. During an interview on 05/09/24 at 04:36 PM the Regional Clinical Consultant said Resident #4 care plan should reflect Resident #4 was receiving antibiotics as ordered as they do not name the medication. The Regional Clinical Consultant said Resident #23's diagnoses of PTSD should have been on his care plan with any triggers he had. The Regional Clinical Consultant said she expected the care plans to be updated timely. The Regional Clinical Consultant said nursing leadership was responsible for updating the care plans. Record review of the facility's policy titled Care Plan dated 12/2018, indicated . It is the policy of this home that staff must develop a comprehensive care plan to meet the needs of the resident . 4. Concerns and Problems . 1. The specific problem as well as the underlying cause should be listed .b. sources are but are not limited to: 1. problems relating to diagnoses .8. Problems related to preventative care .10. All problems identified on all assessments .the resident care plan is the tool used to coordinate all care provided to the resident to be sure care is necessary, appropriate and planned to meet the individual needs of the resident consistent with the physician's plan of care for the resident .the resident care plan must be kept current at all times .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 6 (Resident #44) residents reviewed for quality of care. The facility failed to ensure Resident #44's diabetic wound was being monitored for improvement or worsening. This failure could place residents at risk of complications which include worsening of existing wounds, development of new wounds, and infection. Findings included: Record review of Resident #44's face sheet dated 05/08/24, indicated a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #44 had diagnoses of metabolic encephalopathy (problems with the metabolism that causes brain dysfunction), dementia (memory loss), history of diabetic foot ulcer (an open sore or wound on the foot that develop in patients type 1 or type 2 diabetes), and type 2 diabetes mellitus (long-term condition in which the body has trouble controlling blood sugars and using it for energy). Record review of Resident #44's annual MDS assessment dated [DATE], indicated he was usually understood and understood others. The MDS assessment indicated Resident #44 had a BIMS score of 10, indicating his cognition was moderately impaired. The MDS assessment indicated Resident #44 had a diabetic foot ulcer. Record review of Resident #44's comprehensive care plan dated 02/05/24, indicated Resident #44 had a diabetic ulcer to right foot. The care plan interventions included to monitor/document wound: size, depth, margins: peri wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene, and to document progress in wound healing on an ongoing basis. Record review of Resident #44's physician orders report dated 05/01/24-05/08/24, indicated Resident #44 had an order for diabetic ulcer to right foot with calcium alginate follow with dry dressing and Coban daily with a start date of 04/16/24. Record review of Resident #44's podiatrist routine foot care note dated 12/14/23, did not indicate any measurements for Resident #44's diabetic wound to his right foot. Record review of Resident #44's podiatrist routine foot care note dated 03/25/24, did not indicate any measurements for Resident #44's diabetic wound to his right foot. Record review of Resident #44's weekly skin assessment dated [DATE], indicated yes marked under the question does the resident have a pressure injury, venous, arterial, diabetic ulcer, or surgical wound? If yes complete a wound assessment. The skin assessment under description of findings resolving s/p diabetic ulcer left foot. The weekly skin assessment did not include Resident #44's measurements for the diabetic ulcer to his left foot. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #44's weekly skin assessment dated [DATE], indicated yes marked under the question does the resident have a pressure injury, venous, arterial, diabetic ulcer, or surgical wound? If yes complete a wound assessment. The skin assessment under description of findings resolving s/p diabetic ulcer left foot. The weekly skin assessment did not include Resident #44's measurements for the diabetic ulcer to his left foot. Record review of Resident #44's weekly skin assessment dated [DATE], indicated yes marked under the question does the resident have a pressure injury, venous, arterial, diabetic ulcer, or surgical wound? If yes complete a wound assessment. The skin assessment under description of findings resolving s/p diabetic ulcer left foot. The weekly skin assessment did not include Resident #44's measurements for the diabetic ulcer to his left foot. Record review of Resident #44's electronic medical record on 05/09/24, did not reveal a wound assessment had been completed. During an observation on 05/08/24 at 09:43 am, the Treatment Nurse entered Resident #44's room to provide wound care to his diabetic ulcer. Resident #44's diabetic ulcer was observed to the bottom of his left foot. During an interview on 05/08/24 at 09:55 AM, the Treatment Nurse said the Resident #44 was being seen by the podiatrist regarding his diabetic ulcer and they were keeping up with the wound measurements. The Treatment Nurse said she had not been keeping up with Resident #44 measurements lately since Resident #44 was going to the podiatrist and were monitoring the progression of Resident #44's wound. During an interview on 05/09/24 at 03:50 PM, the DON said she expected the wound assessment to be completed appropriately with wound measurements. The DON said by not documenting wound measurements, they were running a risk for not tracking progression or worsening of the wound. The DON said the treatment nurse was responsible for ensuring the skin assessments were completed with wound measurements. During an interview on 05/09/24 at 4:36 PM, the Regional Director said he expected the treatment nurse to document wound measurements on the skin assessments. The Regional Director said documenting wound measurements allowed them to know if the wound was improving or worsening. The Regional Director said the DON was responsible for ensuring the treatment nurse was completing the skin assessments or wound assessments accurately. Record review of the facility's policy titled Skin Integrity Monitoring System dated 12/2017, indicated . 1. A system will be in place to assure that all residents will be assessed and monitored for any type of skin breakdown .3. A system will be in place to assure any type of skin conditions that do not constitute pressure injuries, will be monitored closely for any type of complications . assessment of the skin area is documented in the clinical software .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 3 of 6 residents (Resident #38, Resident #12, and Resident #33,) reviewed for accidents and hazards. 1. The facility failed to ensure the fall mat was in place for Resident #38. 2. The facility failed to ensure Resident #12 and Resident #33 had a smoking assessment done monthly per facility policy. These failures could place residents at risk for injury. Findings included: Record review of Resident #38's face sheet, dated 05/07/24, indicated Resident #38 was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #38 had diagnoses which included Dementia (loss of memory), anxiety (a feeling of fear, dread, and uneasiness), and depression(sadness). Record review of Resident #38's quarterly MDS assessment, dated 01/19/24, indicated Resident #38 usually understood and was usually understood by others. Resident #38's BIMS score was 04, which indicated she was severely cognitively impaired. Resident #38 required total assistance with toileting, personal hygiene, transfer, dressing, eating, and bed mobility. The MDS did not indicate she had a fall during the 7-day look-back period. Record review of Resident #38's comprehensive care plan dated 01/05/24 indicated Resident #38 was at risk of falls related to the use of antidepressants, poor safety awareness, and diagnosis of dementia. The interventions were for staff to ensure a fall mat was placed at the bedside. Record review of Resident #38's physician orders dated 05/07/24, did not indicate any orders for a fall mat. Record review of Resident #38's MAR dated 05/09/24 revealed: May have a fall mat at the bedside. Record review of Resident #38's MAR dated 05/09/24 revealed RN B signed Resident #38's MAR indicating she had a fall mat on 05/6/24, 05/07/24, 05/08/24 and 05/09/24. During an observation on 05/07/24 at 10:01 a.m., Resident #38 was in her bed with no fall mat on the floor next to her bed. During an observation and interview on 05/08/24 at 9:28 a.m., Resident #38 was in her bed. RN B walked into Resident #38's room and said he did not see a fall mat on the floor. He said he knew she should have had a fall mat for safety. He said he was signing out that Resident #38 had a fall mat but did not ensure she had one. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/09/24 at 6:39 p.m., the DON said if Resident #38 was care planned and was on her MAR to have a fall mat in place then the nurses should have ensured the fall mat was in place for the safety of the resident. 2.Record review of Resident #12's face sheet, dated 05/08/24, indicated Resident #12 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #12 had diagnoses which included anxiety, high blood pressure, and seizures. Record review of Resident #12's quarterly MDS assessment, dated 01/26/24, indicated Resident #12 usually understood and was usually understood by others. Resident #12's BIMS score was 06, which indicated he was moderately cognitively impaired. Resident #12 required assistance with toileting, personal hygiene, transfer, dressing, bed mobility, and set-up for eating. Record review of Resident #12's comprehensive care plan dated 10/16/23 indicated he was a smoker and at risk for burns. The intervention was for staff to do a smoking assessment every month and/or a significant change. Record review of Resident # 12's Smoking assessment dated [DATE] indicated Resident #12 was a smoker. The electronic medical records did not indicate a smoking assessment for March and April 2024. Record review of Resident #12's electronic medical records did indicate a smoking assessment was completed on 05/06/24 after the surveyor asked about the smoking policy. 3. Record review of Resident #33's face sheet, dated 05/07/24, indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included stroke, Parkinson (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), and Paranoid Schizophrenia (a kind of psychosis, which means your mind doesn't agree with reality). Record review of Resident #33's quarterly MDS assessment, dated 03/22/24, indicated Resident #33 was rarely understood and sometimes understood by others. The MDS assessment indicated he had short and long-term memory problems. Resident #33 required assistance with bathing, dressing, bed mobility, personal hygiene, toileting, and setting up for eating. Record review of Resident #33's comprehensive care plan, dated 03/24/24, did not indicate any plan of care or interventions for smoking. Record review of Resident #33's Smoking assessment dated [DATE] indicated Resident #33 was not a smoker. No smoking assessment was in the electronic medical record for March and April 2024. Record review of Resident #33's Smoking assessment dated [DATE] indicated Resident #33 was a smoker after being asked about the smoking policy by the surveyor. During an observation on 05/06/24 at 1:30 p.m., Resident #12 and Resident #33 were outside smoking with staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/08/24 at 9:28 a.m., RN G said the smoking assessment was done by the nurses or the social worker. He said he thought the smoking assessments needed to be done quarterly. RN G said Resident #33 was admitted as a smoker on 02/26/24. RN G looked in the electronic medical record for Resident#12 and Resident # 33 and said he did not see a smoking assessment done for the months of March or April 2024. During an interview on 05/09/24 at 6:39 p.m., the DON said the social worker was responsible for doing the smoking assessments. She said she was not sure when the smoking assessment should be done as she was still new to the facility. The DON called the social worker and asked her how often a smoking assessment needed to be completed and she told her monthly. She looked in the electronic medical records for Resident #40 and Resident #33 and said they did not have a smoking assessment for March and April 2024. She said it was important to do a smoking assessment to see if any changes had occurred since the last assessment and put interventions in place as needed for the safety of the residents. During an interview on 05/09/24 at 6:49 p.m., the Social Worker said she was responsible for completing the smoking assessment. She said she thought the smoking assessments were done yearly until being questioned about the smoking assessments. She said when she became aware of the facility's policy on smoking assessments on 05/06/24, she did all residents who smoked. She said it was important to do the smoking assessment to ensure residents who smoked were safe when smoking. Record review of the facility's policy titled, Smoking, dated December 2017, indicated It is the policy of this home that all residents who smoke will be supervised and smoking will be permitted in designated safe areas only. Procedures: 1. A smoking safety evaluation will be completed, in the clinical software, for all residents who smoke on admission change of condition and monthly #2. The results of the smoking safety evaluation will be entered into the resident care plan and reviewed and updated with change of condition and monthly. 45810

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interviews and record review, the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 22 residents (Resident #23) reviewed for quality of care. The facility did not ensure Resident #23's trauma screening was completed upon admission to the facility. This failure could put residents at an increased risk for severe psychological distress due to re-traumatization. The findings included: Record review of Resident #23's face sheet dated 05/08/23, indicated a [AGE] year-old male who admitted to the facility on [DATE] with diagnosis which included type 2 diabetes mellitus (long-term condition in which the body has trouble controlling blood sugars and using it for energy), post-traumatic stress disorder (disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), hypertensive heart disease (heart condition due to untreated high blood pressure) and paraplegia (leg paralysis). Record review of Resident #23's admission MDS assessment dated [DATE], indicated was usually understood and was able to understand others. The MDS assessment indicated Resident #23's BIMS score was a 9, indicating his cognition was moderately impaired. The MDS assessment indicated Resident #23 had diagnoses of post-traumatic stress disorder. Record review of Resident #23's comprehensive care plan dated 04/05/24, did not indicate Resident #23 had a diagnosis of PTSD or if he had any triggers. Record review of Resident #23's trauma informed care observation dated 04/12/24 indicated the observation was recorded and completed on 05/08/24 by the SW. The assessment indicated Resident #23 had personally experienced a natural disaster, a serious accident, life-threatening illness or injury and physical assault. The assessment indicated Resident #23 had personally experienced and witnessed a combat or war-one. The assessment indicated yes when asked if any of these events bothered him. The assessment under comments indicated years of therapy have helped him cope with PTSD. VA assists as well. The assessment under triggers that remind you of the event indicated loud noises and water. The assessment indicated, under the question how do you react when you are reminded of the event, sometimes anxious. The assessment indicated breathing and thinking about other things helped Resident #23 refocus when he reacted to the events. During an interview on 05/07/24 at 10:59 AM Resident #23 said he had PTSD from Vietnam and Kuwait wars. Resident #23 said loud noises was his trigger. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24 at 09:03 AM, the SW provided Resident #23's completed trauma assessment. The SW said she did not complete Resident #23's trauma assessment until yesterday, 05/08/24, when it was requested. The SW said she had completed the trauma assessment prior but had only documented it her notes and not in Resident #23's electronic medical record. During an interview on 05/09/24 at 3:50 PM, the DON said Resident #23 should have had his trauma assessment completed upon admission. The DON said she knew the SW had completed the trauma assessment but did not have an answer as to why she did not input that information in Resident #23's medical record. The DON said it was important for the trauma assessment to be completed to have access to that information so they could accurately meet Resident #23's needs. The DON said the SW was responsible for completing the trauma assessments. During an interview on 05/09/24 at 04:36 PM, the Regional Director said nurse management was responsible for completing the trauma assessments. The Regional Director said he was unsure of the risks for not completing the trauma assessment or when it should have been completed. During an interview on 05/09/24 at 05:23 PM, the SW said she was responsible for completing the trauma assessments within the first 14 days of admission. The SW said by not completing the trauma assessment timely the staff will not know of any triggers Resident #23 could have. The SW said she educated staff regarding Resident #23's triggers which included loud noises, engine backfire, and water. During an interview on 05/09/24 at 05:27 PM, RN B said she was not aware of Resident #23 having a diagnosis of PTSD or if he had any triggers. RN B said if a resident had the diagnosis of PTSD, the staff should be aware of any triggers the resident had to be able to care for the resident. During an interview on 05/09/24 at 05:33 PM, CNA D said she was unsure if Resident #23 had PTSD or if he had any triggers. CNA D said it was important for staff to be aware so they could properly care for Resident #23. CNA D said Resident #23 triggers should have been documented on his care plan. During an interview on 05/09/24 at 10:16 AM, the DON said they did not have a policy on trauma informed care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview and record review, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 4 of 8 residents (Residents #11, #54, #50, and #55) reviewed for pharmacy services. 1. The facility failed to ensure MA K administered Resident #11's Clindamycin (antibiotic), Eliquis (anticoagulant), Keppra (antiseizure), and Vimpat (antiseizure) timely as ordered at 8:30 a.m. 2. The facility failed to ensure MA K administered Resident #54's Tylenol (pain medication), Coreg (blood pressure), Gabapentin (used to treat pain), and Isosorbide (blood pressure) timely as ordered at 8:30 a.m. 3. The facility failed to ensure MA K administered Resident #50's Tylenol (pain reliever), timely as ordered at 8:30 a.m. 4. The facility failed to ensure MA K administered Resident #55's oxcarbazepine (antiseizure) timely as ordered at 9:00 a.m. This failure could place residents at risk of medical complications and not receiving the therapeutic effects of their medications. Findings included: 1) Record review of a face sheet dated 5/08/2024 indicated Resident #11 was a [AGE] year-old female who admitted on [DATE] with the diagnoses of seizures, anxiety, high blood pressure and depression. Record review of a Quarterly MDS dated [DATE] indicated Resident #11 was sometimes understood and usually understands. Resident #11's BIMs score was a 5 indicating she had severe cognitive impairment. Record review of the comprehensive care plan dated 10/06/2023 indicated Resident #11 was on anticoagulant therapy for a diagnosis of a blood clot. The goal of the care plan was Resident #11 would be free from discomfort. The care plan interventions included Resident #11 would receive her medication as ordered. Resident #11 was care planned for a seizure disorder. The care plan goal indicated Resident #11 would be from injury from seizure activity. The care plan intervention included to give the medications as ordered. The care plan indicated Resident #11 had a potential for side effects related to use of anti-depressants. The goal of the care plan indicated Resident #11 would not have any signs and symptoms of depression. The interventions for the care plan included to administer the medication for the condition. During an observation on 5/06/2024 at 10:00 a.m., MA K prepared and administered Resident #11's medications for administration. Clindamycin (antibiotic) 300 milligrams one, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Eliquis (anti-coagulant) 5 milligrams one, Keppra (anti-seizure) 500 milligrams one, and Vimpat (anti-seizure). Record review of the consolidated physician's orders dated 5/01/2024 - 5/08/2024 indicated Resident #11 was ordered: Clindamycin(antibiotic) capsules 300 milligrams one capsule three times a day 8:30 a.m., 2:00 p.m., and 8:00 p.m. Eliquis (anti-coagulant) 5 milligrams one tablet twice a day at 8:30 a.m. and 8:00 p.m. Keppra (anti-seizure) 500 milligrams one tablet at 8:30 a.m. Vimpat (anti-seizure) 150 milligrams one tablet daily at 9:00 a.m. Record review of the Medication Administration History Report dated 5/06/2024 indicated Resident #11 received her medications as listed: Clindamycin 300 milligrams one capsule at 10:31 a.m. Eliquis 5 milligrams one tablet at 10:31 a.m. Keppra 500 milligrams one tablet at 10:31 a.m. Vimpat 150 milligrams one tablet at 10:31 a.m. 2) Record review of a face sheet dated 5/08/2024 indicated Resident #54 was a [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnoses of chronic pain, and high blood pressure. Record review of an Admission MDS dated [DATE] indicated Resident #54 was usually understood and understands. The MDS indicated Resident #54's BIMs score was a 9 indicating moderately impaired cognition. Record review of a comprehensive care plan indicated Resident #54had a diagnosis of high blood pressure with a goal of the blood pressure would remain within normal limits. The care plan interventions included administer medications as ordered. The comprehensive care plan indicated Resident #54 requires pain management. The goal of the care plan was Resident #54 would have her pain controlled. The interventions included to administer the medications for the condition as ordered. The comprehensive care plan indicated Resident #54 used an anti-depressant. The goal was Resident #54 would not have any signs of depression. The interventions included to administer the medication for the condition as ordered. Record review of the consolidated physician's orders date 5/01/2024 - 5/08/2024 indicated Resident #54 was ordered: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Tylenol (pain medication) 650 milligrams one tablet three times a day at 8:30 a.m., 2:00 p.m., and 8:00 p.m. Coreg (high blood pressure) 12.5 milligrams one tablet twice daily at 8:30 a.m., and 8:00 p.m. Gabapentin (pain medication) 300 milligrams one capsule 4 times daily at 8:30 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. Isosorbide ER (high blood pressure) 30 milligrams one tablet daily at 8:30 a.m. During an observation on 5/06/2024 at 10:22 a.m., MA K prepared and administered Resident #54's medications as follows: Tylenol (mild pain reliever) 650 milligrams one Coreg (high blood pressure) 12.5 milligrams one Gabapentin (pain medication) 300 milligrams one Isosorbide ER (high blood pressure) 30 milligrams one Record review of the Medications Administration History dated 5/06/2024 indicated Resident #54 received her medications as listed: Tylenol 650 milligrams one tablet administered at 10:31 a.m. Coreg 12.5 mg one tablet administered at 10:31 a.m. Gabapentin 300 milligrams one capsule administered 10:32 a.m. Isosorbide ER 30 milligrams one tablet administered at 10:31 a.m. 3) Record review of a face sheet dated 5/08/2024 indicated Resident #50 was a [AGE] year-old male who admitted on [DATE] with the diagnoses of stroke, kidney disease, and anxiety. Record review of the Admission MDS dated [DATE] indicated Resident #50 was usually understood and usually understands. The MDS indicated Resident #50 had moderate cognitive impairment. Record review of the comprehensive care plan dated 3/08/2024 indicated Resident #50 had occasional generalized discomfort and the goal of the care plan was Resident #50's pain would be controlled. The intervention of the care plan included to administer the medication for the condition. During an observation and interview on 5/06/2024 at 10:34 a.m., MA K prepared Resident #50's medications for administration as indicated: Tylenol (mild pain reliever) 500 milligrams two caps (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the consolidated physician's orders dated 5/01/2024 - 5/08/2024 indicated Resident #50 was ordered: Tylenol (mild pain reliever) 500 milligrams 2 tablets twice a day at 8:30 a.m. and 8:00 p.m. Record review of the Medication Administration History dated 5/06/2024 indicated Resident #50 received: Tylenol 500 milligrams 2 tablets at 10:44 a.m. 4) Record review of a face sheet dated 5/08/2024 indicated Resident #55 was an [AGE] year-old-male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia (memory loss), Bi-polar disorder (mental illness), and pain. Record review of a Quarterly MDS dated [DATE] indicated Resident #50 was usually understood and usually understands. The MDS indicated Resident #50 had moderate cognitive impairment. Record review of the comprehensive care plan dated 9/25/2023 indicated Resident #50 had a diagnosis of depression and the goal of the care plan was he would remain free of symptoms of depression. The interventions included to administer the medications as ordered. Record review of the consolidated physician's orders dated 5/01/2024 - 5/08/2024 indicated Resident #50 was ordered: Oxcarbazepine 150 milligrams one tablet twice a day at 9:00 a.m. and 9:00 p.m. During an observation on 5/06/2024 at 10:50 a.m., MA K prepared and administered Resident #55's medications as follows: Oxcarbazepine (anti-seizure) 150 milligrams one Record review of the medications Administration History dated 5/06/2024 indicated Resident #50 received: Oxcarbazepine 150 milligrams one tablet administered at 10:53 a.m. MA K said Resident #55's medications were late for administration because she was called in to work and arrived around 6:35 a.m., instead of 6:00 a.m. MA K said 6:00 a.m. - 2:00 p.m. was not her normal shift to work. During an interview on 5/09/2024 at 11:51 a.m., the DON said she expected the medications to be administered as scheduled. The DON said residents could suffer adverse effects when the medications were not administered timely. The DON said she was new to the facility and was not aware there was a report to monitor the timeliness of medication administration until the surveyor asked for such a report. The DON said she was responsible for monitoring to ensure medications were passed timely along with the nurses. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/09/2024 at 1:00 p.m., the RDO said he expected the medications to be administered within the time allotted and based on the physician's orders. The RDO said when medications were not administered timely the effectiveness of the medication could be affected. The RDO said the DON and nursing was responsible for ensuring the medications were passed timely. The RDO said random checks was a way medications administration could be monitored. During an interview on 5/09/2024 at 2:42 p.m., MA K said the medications were passed late due to her arriving late to cover the open shift. MA K said this was a usual occurrence and has happened often. MA K said late administration of medications could cause symptoms to increase. During an interview on 5/09/2024 at 2:52 p.m., RN B said she expected the medications to be administered according to the schedule to ensure effectiveness. RN B said someone's pain level or blood pressure in particularly could be affected. Record review of a Medication-Administration policy dated 12/2017 indicated it was the policy of this home that medications will be administered and documented as ordered by the physician and in accordance with state regulations .8. Medications are administered within 60 minutes of the scheduled time, unless otherwise specified by the physician.

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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** 46928 Based on interviews and record reviewss, the facility failed to ensure residents who used psychotropic drugs were not given those drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 of 5 residents (Resident #62) reviewed for unnecessary psychotropic drugs. The facility failed to follow the pharmacy recommendation to discontinue Resident #62's Seroquel/quetiapine (antipsychotic medication) on 04/25/24 therefore Resident #62 received 13 more doses of Seroquel. This failure could place residents at risk for adverse consequences such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. Findings included: Record review of Resident #62's face sheet dated 05/08/24, indicated an [AGE] year-old male who admitted to the facility on [DATE], with diagnoses which included dementia (memory loss), insomnia (problems with falling and staying asleep), left femur fracture (left thighbone break), and weakness. Record review of Resident #62's admission MDS assessment dated [DATE], indicated he was usually understood and usually understood others. The MDS assessment indicated he had a BIMS score of 6, which indicated his cognition was severely impaired. The MDS assessment indicated Resident #62 had taken antipsychotic medications within the last 7 days of the look back period. Record review of Resident #62's comprehensive care plan dated 04/02/24, indicated Resident #62 had a potential for side effects related to psychotropic med use of anti-psychotic meds. The care plan intervention included to administer medication for condition as ordered and pharmacy consultant to review meds periodically for possible reduction. Record review of Resident #62's physician order report dated 04/08/24-05/08/24, indicated he had an order for quetiapine 25mg give 3 tablets to equal 75mg at bedtime with a start date of 03/17/24. Record review of Resident #62's medication administration record dated 04/01/24-04/30/24 indicated he had been receiving quetiapine 75mg daily. Record review of Resident #62's pharmacy recommendation dated 03/23/24, indicated federal guidelines for long-term care facilities require an evaluation of antipsychotic usage upon admission. This resident was recently admitted with an order for quetiapine 75mg HS to treat DX NEEDED . The pharmacy recommendation indicated under physician's response had agree checked with d/c quetiapine signed by Resident #62's physician and dated 04/25/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/09/23 at 03:03 PM, the DON said the ADON and herself were responsible for ensuring the pharmacy recommendations were completed. The DON said she received the recommendations via email. She said after she received them she gave the medical director the recommendations he had to review. The DON said any new orders on the recommendations were given to her or the ADON. The DON said Resident #62 should have had his Seroquel discontinued on 04/25/24 when the medical director signed the pharmacy recommendation. The DON said she was unsure of how it was missed. The DON said the medical director usually referred the residents to psych services, so she was unsure what happened. The DON said the pharmacy recommendation clearly stated to discontinue the quetiapine and failure to not complete the order could cause negative effects of antipsychotic medications. During an interview on 05/09/24 at 4:36 PM, the Regional Director said he expected the pharmacy recommendations to be followed through. The Regional Director said nursing should have had implemented the physician's order. The Regional Director said nurse management was responsible for ensuring the pharmacy recommendations were completed. Record review of the facility's policy titled Behavior Management - Psychoactive Medication - Antipsychotic Drug Therapy dated 12/2018, indicated . It is the policy of this home to use antipsychotic medications per CMS guidelines and to perform dose reductions and monitoring as required by regulation, to promote the highest level of resident care and safety. A gradual dose reduction is a tapering of the resident's daily dose to determine if the resident's symptoms can be controlled by a lower dose or to determine if the dose can be eliminated altogether . b. The physician can order the dose reduction suggested, order an alternative dosage reduction schedule, or state that it is clinically contraindicated to adjust the dosage, with justification for this determination .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review, the facility failed to ensure that it was free of medication error rate of 5 percent or greater. The facility had a medication error rate of 38% based on 16 errors out of 42 opportunities, which involved 4 of 8 residents (Residents #11, #54, #50, and # 55) reviewed for pharmacy services. The facility failed to ensure Residents 11, 54, 50, and 55 medications were administered during the scheduled time. This failure could place residents at risk for not receiving the intended therapeutic benefit of their medications or receiving them as prescribed, per physician orders. Findings included: 1) Record review of a face sheet dated 5/08/2024 indicated Resident #11 was a [AGE] year-old female who admitted on [DATE] with the diagnoses of seizures, anxiety, high blood pressure and depression. Record review of a Quarterly MDS dated [DATE] indicated Resident #11 was sometimes understood and usually understood others. Resident #11's BIMS score was a 5 indicating she had severe cognitive impairment. Record review of the comprehensive care plan dated 10/06/2023 indicated Resident #11 was on anticoagulant therapy for a diagnosis of a blood clot. The goal of the care plan was Resident #11 would be free from discomfort. The care plan interventions included Resident #11 would receive her medication as ordered. Resident #11 was care planned for a seizure disorder. The care plan goal indicated Resident #11 would be from injury from seizure activity. The care plan intervention included to give the medications as ordered. The care plan indicated Resident #11 had a potential for side effects related to use of anti-depressants. The goal of the care plan indicated Resident #11 would not have any signs and symptoms of depression. The interventions for the care plan included to administer the medication for the condition. Record review of the consolidated physician's orders dated 5/01/2024 - 5/08/2024 indicated Resident #11 was ordered: Buspirone (anti-anxiety) 10 milligrams one tablet at 8:30 a.m., 2:00 p.m., and 8:00 p.m. Clindamycin(antibiotic) capsules 300 milligrams one capsule three times a day 8:30 a.m., 2:00 p.m., and 8:00 p.m. Eliquis (anti-coagulant) 5 milligrams one tablet twice a day at 8:30 a.m. and 8:00 p.m. Lasix (diuretic) 20 milligrams one tablet twice a day at 8:30 a.m. and 8:00 p.m. Keppra (anti-seizure) 500 milligrams one tablet at 8:30 a.m. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Medication Administration History Report dated 5/06/2024 indicated Resident #11 received her medications as listed: Buspirone 10 milligrams one tablet at 10:31 a.m. Clindamycin 300 milligrams one capsule at 10:31 a.m. Eliquis 5 milligrams one tablet at 10:31 a.m. Lasix 20 milligrams one tablet at 10:31 a.m. Keppra 500 milligrams one tablet at 10:31 a.m. During an observation on 5/06/2024 at 10:00 a.m., MA K prepared and administered Resident #11's medications for administration. Buspirone (anti-anxiety) 10 milligrams one tablet, Clindamycin 300 milligrams one, Eliquis (anti-coagulant) 5 milligrams one, Lasix (diuretic) 20 milligrams one, Keppra (anti-seizure) 500 milligrams one, 2) Record review of a face sheet dated 5/08/2024 indicated Resident #54 was a [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnoses of chronic pain, and high blood pressure. Record review of an Admission MDS dated [DATE] indicated Resident #54 was usually understood and understood others. The MDS indicated Resident #54's BIMS score was a 9 indicating moderately impaired cognition. Record review of a comprehensive care plan indicated Resident #54 had a diagnosis of high blood pressure with a goal of the blood pressure would remain within normal limits. The care plan interventions included administer medications as ordered. The comprehensive care plan indicated Resident #54 required pain management. The goal of the care plan was Resident #54 would have her pain controlled. The interventions included to administer the medications for the condition as ordered. The comprehensive care plan indicated Resident #54 used an anti-depressant. The goal was Resident #54 would not have any signs of depression. The interventions included to administer the medication for the condition as ordered. Record review of the consolidated physician's orders date 5/01/2024 - 5/08/2024 indicated Resident #54 was ordered: Tylenol (pain medication) 650 milligrams one tablet three times a day at 8:30 a.m., 2:00 p.m., and 8:00 p.m. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coreg (high blood pressure) 12.5 milligrams one tablet twice daily at 8:30 a.m., and 8:00 p.m. Fluoxetine (anti-depressant) 40 milligrams one capsule twice a day at 8:30 a.m., and 8:00 p.m. Gabapentin (pain medication) 300 milligrams one capsule 4 times daily at 8:30 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. Isosorbide ER (high blood pressure) 30 milligrams one tablet daily at 8:30 a.m. Spironolactone (diuretic) 50 milligrams one tablet daily at 8:30 a.m. Record review of the Medications Administration History dated 5/06/2024 indicated Resident #54 received her medications as listed: Tylenol 650 milligrams one tablet administered at 10:31 a.m. Coreg 12.5 mg one tablet administered at 10:31 a.m. Fluoxetine 40 mg one capsule administered at 10:32 a.m. Gabapentin 300 milligrams one capsule administered 10:32 a.m. Isosorbide ER 30 milligrams one tablet administered at 10:31 a.m. Spironolactone 50 milligrams one tablet administered at 10:31 a.m. During an observation on 5/06/2024 at 10:22 a.m., MA K prepared and administered Resident #54's medications as follows: Tylenol (mild pain reliever) 650 milligrams one Coreg (high blood pressure) 12.5 milligrams one Fluoxetine (antidepressant) 40 milligrams one Gabapentin (pain medication) 300 milligrams one Isosorbide ER (high blood pressure) 30 milligrams one Spironolactone (diuretic) 50 milligrams one 3) Record review of a face sheet dated 5/08/2024 indicated Resident #50 was a [AGE] year-old male who admitted on [DATE] with the diagnoses of stroke, kidney disease, and anxiety. Record review of the Admission MDS dated [DATE] indicated Resident #50 was usually understood and usually understood others. The MDS indicated Resident #50 had moderate cognitive impairment. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the comprehensive care plan dated 3/08/2024 indicated Resident #50 had occasional generalized discomfort and the goal of the care plan was Resident #50's pain would be controlled. The intervention of the care plan included to administer the medication for the condition. Record review of the consolidated physician's orders dated 5/01/2024 - 5/08/2024 indicated Resident #50 was ordered: Tylenol (mild pain reliever) 500 milligrams 2 tablets twice a day at 8:30 a.m. and 8:00 p.m. Sodium Bicarbonate (supplement) 325 milligrams two tablets three times daily at 8:30 a.m., 2:00 p.m., and 8:00 p.m. Record review of the Medication Administration History dated 5/06/2024 indicated Resident #50 received: Tylenol 500 milligrams 2 tablets at 10:44 a.m. Sodium Bicarbonate 325 milligrams two tablets at 10:44 a.m. During an observation and interview on 5/06/2024 at 10:34 a.m., MA K prepared Resident #50's medications for administration as indicated: Tylenol (mild pain reliever) 500 milligrams two caps Sodium Bicarbonate (supplement) 325 milligrams one 4) Record review of a face sheet dated 5/08/2024 indicated Resident #55 was an [AGE] year-old-male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia (memory loss), Bi-polar disorder (mental illness with mood swings), and pain. Record review of a Quarterly MDS dated [DATE] indicated Resident #50 was usually understood and usually understood others. The MDS indicated Resident #55 had moderate cognitive impairment. Record review of the comprehensive care plan dated 9/25/2023 indicated Resident #55 had a diagnosis of depression and the goal of the care plan was he would remain free of symptoms of depression. The interventions included to administer the medications as ordered. Record review of the consolidated physician's orders dated 5/01/2024 - 5/08/2024 indicated Resident #55 was ordered: Guaifenesin 600 milligrams one tablet twice daily 9:00 a.m. and 9:00 p.m. Oxcarbazepine 150 milligrams one tablet twice a day at 9:00 a.m. and 9:00 p.m. Risperidone 0.5 milligrams one tablet twice daily at 9:00 a.m. and 9:00 p.m. Record review of the medications Administration History dated 5/06/2024 indicated Resident 55 received: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Guaifenesin 600 milligrams one tablet administered at 10:53 a.m. Oxcarbazepine 150 milligrams one tablet administered at 10:53 a.m. Risperidone 0.5 milligrams one tablet administered at 10:53 a.m. During an observation on 5/06/2024 at 10:50 a.m., MA K prepared and administered Resident #55's medications as follows: Guaifenesin (expectorant) 600 milligrams one Oxcarbazepine (anti-seizure) 150 milligrams one Risperidone (anti-psychotic) 0.5 milligrams one During an interview on 5/06/2024 at 10:50 a.m., MA K said Resident #55's medications were late for administration because she was called in to work and arrived around 6:35 a.m., instead of 6:00 a.m. MA K said 6:00 a.m. - 2:00 p.m. was not her normal shift to work. During an interview on 5/09/2024 at 11:51 a.m., the DON said she expected the medications to be administered as scheduled. The DON said residents could suffer adverse effects when the medications were not administered timely. The DON said she was new to the facility and was not aware there was a report to monitor the timeliness of medication administration until the surveyor asked for such a report. The DON said she was responsible for monitoring to ensure medications were passed timely along with the nurses. During an interview on 5/09/2024 at 1:00 p.m., the RDO said he expected the medications to be administered within the time allotted and based on the physician's orders. The RDO said when medications were not administered timely the effectiveness of the medication could be affected. The RDO said the DON and nursing was responsible for ensuring the medications were passed timely. The RDO said random checks was a way medications administration could be monitored. During an interview on 5/09/2024 at 2:42 p.m., MA K said the medications were passed late due to her arriving late to cover the open shift. MA K said this was a usual occurrence and has happened often. MA K said late administration of medications could cause symptoms to increase. During an interview on 5/09/2024 at 2:52 p.m., RN B said she expected the medications to be administered according to the schedule to ensure effectiveness. RN B said someone's pain level or blood pressure in particularly could be affected. Record review of a Medication-Administration policy dated 12/2017 indicated it was the policy of this home that medications will be administered and documented as ordered by the physician and in accordance with state regulations .8. Medications are administered within 60 minutes of the scheduled time, unless otherwise specified by the physician.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record, the facility failed to ensure drugs and biologicals used in the facility were stored and secured properly for 1 of 1 medication storage refrigerators, and 1 of 6 medication carts (Zone 7 medication cart) 1. The facility failed to provide a separately locked, permanently affixed compartment for storage of controlled drugs in the refrigerator of the medication room. 2. The facility failed to ensure MA E locked her medication cart and secure the keys to the medication cart during medication pass. These failures could place residents at risk for a drug diversion of their medications. Findings included: During medication pass observation on 5/07/2024 at 9:25 a.m., MA E left the medication cart to administer medications to Resident #6 in room [ROOM NUMBER] leaving the medication cart unlocked, with the keys to the cart on the top right-hand side. During an interview on 5/07/2024 at 9:25 a.m., MA E said she should have locked her cart and taken the keys with her when she returned to the medication cart. MA E said anyone could have taken any of the medications. During an observation and interview on 5/07/2024 at 11:50 a.m., the medication room at the nursing station with the only medication refrigerator had a small metal box inside, with a large chain attached to the box. The box was removed by LVN F and using a key she opened the box. LVN F revealed there was a bottle of liquid Lorazepam (anti-anxiety) medication inside the unaffixed lock box. LVN F said they had recently had to purchase a new refrigerator and this lock box appeared to have not been reattached to the wall of the refrigerator. LVN F said anyone could have walked off with the entire box. LVN F said the nurses were responsible for reporting the unaffixed lock box to the management nurses. During an interview on 5/09/2024 at 11:58 a.m., the DON said she was unaware the refrigerator lock box was not secured to the refrigerator. The DON said the lock box should have been permanently affixed to prevent drug diversions. The DON said she was responsible for monitoring the security of narcotics. The DON said she expected the medication carts to remain locked when not in sight, and use. The DON said the keys to the medication carts should be with the person assigned to the medication cart. During an interview on 5/09/2024 at 1:03 p.m., the RDO said he expected the narcotics to be double locked and permanently affixed to the refrigerator. The RDO said the DON and Administrator were ultimately responsible to ensure drug diversions were prevented. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/09/2024 at 3:00 p.m., RN B said she expected the CMAs to always keep the cart keys with them. RN B said when the keys were left on the top of the medication cart. the medications could have been stolen. Record review of a Medication Storage-in the home policy dated 12/2017 indicated the policy of this home was that medications would be stored appropriately as to be secure from tampering, exposure or misuse .2. Only licensed nurses, the consultant pharmacist, and those lawfully authorized to administer medications (medication aides) are allowed to access to medications. Medication rooms, carts, and medications supplies are locked or attended by persons with authorized access. 9. Scheduled lll and IV controlled medications are stored separately from other medications in a locked drawer or compartment designated for that purpose.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on interview and record review, the facility failed to have a policy identifying those cirumstances when the loss or damage of dentures was the facility's responsibility and failed to provide or obtain dental services to meet the needs of each resident for 1 of 9 (Resident #30) residents reviewed for dental services. The facility failed to provide dental services when Resident #30 lost his dentures. The facility failed to have policies and procedures for lost dentures. This failure could affect residents by placing them at risk for oral complications and diminished quality of life. Findings included: Record review of the face sheet dated 05/08/2024 indicated Resident #30 was an [AGE] year-old male readmitted to the facility on [DATE] with diagnoses including encounter for surgical aftercare following surgery of genitourinary system (organs of the reproductive and urinary system), colitis (inflammation of the colon), calculus (stone) of kidney, hematuria(blood in urine), weakness, astigmatism (a curvature in the lens of the eye), intermittent explosive disorder (mental health disorder marked by frequent impulsive anger and/or outburst of aggression), muscle wasting, insomnia (inability to sleep), chronic pain, flaccid hemiplegia (lack of voluntary moment in a limb) affecting left dominant side. Record review of the Quarterly MDS assessments dated 03/08/2024 indicated Resident #30 understood others and was understood by others. The MDS indicated Resident #30 had a BIMS score of 10 and was moderately cognitively impaired. The MDS indicated Resident #30 did not have any mouth or facial pain, discomfort, or difficulty swallowing. Record review of the physician orders dated 10/26/2023 indicated Resident #30 had an order dated 01/26/2021 which indicated may have dental consults and treatment if indicated as needed. Record review of Resident #30's electronic data record indicated no dental referral had been made. During an interview on 05/07/2024 at 10:13 a.m., Resident #30's family member said the facility lost his top dentures right after he was admitted . Resident #30's family member voiced concerns regarding a referral for dental services to be provided at the facility. During an interview on 05/07/2024 at 10:40 a.m., Resident #30 said he had no dentures. Resident #30 said he could eat but he would like to get his teeth back. Resident #30 said his family member was trying to get him an appointment to get dentures at the facility. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/07/2024 at 12:13 p.m., the Social Worker said she had reached out to the corporate office regarding Resident #30's lost dentures and was told the facility was not responsible for dentures. The Social Worker said the corporate office informed her there was no policy regarding lost dentures. The Social Worker said corporate had told her the facility was not Resident #30's representative payee on his insurance and therefore she did not make any type of referral. The Social Worker was not able to provide any documentation of communication with the corporate office. The Social Worker said she had not followed up because Resident #30's family member had not mentioned it to her since that time back in January. The Social Worker said it was important to make dental referrals appropriately and timely to prevent weight loss and ensure the residents' needs were being met. During an interview on 05/08/2024 at 4:00 p.m., the DON said she was not aware of Resident #30's lost dentures. The DON said she expected the Social Worker to ensure and handle those types of dental referrals appropriately and timely, so the residents did not have any type of deficits such as weight loss. The DON said she had started at the facility approximately 2 months ago and this was the first time she heard of any incidents involving Resident #30 and missing dentures. The DON said she was not familiar with the dental/denture procedures. During an interview on 05/09/2024 at 09:24 a.m., the DON said the facility did not have a policy regarding dental/dentures care/referrals. 45810

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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. 33249 Based on observations, interviews, and record review, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 7 of 7 confidential residents reviewed for food and nutrition services. The facility failed to ensure dietary staff provided food that was palatable and appetizing temperature on 5/08/2024 for confidential residents. These failures could place residents at risk of decreased food intake, hunger, and unwanted weight loss. Findings included: During an initial tour interview on 5/06/2024 between 9:28 a.m. - 4:00 p.m., 2 confidential residents voiced their meal trays, when received, were cold. During a confidential group interview on 5/07/2024 at 2:00 p.m., 5 residents said the food trays served on the halls were cold. Record review of the food temperature log dated May 8,2024 indicated the Regular meat's temperature at the time of serving was 188 degrees Fahrenheit, the cooked vegetables were 170- and 171-degrees Fahrenheit, and the dessert was 33 degrees Fahrenheit. During an observation on 5/08/2024 at 11:50 a.m., the tray cart with the test tray left the kitchen preparation area. The tray cart was reviewed by nurses and left the dining room and went directly to the hall. The trays were passed starting from 11:53 a.m. and ending when the test tray arrived in the work room at 12:10 p.m. The resident trays nor the test tray were prepared on warmed plates using a plate warmer. During a test tray interview with the Dietary Manager and State Surveyors on 5/08/2024 12:10 p.m., The Dietary Manager stated the following regarding the regular food diet for lunch served on 5/08/2024: chicken fajita taco tasted like chicken fajita taco but was cold; beans were hot and seasoned well, Mexican corn was warm at best, and gelatin was cold. The Surveyors stated chicken fajita was cold, the beans were hot, corn was warm at best, and gelatin was cold. During an interview on 5/09/2024 at 11:44 a.m., the DON said she expected the meals to be served at the standard required temperatures. The DON said the food served at a palatable temperature would prevent decreased intake and prevent weight loss. The DON said the Dietary Manager was responsible for ensuring palatability. During an interview on 5/09/2024 R 12:52 p.m., the RDO said he expected the meals to be palatable regarding temperature and taste. The RDO said he said palatability ensured enjoyable meals. The RDO said nursing and the dietary department was responsible for ensuring meals were palatable. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/09/2024 at 2:37 p.m., the Dietary Manager said the test tray tasted good, but the temperature needed improvement. The Dietary Manager said the cold plate could have caused the food temperature to drop. The Dietary Manager said it was important the residents enjoyed their food and should be a priority. During an interview on 5/09/2024 at 3:30 p.m., the RNC indicated there was no policy on the palatability of food.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, 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. 1. The facility failed to ensure 3 sheet pans were free from a brown colored grease like build up on the inside corners of the sheet pans. 2. The facility failed to ensure 2 cast iron skillets were free from a carbon build up not covering the inside walls and the outside of the skillet. 3. The facility failed to ensure the juice machine was free from dusty like material on the front and sides. These failures could place residents at risk for food borne illness. Findings included: During observations on initial tour on 5/06/2024 at 9:28 a.m., the following was found: *2 cast iron skillets with a large amount of black encrusted carbon buildup on the inside and the outside. *3-1/4 sheet pans with dark brown build up appears to be caked on grease material was on the inside corners of each pan. *Juice machine had dust buildup on the two sides and the front of the machine. During an interview with the on 5/06/2024 at 9:30 a.m., the cook said she used the sheet pans to cook the breakfast meats, and the cast iron skillets were used to fry fish on Fridays. The [NAME] said the pans should be cleaned better, to remove the brown material. The [NAME] said the pans were not considered clean enough to cook food. Record review of the Daily Cleaning Schedule dated May 2024 the sheet pans, the cast iron skillets, and the juice machine was not listed on the cleaning schedule duties. During an interview on 5/09/2024 at 11:48 a.m., the DON said she expected the dietary department to be clean according to basic kitchen standards. The DON said unsanitary cleaning practices could lead to undesirable events including food borne illnesses. The DON said the Dietary Manager and staff were responsible for ensuring kitchen sanitation. During an interview on 5/09/2024 at 12:57 p.m., the RDO indicated he expected the dietary department to be clean including the machines, and pans. The RDO said the Dietary Manager was responsible for ensuring kitchen sanitation. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/09/2024 at 2:40 p.m., the Dietary Manager said she would have to remove and replace the iron skillets after the Friday menu items of fish. The Dietary Manager said the pans could not be cleaned and could make someone ill. The Dietary Manager said she would have to ensure the juice machine was clean to prevent dust from getting in the drinks. Record review of the General Kitchen Sanitation policy dated October 1, 2018 indicated the facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All Nutrition and Food service employees will maintain clean, sanitary kitchen facilities in accordance with the state and US Food Codes in order to minimize the risk of infection and food borne illness 3. Keep food-contact surfaces of all cooking equipment free of encrusted grease deposits and other accumulated soil. Record review of the Food Code dated 01/18/23 and accessed online at www.fda.gov/[NAME]/164194 on 5/13/2024 revealed: 4-101.11 Characteristics Material that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be: A). Safe, B). Durable, corrosion-resistant, and non-absorbent . D). Finished to have a smooth, easily cleanable surface 4-101.12 Cast Iron, Use Limitation. (A) Except as specified in (B) and (C) of this section, cast iron may not be used for UTENSILS or FOOD-CONTACT SURFACES of EQUIPMENT. (B) Cast iron may be used as a surface for cooking. (C) Cast iron may be used in UTENSILS for serving FOOD if the UTENSILS are used only as part of an uninterrupted process from cooking through service.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review, the facility failed to ensure the medical record was complete and accurately documented for 1 of 22 residents (Resident #10) reviewed for resident records. The facility failed to accurately update Resident #10's comprehensive care plan with her code status. This failure could affect residents of the facility by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, psychosocial outcome and inaccurate medical records. Findings included: Record review of Resident #10's face sheet dated [DATE], indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included Alzheimer's (a progress disease that destroys memory and other important mental functions), atrial fibrillation (irregular often rapid heart rate that commonly causes poor blood flow), depression (persistent depressed mood), and anxiety. Record review of Resident #10's significant change in status MDS assessment dated [DATE], indicated Resident #10 was usually understood and usually understood others. The MDS assessment indicated Resident #10's BIMS score was a 5, which indicated her cognition was severely impaired. Record review of Resident #10's comprehensive care plan dated [DATE], indicated Resident #10 was a full code CPR order in place. The care plan interventions indicated to review medical record to ensure that proper documents were signed. Record review of Resident #10's physician order report dated [DATE]-[DATE], indicated Resident #10 had an order for code status DNR (do not resuscitate) with a start date of [DATE] . Record review of Resident #10's Out of Hospital Do-Not-Resuscitate (OOH-DNR) order indicated Resident #10's family member had signed the order on [DATE] and was notarized. The OOH-DNR order indicated the physician had signed the order on [DATE]. During an interview on [DATE] at 3:50 PM, the DON said Resident #10 comprehensive care plan should have been updated to indicate her code status had changed from full code to DNR whenever they received the order for DNR. The DON said nurse leadership was responsible for updating the care plans. The DON said failure to update Resident #10's care plan could place Resident #10 at risk for receiving CPR. The DON said that was not something they would have want to happen since Resident #10 had a DNR. During an interview on [DATE] at 05:23 PM, the Regional Clinical Consultant said she expected the care plans to updated timely. The Regional Clinical Consultant said Resident #10's care plan should have reflected the updated code status so plan of care was appropriate. The Regional Clinical Consultant said nursing leadership was responsible for updating the care plans. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Care Plan dated ,d+[DATE], indicated . It is the policy of this home that staff must develop a comprehensive care plan to meet the needs of the resident .10. To update the resident care plan . changes and dated on problems per home policy . if the entry must be changed significantly, the plan will look neater if the entry is lined out and reference made to the new entry .the resident care plan is the tool used to coordinate all care provided to the resident to be sure care is necessary, appropriate and planned to meet the individual needs of the resident consistent with the physicians plan of care for the resident .the resident care plan must be kept current at all times .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure the quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 2 of 3 residents (Resident #40 and Resident # 18) reviewed for hospice services. The facility failed to maintain Resident #40's hospice binder containing information related to hospice services provided for the resident. The facility failed to obtain Resident #18's most recent hospice plan of care. These deficient practices could place residents who receive hospice services at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. The findings included: 1. Record review of Resident #40's face sheet, dated 05/07/24 indicated he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease {COPD}(a chronic inflammatory lung disease that causes obstructed airflow from the lungs), Congestive heart failure(CHF), or heart failure, (a long-term condition in which your heart can't pump blood well enough to meet your body's needs), dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), hypertension (high blood pressure), and Diabetes Mellitus (a group of diseases that affect how the body uses blood sugar (glucose). Record review of Resident 40's admission MDS assessment, dated 03/22/24, indicated Resident #40 was usually understood and usually understood by others. Resident #40 BIMs score was a 05 indicating he was cognitively moderately impaired. The MDS indicated Resident #40 required assistance with his ADLs. The MDS indicated he was receiving hospice service. Record review of Resident 48's Physician order dated 03/15/24 revealed Resident #40 was admitted to hospice with a diagnosis of COPD. Record review of Resident #40's comprehensive care plan, dated 03/18/24, revealed Resident #40 was admitted to hospice for a diagnosis of COPD. The intervention was staff would notify the hospice of any changes, the staff would coordinate care with the hospice, staff would monitor for signs or symptoms and the effectiveness of medication/ and monitor for relief. Record review of Resident #40's hospice binder could not be located. (continued on next page)

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	675812	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Pines Nursing and Rehab	910 S Beech St Winnsboro, TX 75494

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24 at 2:00 p.m., RN G said he could not locate Resident #40's binder. He said he would reach out to hospice for them to bring him a binder. He said the hospice book was a way of communication between the hospice and the facility to manage Resident #40's care. He said the book contained his diagnosis, care plan, and medication list. He said it was also important for documentation if the nurses or aides had concerns during their visits. During a phone interview on 05/09/24 at 4:19 p.m., Hospice RN J said it was the responsibility of the nurses to drop off the hospice updates when they visited the residents. She said she could not say why Resident #40 book was not at the facility. She said Resident #40 had a hospice aide three times a week and a nurse once a week. She said Resident #40 was due to have his recertification on 05/22/24. She said Resident #40 had his last hospice bi-weekly meeting on 05/06/24. She said it was important to have the hospice binder in the facility to help correlate with care. She said she would bring him a binder today (05/09/24). During an interview on 05/09/24 at 6:39 p.m., the DON said the hospice company was responsible for ensuring the hospice book was in the facility and updated. She said the books were utilized for communication between the hospice company and the facility on Resident #40's care. She said she was made aware the hospice book for Resident #40 could not be located. She said it was important to have the hospice binder at the facility for continuity of care. 46928 2. Record review of Resident #18's face sheet dated 05/09/24, indicated a [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #18 diagnoses included senile degeneration of brain (mental deterioration), dysphagia (difficulty swallowing), protein calorie malnutrition (inadequate protein and calorie intake), anxiety and depression (persistent depressed mood). Record review of Resident #18's quarterly MDS assessment dated [DATE], indicated she was able to sometimes understand others and sometimes made herself understood. The MDS assessment indicated Resident #18 had a BIMS score of 2, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #18 received hospice care within 14 days of the look back period while a resident at the facility. Record review of Resident 18's comprehensive care plan last reviewed/revised on 03/18/24, indicated Resident #18 required hospice services as evidenced by terminal illness. The care plan interventions indicated to communicate with hospice when any changes were indicated in the resident's plan of care. Record review of Resident #18's hospice binder indicated the last hospice plan of care update report was dated 03/15/24. The hospice plan of care did not indicate Resident #18 had orders for Xanax or acetaminophen as it indicated on Resident #18's facility physician order report. Record review of Resident #18's physician order report dated 05/01/24-05/09/24, indicated she had the following orders: *Admit to [hospice company] services for end-of-life care for senile degeneration of the brain with a start date of 03/19/24. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Xanax (antianxiety medication) 0.5mg twice a day with a start date of 03/26/24. *Acetaminophen 500mg give 2 tablets every 4 hours as needed for pain/fever 100.9 or greater with a start date of 03/07/24. During an interview on 05/09/24 at 11:53 AM, the Hospice DON said they tried to send updated hospice care plans after every IDG meeting or monthly. The Hospice DON said Resident #23's last plan of care should have been updated at the end of March 2024. The Hospice DON the Hospice Case Manager was responsible for ensuring Resident #18 had the most recent plan of care at the facility. The Hospice DON said it was important for the most recent hospice plan of care to be at the facility so facility staff could see if there has been any medication changes or updates to the plan of care. The Hospice DON said the office manager printed the current hospice plans of care so the hospice staff could deliver to the facility and update the hospice binder. The Hospice DON said it was ultimately the responsibility of the Hospice Case Manager to ensure that was being done. During an interview on 05/09/24 at 12:05 PM, the Hospice Case Manager said they had IDG meetings every 2 weeks, and they usually updated the hospice binder after the IDG meeting or at the end of the month. The Hospice Case Manager said they had been pretty behind in getting those updated care plans to the facility. The Hospice Case Manager said she was responsible for ensuring the hospice binders at the facility were kept up to date. The Hospice Case Manager said it was important for keeping the updated plans of care so facility could be aware of any changes to the plan of care. During an interview on 05/09/24 at 3:50 PM, the DON said she expected the hospice to keep their binders or paperwork to be up to date. The DON said the plan of care changes all the time and there needs to be updated documentation in the resident's medical record for coordination of care. The DON said not having the updated plan of care Resident #18 was at risk for not receiving the right meds or the right care. The DON said the hospice company was responsible for ensuring the hospice paperwork is up to date. During an interview on 05/09/24 at 4:36 PM, the Regional Director said he expected the hospice provider to be updating notes, status updates, and any order changes in the resident's hospice binder. The Regional Director said he was unsure of when the hospice plan of care should be updated but not keeping them updated was lack of coordination of care. During an interview on 05/09/24 at 10:16 AM, the DON said they did not have a policy on hospice services .

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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** 45810 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 22 residents (Resident #14, Resident #17) and laundry services reviewed for infection control practices. 1. The facility failed to ensure Resident #14's catheter bag was not touching the floor. 2. The failed to ensure CNA H wiped correctly and performed hand hygiene while providing incontinent care for Resident #17. 3. The facility failed to ensure laundry staff handled infectious laundry using the appropriate PPE. 4. The facility failed to ensure soiled laundry was transported to prevent the spread of infection. These failures could place residents and staff at risk for cross contamination and the spread of infection. Findings included: 1.Record review of a face sheet dated 05/09/2024 indicated Resident #14 was an [AGE] year-old female who readmitted on [DATE] with diagnosis including encounter for surgical aftercare - surgery on skin and subcutaneous tissue, urinary tract infection, schizoaffective disorder (is a mental health disorder combined with hallucinations, depression, mania and psychosis), gastro reflux (a digestive disease in which stomach acid or bile irritates the food pipe lining), dysphagia (difficulty swallowing), gastrostomy status (an opening in the stomach from the abdominal wall made surgically for the introduction of food), parkinsonism (a disorder of the central nervous system that affects movement, often including tremors), hypertension (condition in which the force of the blood against the artery walls is too high), dementia (a general decline in cognitive abilities. Record review of the most recent comprehensive MDS dated [DATE] indicated Resident #14 usually made herself understood and usually understands. Resident #14 had a BIMS (brief interview for mental status) score of 9 which indicated Resident #14 was moderately cognitively impaired. The assessment indicated Resident #14 did not reject care necessary to achieve the resident's goals for health or well-being. The MDS indicated Resident #14 required total dependence with bed mobility, transfers, dressing, toileting, personal hygiene, bathing and beating. Record review of the care plan revised on 05/07/2024 indicated Resident #14 required an indwelling urinary catheter with interventions of assess drainage - record the amount, type, color and odor. Avoid lying on tubing. Do not allow drainage tube to touch the floor. Position bag below the bladder. Store the collection bag inside a protective dignity cover. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the physician order dated 02/02/2024 indicated Resident #14 has a foley catheter for urinary retention as follows: During an interview and observation on 05/06/2024 at 9:57 a.m., Resident #14 was lying in bed asleep and was non-interview able. Resident #14's indwelling foley catheter urinary bag was laying on the floor. During an observation on 05/06/20241 at 12:00 p.m., Resident #14's indwelling foley catheter urinary bag was laying on the floor. During an observation on 05/06/2024 at 1:47 p.m., Resident #14's indwelling foley catheter urinary bag was laying on the floor. During an observation on 05/06/2024 at 3:15 p.m., Resident #14's indwelling foley catheter urinary bag was laying on the floor. During an interview on 05/06/2024 at 2:39 p.m., CNA H said Resident #14's indwelling foley catheter urinary bag should not had been laying on the floor. CNA H said Resident #14 could get an infection from the dirty floor contaminants. CAN H said she had not noticed the urinary bag on the floor in Resident #14's room. CNA H said she was assigned to Resident #14. CNA H said everyone was responsible to prevent infections. During an interview on 05/07/2024 at 2:02 p.m., LVN F said Resident #14's indwelling foley catheter urinary bag should not had been laying on the floor. LVN F said Resident #14 was under her care and hall and she had not noticed the urinary bag laying on the floor. LVN F stated that the urinary catheter bag being laid on the floor could place Resident #14 at a high risk for cross contamination. During an interview on 05/09/2024 at 4:07 PM, the DON said the urinary drainage bag should not by on the floor. The DON said staff should ensure the bags are keep below the bladder but not on or touching the floor. The DON said this these places the resident at risk of infection due to cross contamination. The DON said all staff were responsible for preventive measure for the health and wellbeing of the residents. The DON said the charges nurses should monitor the residents to ensure the urinary bags are correctly placed. 45879 2.Record review of Resident #17's face sheet, dated 05/07/24, indicated a [AGE] year-old female who was admitted to the facility on [DATE]with the diagnoses which included anxiety (a feeling of fear, dread, and uneasiness, Dementia (loss of memory), and depression(sadness). Record review of Resident #17's quarterly MDS assessment, dated 01/31/24, indicated Resident #17 was sometimes understood and rarely understood by others. Resident #17's BIMS score was 08, which indicated he was cognitively moderately impaired. The MDS did indicate Resident #17 had short and long-term memory problems. The MDS indicated Resident #17 required total assistance with bathing, toileting bed mobility, dressing, personal hygiene, transfers, and eating. The MDS indicated she was always incontinent of bowel and bladder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #17's care plan dated 05/12/23 indicated Resident #17 was incontinent of bowel and bladder. The interventions were for staff to change her clothes and linen as needed, provide incontinent care as needed, and notify the physicians of any concerns. During an observation on 05/06/24 at 12:48 p.m., CNA H was performing incontinent care on Resident #17 who was incontinent of urine and had a bowel movement. She cleaned her peri area using the same wipe using a front-to-back and back-to-front motion. She then turned Resident #17 on her left side while touching her skin with the same dirty gloves on. CNA H then wiped Resident #17's buttock with a wipe using front-to-back and back-to-front motion with the same wipe which contained bowel. CNA H grabbed a clean brief without changing her gloves or hand hygiene and applied it to Resident #17. CNA H then turned Resident #17 on her back and pulled up the covers with the same dirty gloves. CNA H then gathered her equipment and performed hand hygiene. During an interview on 05/06/24 at 12:48 p.m., CNA H said she did not realize she did not perform hand hygiene or change her gloves before turning or touching Resident #17's skin, covers, or clean brief. She said she did not realize she wiped in a front-to-back and back-to-front motion. She said you should wipe front to back only. She said she knew without hand hygiene she could spread infection. She said she had been trained on infection control and peri care but could not remember how long ago it was. During an interview on 05/09/24 at 6:39 p.m., the DON said she expected the CNA to perform peri care correctly. She said staff should change their gloves between clean and dirty and use hand hygiene. She said nurse management was responsible for ensuring staff knew how to perform peri care and handwashing correctly. The DON said failure to do appropriate incontinence care and handwashing could cause infections. 33249 5.During an observation and interview on 5/06/2024 at 11:54 a.m., Laundry staff L indicated she was unaware of any resident linen that required special handling at this time. Laundry staff L when asked about appropriate PPE to use with special linen she could not provide goggles/shield for eye protection. Laundry staff L said she had never seen any eye protection equipment in the laundry department. During the interview the Housekeeping Supervisor approached and indicated she was unaware of any special linen needs at present time, and she was not aware eye protection was needed for laundry handling. During an observation and interviews on 5/08/2024 at 9:55 a.m., Laundry staff L was walking down Zone 5 hallway with a large rolling gray garbage can filled and overflowing by a foot high of exposed dirty linen. Laundry staff L was pushing the barrel with her bare hands. When asked about the transport of dirty linen in the manner laundry staff L said she was unaware this method was not appropriate for infection control purposes. During an interview with the Housekeeping Supervisor who approached her staff member said, you know I have told you this was not the way to handle the linen. The Housekeeping Supervisor said she had multiple in-services on the handling of linen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/09/2024 at 12:00 p.m., the DON said she expected hand hygiene was to be completed when removing gloves, in between residents' medication administration and the provision of meal trays. The DON said when hand hygiene was to performed infections could increase. The DON said she was not aware the facility disinfectant was not effective for a disinfectant for clostridium difficile. The DON said the infection preventionist had most of the role of ensuring prevention of infections. The DON said the IP was on leave at the present time. During an interview on 5/09/2024 at 1:05 p.m., the RDO said he expected the facility to sanitize for clostridium difficile accordingly. The RDO said once he found out the chemical Room Sense 200 was not effective for sanitization of clostridium difficile he implemented the use of bleach water 1:10 ration according to CDC guidelines. The RDO said he expected the staff to be in-serviced on the spread of infections through in-servicing and continuing educations. The RDO said the DON and Infection preventionist were responsible for random return demonstrations and monitoring for prevention of infections. During an interview on 5/09/2024 at 3:00 p.m., RN B said she expected all staff to perform hand hygiene between each resident to prevent the spread of infection. During an interview 05/09/2024 at 4:07 p.m., the DON said dirty and soiled laundry should not be transported out in the open due to the risk of infection and cross contamination. The DON said she expected the clean linens and residents' clothing to be distributed per the proper protocol per housekeeping, but she had not been employed long enough at the facility to give an accurate answer. The DON said and she expected all staff to ensure infection preventives were utilized daily to protect the residents' health and wellbeing by proper handwashing, bagging and transporting soiled linen in closed containers, using PPE appropriately and properly. The DON said she and the ADON were responsible for infection control education. 30527 6. During an observation and interview on 05/06/2024 at 11:19 am., Laundry staff L was seen in the hall of zone 5 pushing an uncovered laundry cart that had clean clothes exposed. Laundry staff L said she covered the laundry cart while she transported it from the laundry building outside, but once she entered the facility, she was not required to cover the laundry cart while she delivered to the residents. During an observation on 05/07/2024 at 12:31 pm, Laundry staff L was seen in the hall of zone 8 pushing an uncovered laundry cart that had clean clothes exposed. During an observation on 05/07/2024 at 3:38 pm, Laundry staff L was seen in the hall of zone 2 pushing an uncovered laundry cart that had clean clothes exposed. During an observation on 05/08/2024 at 12:37 pm, Laundry staff L was seen in the hall of zone 2 pushing an uncovered laundry cart that had clean clothes exposed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview 05/09/2024 at 4:07 p.m., the DON said dirty and soiled laundry should not be transported out in the open due to the risk of infection and cross contamination. The DON said she expected the clean linens and residents' clothing to be distributed per the proper protocol per housekeeping, but she had not been employed long enough at the facility to give an accurate answer. The DON said and she expected all staff to ensure infection preventives were utilized daily to protect the residents' health and wellbeing by proper handwashing, bagging and transporting soiled linen in closed containers, using PPE appropriately and properly. During an interview on 05/09/2024 at 4:45 pm, the Housekeeping Supervisor said she had worked at the facility for over 2.5 years and had no policies regarding linens distribution and dirty laundry services. The Housekeeping Supervisor said she had educated the laundry aides and expected the staff to keep the clean laundry covered while transported it from the laundry building outside and required to cover the laundry cart of clean clothing while delivered to the residents to prevent cross contamination. Record review of an In-service Training Report dated 3/21/2024 indicated there was an in-service on the completion of resident meals before chemicals and cleaning begins. The in-service failed to include handling of linen. Record review of a Disinfectant data labeling (Room Sense 200) failed to indicate the effectiveness in the spread of clostridium difficile in the areas of bactericidal, mildew stat, fungicidal, or virucidal. Record review of the facility policy Incontinent Care/ Perineal Care with or without a catheter effective 12/2017 indicated: Policy It is the policy of this home to provide incontinent care to residents in a manner in which provides privacy, promotes dignity and ensures no cross contamination. Procedure 1. Beginning steps a. Wash hands. Wear gloves and follow standard precautions if contact with blood or body fluids is likely .3. If resident heavily soiled with feces, turn resident on side .Discard soiled gloves along with soiled brief and or wipes wash hands with soap and water .5. Sanitize hands and put on gloves. 6. Proceed with perineal care . Record review of the facility policy Medication -Administration effective 12/2017 indicated: Policy It is the policy of this home that medications will be administered and documented as ordered by the physician and in accordance with state regulations. Procedure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Medications are prepared, administered, and recorded only by licensed nursing, certified medication aides, medical, pharmacy, or other personnel authorized by state laws and regulations to administer medications .EYE DROPS/OINTMENT ADNIBISTRATION .3. Cleanse hands .7. Wipe excess medication from around the eye with tissue if needed .10. Wash hands .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy and providing written rationale, by the provider, when an antibiotic Zithromax was used despite criteria, to determine the appropriate use of an antibiotic for 1 of 6 residents (Residents #44) reviewed for antibiotic use. The facility failed to ensure Resident #44 had documented signs and symptoms and diagnosis to support the use of prescribed antibiotic Zithromax. This failure could place residents receiving antibiotics at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased antibiotic-resistant infections. Findings included: Record review of Resident #44's face sheet dated 05/08/24, indicated a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #44 had diagnoses of metabolic encephalopathy (problems with the metabolism that causes brain dysfunction), dementia (memory loss), history of diabetic foot ulcer (an open sore or wound on the foot that develop in patients type 1 or type 2 diabetes), and type 2 diabetes mellitus (long-term condition in which the body has trouble controlling blood sugars and using it for energy). Record review of Resident #44's annual MDS assessment dated [DATE], indicated he was usually understood and understood others. The MDS assessment indicated Resident #44 had a BIMS score of 10, indicating his cognition was moderately impaired. Record review of Resident #44's physician order report dated 05/01/24-05/08/24 did not indicate the order for the antibiotic Zithromax since medication had been completed. Record review of Resident #44's comprehensive care plan on 05/09/23, did not address the antibiotic Zithromax since Resident #44 was no longer taking it. Record review of Resident #44's skilled nurses note dated 04/25/24, indicated Resident #44 did not have a fever, cough, or an upper respiratory infection. The nurses note indicated . New order: Zpak (Zithromax) + Medrol pack. The note did not indicate the signs or symptoms Resident #44 was having to warrant the use of the antibiotic. Record review of Resident #44's progress note dated 04/26/24 at 01:57 PM, indicated . the resident has not had any cough today. Lungs are clear to auscultation . Record review of Resident #44's progress note dated 04/27/24 at 12:20 AM, indicated . no cough or congestion heard at this time. Record review of Resident #44's progress note dated 04/28/24 at 12:21 AM, indicated . no cough or congestion heard at this time. (continued on next page)

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #44's medication administration history dated 04/01/24- 04/30/24, indicated he had received Zithromax 250mg 2 tablets on 04/26/24 and Zithromax 250mg one tablet from 04/27/24-04/30/24 . During an interview on 05/09/24 at 3:26 PM, RN B said Resident #44 started a Zpak on 4/25/24 because he was having a cough, congested and symptoms of respiratory infection. RN B reviewed Resident #44's progress notes and she said Resident #44's progress notes did not indicate he was having symptoms of URI and said it should have been documented. RN B said the nurse that spoke with the physician and obtained the order was responsible for documenting findings that warranted the use of the antibiotic Zithromax. During an interview on 05/09/24 at 3:50 PM, the DON said Resident #44 should have had documentation in the progress notes if he was having any symptoms that warranted the use of the antibiotic Zithromax. The DON reviewed Resident #44's order and said Resident #44 started the antibiotic for a cough but there was no other solid documentation Resident #44 as to why Resident #44 started the antibiotic Zithromax. The DON said they should have documented signs and symptoms along with MD notification and follow up orders. The DON said the nurse who notified the MD was responsible for ensuring documentation for the antibiotic use. The DON said since there was no documentation regarding the need for antibiotic Resident #44 was a risk for receiving an unnecessary medication. The DON said they followed the antibiotic stewardship process. The DON said the ADON was the infection preventionist and was responsible for monitoring the antibiotic stewardship program at the facility. The DON said the ADON was on leave. During an interview on 05/09/24 at 04:36 PM, the Regional Director said if a resident was having signs and symptoms that warranted an antibiotic, a call to the physician should be made and an assessment completed. The Regional Director said not having proper documentation could place the resident at risk of an unwarranted order. The Regional Director said nurse management was responsible for ensuring proper documentation was in place and monitoring the antibiotic stewardship program at the facility. Record review of the facility's policy titled, Antibiotic Stewardship, dated 12/01/18, indicated . The facility will establish a multidisciplinary antimicrobial stewardship program (ASP) that defines and provides guidance for optimal antimicrobial use 5. When facility staff suspects a resident has an infection, the nurse should perform and document a complete assessment of the resident using established and accepted assessment protocol to determine if the resident status meets minimum criteria for initiating antibiotics. This facility uses McGreers Criteria for Initiation of Antibiotics in Long-Term Care Residents . 45810