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	06/25/2025

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

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs, for 1 of 5 (Resident #53) residents reviewed. The facility failed to care plan Resident #53's JP, also called a Jackson Pratt drain (a surgical suction drain that gently draws fluid from a wound to help you recover after surgery). This failure could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. The findings included:Findings included:1. Record review of Resident #53's face sheet, dated 06/25/25, indicated an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included Chronic kidney disease, also called chronic kidney failure (involves a gradual loss of kidney function), malignant neoplasm of kidney (a cancerous tumor in the kidney) diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and high blood pressure.Record review of Resident #53's admission MDS assessment, dated 04/21/25, indicated Resident #53 understood others and was understood by others. The MDS assessment indicated he had a BIMS score of 13, indicating he was cognitively intact. Resident #53 required assistance with bathing, toileting, dressing, bed mobility, personal hygiene, and eating. The MDS did not indicate the JP drain. Record review of Resident #53 's physician orders dated 04/19/24 indicated to empty the JP drain and document any drainage each shift and as needed. Record review of Resident #53 's physician orders dated 04/21/24 indicated to cleanse JP drain insertion site with normal saline and apply a gauze dressing; changed dressing every shift and as needed.Record review of Resident #53 's physician orders dated 04/21/24 indicated to monitor JP drain site for signs of infection: redness, swelling, warmth, purulent drainage (a thick, opaque, and often yellow or greenish fluid that indicates a wound infection), or fever. Notify the physician of any concerns.Record review of Resident#53's care plan, revised date of 05/15/25, did not indicate he had a JP drain. During an observation and interview on 06/23/25 at 11:24 a.m., Resident #53 was in his bed. Resident #53 had a JP drain on his right side. He said he had the JP drain since his admission.Record review of Resident #53 's care plan dated 06/24/25, after the surveyors' intervention indicated Resident #53 had a JP drain. The interventions were for staff to clean and treat the site as ordered and as needed .During an observation and interview on 06/24/25 at 2:57 p.m., the MDS coordinator looked at Resident #53's care plan and said she did not see the care plan for his JP drain. She said she was aware he had a JP drain and was not aware why it had not been care planned. The MDS coordinator said she and the IDT worked together to do the care plans. She said it was important to care plan the residents' care needed. She said she would care plan his JP drain. During an interview on 06/25/25 at 3:05 p.m., the DON said the MDS coordinator was responsible for completing the care plans. She said each IDT member was responsible for the acute care plans (IE: the treatment nurse did wounds, ADON did infections, and the DON did falls). The DON said she was unaware that Resident #53's JP drain was not care planned. She said the care plan painted a picture of the care the resident should receive. During an interview on 06/25/25 at 3:31 p.m., the Administrator said all disciplines should work together to complete a resident's care plan, but the MDS nurse was the overseer. He said Resident #53 was at risk of an infection if his JP drain was not cared for correctly. He said care plans were generated to provide each resident with the best care.Record review of the facility policy titled Care plans, Comprehensive Person-Centered, dated 12/2017, indicated Policy Statement: It is the policy of this home that staff must develop a comprehensive care plan to meet the needs of the resident. Plan: #6c. Individualize care to ensure the care plan is person-centered for the unique needs of the resident. 12. Resident Care Plan Documentation and Use of The Plan: C. The resident care plan must be always kept current.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 21 residents (Resident #170) reviewed for supervision.The facility failed to ensure Resident #170 eloped (via foot) from the facility to a local energy service company (0.7 miles) on the night of 06/13/25 at 7:45 PM. Resident was found 4 1/2 hours later at 12:24 am on 6/14/25.The noncompliance was identified as PNC. The IJ began on 6/13/25 and ended on 6/14/25. The facility had corrected the noncompliance before the survey began.This failure could place residents at risk for injuries due to not receiving the appropriate level of supervisionFindings included:Record Review of profile sheet dated 6/24/25 at 12:20 p.m., indicated, Resident #170 was diagnosed with dementia without behavioral disturbance (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life).Record Review of Resident #1's care plan, dated on 06/13/25, indicated Resident #170 resided in the secure unit related to risk for elopement. The care plan goal included: Safety will be maintained, and resident will wander about unit without the occurrence of any injury through the next review date. The care plan interventions included: Activity Director to monitor/discuss activity preferences; Call by name when providing care, involve in care as much as possible; Explain procedures, using terms/gestures resident can understand-repeat PRN; Keep environment free of possible hazards and Monitor to assure resident safety.Record Review of observation detail report on Resident #170 dated on 6/13/25 at 0027 indicated, Resident #170 had a history of wandering prior to admission; resident exhibits wandering behavior; resident had (1) or more occasions attempted to exit or had exited the facility in a effort to wander away; resident follows others around, if someone exits the facility the resident will follow; resident had a medical diagnosis associated with confusion; resident experienced increased confusion, occurring with high risk factors; resident exhibits behavior typical boredom, (1) goes to door, turns doorknob, but does not exit (2) walks to window and gazes outside,(3) wanders into other resident or facility rooms to observe and or engage in conversation with other residents and or staff members, etc. The observation report indicated the potential interventions included the secure unit. The observation report indicated the safety awareness: resident recognized stop lights and signs; resident knew precautions when crossing the street; resident can state name; resident did not know the location of current residence; resident physical needs.Record Review of progress Note from LVN G dated 6/13/25 at 7:54 pm indicated, Resident #170, Resident up walking in common area adjusting well to surroundings makes needs known denies pain or discomfort.Record Review of Event report dated 6/13/25 at 10:30 pm indicated, resident was located approximately 1 mile from the facility at 0024; Possible contributing factors: Alzheimer's Disease, Dementia, and terminal illness; Unsettled relationships: Absence of personal contact with family/friends and does not adjust easily to change in routine; Inventions: Resident was taken back home with family.Record Review of a typed note by the Administrator dated on 6/13/25 at 10:30 pm indicated, Notifications were made to the medical director, Administrator, DON, Hospice company, LTC management team and family members. Record Review of the EMS report on Resident #170 on 6/14/25 at 0029 indicated, Resident #170 did not need treatment or transport. EMS released the resident to resident #170's family member.Record Review of progress note from RN H on 6/14/24 at 1:15 am indicated, Writer was notified by charge nurse at approximately 20:30 resident could not be located within secured unit, or facility. Facility grounds and surrounding areas searched. Unable to locate resident. Local police department contacted for assistance. Family and hospice company, MD contacted. Resident located off facility property at approx. 00:24. Head to toe assessment completed by local fire department with 0 injuries or skin concerns reported to writer. Resident ambulating, talking with 0 concerns visualized. Family along with local police department retuned resident to facility, family gathered medications and belongings and resident was discharged into family care at this time. Hospice and MD aware.Record review of provider self-reporting of LTC incident dated 6/14/25 at 12:52 pm indicated, this incident occurred on 6/13/25 at 8:30 pm regarding a missing Resident #170. The report indicated at approximately 2021 on June 13, 2025, the director of nursing notified the Administrator that a resident was unaccounted for and potentially missing from the facility. The Administrator immediately contacted the corporate team and instructed all departmental staff to return to the facility to assist in a coordinated search effort. The report indicated immediate facility actions taken elopement risks assessments were reviewed and updated; abuse and neglect in-services provided to all staff; elopement prevention and response in service training was conducted; Notification made;

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents requiring respiratory care were provided such care, consistent with professional standards of practice for 1 of 2 residents reviewed for respiratory care (Residents #1).The facility failed to ensure Resident #1's oxygen filter was in the back of the concentrator.This failure could place residents who require respiratory care at risk for respiratory infections and exacerbation of respiratory disease.Findings Included:Findings Included:Record review of Resident #1's face sheet dated 06/25/25 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses heart failure, personal history of COVID, altered mental status, anxiety, and high blood pressure. Record review of Resident #1's quarterly MDS dated [DATE] indicated she made herself understood and was able to understand others. The MDS also indicated she had a BIMS score of 3 which indicated she had severely impaired cognition. The MDS also indicated she used oxygen while she was a resident. Record review of Resident #1's care plan dated 11/12/24 indicated she had and ADL selfcare deficit related to impaired cognition and impaired mobility with interventions for staff to provide supervision and assist resident to the bathroom when needed, provide supervision ad assist with transfers as needed, and provide moderate assistance with showers 3 times a week. The care plan also indicated Resident #1 had oxygen therapy with a goal for resident to have no signs and symptoms of poor oxygen absorption and interventions to provide oxygen per MD orders and monitor for signs and symptoms of respiratory distress. Record review of Resident #1's physician order report dated 05/25/2025-06/25/2025 indicated she had an order for:Oxygen: Change oxygen tubing, bubble humidification, and clean filters in use Q week. Once a day on Sunday night shift 22:00-06:00(10:00pm-6:00 am) with a start date 08/15/2022 and no end date. Record review of Resident #1's respiratory administration history dated 06/01/2025-06/25/2025 indicated LVN K signed off as completing the order:Oxygen: Change oxygen tubing, bubble humidification, and clean filters in use Q week. Once a day on Sunday night shift 22:00-06:00(10:00pm-6:00 am) on 06/22/25. During an observation and interview on 06/23/25 at 11:25 AM Resident #1 was sitting in her room and had an oxygen concentrator beside her bed that did not have a filter in it. Resident #1 said she used her oxygen every night. During an observation on 06/24/25 at 08:40 AM Resident #1's oxygen concentrator in her room had no filter. During an observation on 06/25/25 at 08:15 AM Resident #1's oxygen concentrator in her room had no filter. During an observation and interview on 06/25/25 at 03:39 PM Resident #1's oxygen concentrator in her room had no filter and LVN L said the oxygen filters and the tubing were changed out by night shift nurse on Sundays. LVN L said there should have been a filter in the concentrator. She said the failure placed Resident #1 at risk infection because the filter was used to block dirt, bacteria, and trash from going into her nasal cavity. During an interview on 06/25/25 at 03:53 PM the DON said her expectation was for the oxygen concentrator filter to be in place and clean. The DON said the night shift nurses were responsible for changing the tubing and cleaning the filters on Sundays. The DON said the failure placed a risk is for the oxygen concentrator not working properly and placed a risk for infection. During an interview on 06/25/25 at 04:03 PM the Administrator said he expected the staff to be properly trained and for nurses to inspect and change the oxygen concentrator tubing and filters He said the floor nurses should ensure the filters were replaced correctly and working properly. The Administrator said the DON as well as the floor nurses were responsible for ensuring the oxygen concentrators were clean and operating properly. The Administrator said the failure placed Resident #1 at risk of contamination. During an attempted call on 06/25/25 at 04:19 PM LVN K (the night nurse who signed the order for cleaning the oxygen filter as completed) did not answer. Record review of the facility policy Respiratory Therapy Equipment dated 12/2017 indicated:POLICYIt is the policy of this home that residents on respiratory therapy will have appropriate treatment. Only trained licensed staff will administer respiratory therapy. Respiratory equipment used to provide therapy will be maintained appropriately.PROCEDUREOxygen Administration1. Obtain equipment (i.e., oxygen tubing, reservoir, and distilled water) .9. Wash filters from oxygen concentrators every 7 days in soapy water. Rinse and squeeze dry .

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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. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 3 residents (Resident #15) reviewed for trauma-informed care. The facility did not ensure Resident #15's care plan had specific triggers for his diagnosis of PTSD, also known as post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). Resident #15 had a history of trauma.This failure could put residents at an increased risk for severe psychological distress due to re-traumatization.Findings included:Record review of Resident #15's face sheet, dated 06/25/25, indicated Resident #15 was a [AGE] year-old male, re-admitted to the facility on [DATE] with diagnoses which Post-traumatic stress disorder also known as PTSD (a mental health condition that can develop after a person has experienced or witnessed a traumatic event), Parkinson (a progressive neurological disorder that primarily affects movement, but also has non-motor symptoms), and depression(sadness).Record review of Resident #15's quarterly MDS, dated [DATE], indicated Resident #15 usually understood others and made himself understood. Resident #15 had a BIMS score of 09, which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #15 had a diagnosis of post-traumatic stress disorder. Record review of Resident #15's trauma assessment dated [DATE] indicated he had a history of trauma, PTSD, and physical assault.Record review of Resident #15's comprehensive care plan, dated 01/27/25, indicated Resident #15 had a diagnosis of PTSD, at risk for anxiety, hallucinations, irritability, difficulty sleeping, lack of interest in activities, and easily startled/frightened. The interventions were to administer medications per physician orders, provide extra time and address resident slowlyand calmly to attempt to decrease risk of startling resident.During an interview on 06/25/25 at 9:42 a.m., CNA N said she was Resident #15's aide and was not aware he had a diagnosis of PTSD or what his triggers were.During an interview on 06/25/25 at 9:48 a.m., LVN O said she was aware Resident #15 had PTSD but did not know his specific triggers. She said it was important to know if someone had trauma, triggers, and how to manage their triggers. She said they could have triggers from the war, military, or anything. She said staff should be aware of any triggers the resident had to be able to care for the resident.During an interview on 06/25/25 at 9:50 a.m., the Social Worker provided Resident #15's completed trauma assessment. She verified he had PTSD on his assessment. She said his triggers were loud noises and water. The Social Worker looked at Resident #15's care plan and did not see where his specific triggers were care planned. The Social Worker said PTSD/trauma and the triggers should be placed in the care plan by either her or the MDS Coordinator. The Social Worker said it was important to have Resident #15's triggers on the care plan so that staff were aware of his triggers.During an interview on 06/25/25 at 9:52 a.m., the MDS coordinator said the SW usually did the PTSD care plan. She said the care plan was implemented so that staff would know what triggers to look for. She looked at Resident #15's care plan and saw where he could be startled but did not specifically say loud noises or water. She said she would add to his care plan so staff would be aware.During an interview on 06/25/25 at 10:02 a.m., Resident #15 was lying in his bed. He said he had been in the Vietnam War, and his triggers were loud noises, war pictures, and water at times. He said it rained a lot during the war. During an interview on 06/25/25 10:52 a.m., the DON said she updated his care plan to reflect exactly what the trauma assessment said and did an in-service so that staff were aware of Resident #15's triggers. The DON did not provide the surveyor with the in-service given on Resident #15 triggers.During an interview on 06/25/25 02:53 p.m., the DON said they did not have a policy on trauma or informed care. During an interview on 06/25/25 at 3:05 p.m., the DON said the Social Worker was responsible for the trauma-informed assessments. She said the MDS coordinator was responsible for the comprehensive care plans. She said she expected the triggers to be on the care plan so that staff were aware of the triggers. She said if the triggers were not care planned, staff would not know the trigger and how to care for the resident.During an interview on 06/25/25 at 3:31 p.m., the Administrator said the care plan should reflect the assessment. He said the assessment should be done by the SW, and she should make sure the care plan matches. He said he should follow up to make sure the care plan and audits match. He said the trauma care plan should be specific to the resident's triggers, and if not, staff will not know what not to do or what could cause a trigger.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** BASED on interview and record review, the facility failed to ensure the drug regimen was free from unnecessary drugs for 1 of 21 residents reviewed for medications. (Resident #30)The facility failed to ensure Resident #30's Remeron (mirtazapine) (antidepressant medication) was decreased on 04/10/25 when the medical director signed the pharmacy recommendation and agreed to decrease the Remeron (mirtazapine) from 22.5mg to 15mg every night. This failure could place residents who received antipsychotic medications at risk of receiving unnecessary medication.Findings include:Record review of Resident #30's face sheet dated 06/25/25 indicated he was an [AGE] year-old male who re-admitted to the facility on [DATE] with the diagnoses Alzheimer's disease, diabetes mellitus, heart disease, depression, and anxiety. Record review of Resident #30's significant change MDS dated [DATE] indicated he usually makes himself understood and usually understood others. The MDS also indicated he had a BIMS score of 5 which indicated severely impaired cognition. The MDS also indicated Resident #30 was dependent on staff for transfers, bed mobility, bathing and eating. Record review of Resident #30's care plan dated 04/17/25 indicated he had potential for side effects related to psychotropic medication use (antipsychotic, antidepressant) with interventions in place for the pharmacy consultant to review medications periodically for possible reduction, and for the staff to administer medications for conditions as ordered.Record review of Resident #30's physician order report dated 05/25/25-06/25/25 indicated he had and order for:1.Remeron (mirtazapine) 15mg tablet oral to give with 7.5mg tablet to=22.5mg once a day at 18:00-22:00(6:00 PM-6:00 AM) with a start date of 06/11/24 and no end date.2.Mirtazapine 7.5mg tablet oral to give with 15mg tablet to=22.5mg once a day at 18:00-22:00(6:00 PM-6:00 AM) with a start date of 06/11/24 and no end date.Record review of Resident #30's note to attending physician/prescriber dated 03/30/25 indicated Resident #30 had been taking the antidepressant REMERON 22.5MG QD since 5/2024. The note to the attending physician/prescriber was signed in agreement by the MD with a rationale to decrease the Remeron (mirtazapine) from 22.5mg to 15mg every night. Record review of Resident #30's medication administration record dated 06/01/25-07/01/25 indicated Resident #30 continued to receive the Remeron (mirtazapine) 22.5mg dose every night until 06/25/25 after surveyor intervention. During an interview on 06/25/25 at 03:30 PM LVN M said she was not taking care of Resident #30 in April 2025, she was working in the locked unit. She said that by reading the order noted by the physician on the note to attending physician/prescriber dated 03/30/25 she would have changed the order for the Remeron (mirtazapine). During an interview on 06/25/25 at 03:51 PM the DON said she oversaw the process for the pharmacy recommendations. She said the charge nurses gets the signed orders and the nurse would be responsible for changing the orders and provide the signed note to the attending physician/prescriber to the DON for follow up to ensure the orders were completed. She said she just missed Resident #30's note to the attending physician/prescriber. The DON said the charge nurse possibly did not give the note to her after completing it to verify and ensure order was carried out. The DON gave Resident #30's signed note to attending physician/prescriber dated 03/30/25 to the ADON for the orders to be updated in the computer and told the ADON to notify the MD. The DON said the failure placed a risk for Resident #30 having improper doses of medication and unnecessary medications. During an interview on 06/25/25 at 04:07 PM the Administrator said his expectation was for the nursing staff to ensure gradual dose reductions from the pharmacy and nursing orders were followed. The Administrator said the failure placed a risk for Resident #30 but he was not exactly sure about what risk, but he said he expected the medication to be decreased as ordered. Record review of the facility policy Behavior Management-Psychoactive Medication-Antipsychotic Drug Therapy dated 12/2017 indicated:POLICYIt 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. DEFINITIONS1. 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 .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (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	06/25/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that it was free of medication error rate of 5 percent or greater. The facility had a medication error rate of 6.9%, based on 2 errors out of 29 opportunities, which involved 2 of 6 residents (Resident #66 and Resident #1) reviewed for medication administration.The facility failed to ensure LVN P administered Resident #66's medication of Omeprazole (a medication used to treat conditions involving excessive stomach acid production) correctly on 06-24-25.The facility failed to ensure LVN Q administered Resident #1's medication of fluticasone (a corticosteroid used to treat a variety of inflammatory conditions, primarily those related to allergies and asthma) correctly on 06-24-25.These failures could place residents at risk of not receiving therapeutic effects of their medications and possible adverse reactions.Findings included:1.Record review of a face sheet dated 06/25/225 indicated Resident #66 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included Coronary artery disease also known as CAD (a narrowing or blockage of your coronary arteries, which supply oxygen-rich blood to your heart), dementia (deterioration of memory, language, and other thinking abilities with behaviors), GERD or gastroesophageal reflux disease (a digestive disorder where stomach acid frequently flows back into the esophagus, causing irritation and discomfort). and high blood pressure. Record review of the admission MDS assessment dated [DATE] indicated Resident #66 understood others and was understood by others. The MDS assessment indicated Resident #66's BIMS score was a 12, which indicated his cognition was moderately impaired. Record review of Resident #66's Order Summary Report dated 04/21/25 indicated the following order: Omeprazole 20 mg tablet, delayed release; give: 2 tablets by mouth twice a day.Record review of Resident #66's June 2025 MAR indicated his Omeprazole 40mg was given on 06/24/25 by LVN P.Record review of Resident #66's care plan, last reviewed 05/21/25, indicated he had a diagnosis of GERD. The interventions were for staff to administer medications as ordered and monitor/document side effects and effectiveness.During an observation of medication administration on 06/24/25 starting at 8:24 a.m., LVN P administered one Omeprazole 20 mg but did not administer two 20mg tablets to equal 40 mg for Resident #66.During an attempted interview on 06/25/25 at 10:18 AM, LVN P did not answer the phone; a message was left.2. Record review of a face sheet dated 06/25/225 indicated Resident #1 was an [AGE] year-old female re-admitted to the facility on [DATE] with diagnoses which included heart failure also known as congestive heart failure(occurs when the heart muscle can't pump enough blood to meet the body's needs), dementia (deterioration of memory, language, and other thinking abilities with behaviors), GERD or gastroesophageal reflux disease (a digestive disorder where stomach acid frequently flows back into the esophagus, causing irritation and discomfort). and high blood pressure. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #1 usually understood others and was usually understood by others. The MDS assessment indicated Resident #1's BIMS score was 03, which indicated her cognition was severely impaired. Record review of Resident #1's Order Summary Report dated 04/21/25 indicated the following order:Flonase Allergy Relief (fluticasone) spray, suspension; 50 mcg; give 2 sprays; each nasal twice a day.During an observation of medication administration on 06/24/25, starting at 8:49 a.m., LVN Q administered one spray of fluticasone 50 mcg but did not administer two 50 mcg sprays to Resident #1.During an interview on 06/25/25 at 2:04 p.m., LVN Q said she should have given Resident #1 2 sprays to each nostril. She said she thought she gave 2 sprays, but looking back, she did not. She said she should have followed the physician's order. She said she was not aware how the resident would be effected if she did not receive 2 nasal sprays.During an interview on 06/25/25 at 3:05 p.m., the DON said she expected nurses to follow orders and give medication as ordered. She said she, the ADON, and the pharmacist monitored the nurses to ensure they were administering medications correctly by conducting periodic medication checkoffs. The DON said if medications were not administered per the doctors' orders, the problem or reason the medication was intended for was not going to be resolved. She said they did not have a policy on physicians' orders.During an interview on 06/25/25 at 3:31 p.m., the Administrator said he expected medications to be administered per the doctors' orders and for there not to be any mistakes. The Administrator said the DON and ADON were responsible for monitoring to ensure medication errors did not occur. The Administrator said medication errors could affect residents depending on the medication and why ordered.Record review of the facility policy titled, Medication Administrator, dated 12/2017, indicated, Policy: It is the policy of this home that medications will be administered and documented as ordered by the

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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** Based on observation, interview, and record review, the facility failed store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 21 residents reviewed in sample (Resident #1).The facility failed to ensure Resident #1 did not have hibliclens antiseptic skin cleanser (skin cleanser usually used in surgery to prevent skin infections) in her bathroom on the shelf.These failures could place residents at risk of injury.Record review of Resident #1's face sheet dated 06/25/25 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses heart failure, personal history of COVID, altered mental status, anxiety, and high blood pressure. Record review of Resident #1's quarterly MDS dated [DATE] indicated she made herself understood and was able to understand others. The MDS also indicated she had a BIMS score of 3 which indicated she had severely impaired cognition. The MDS also indicated she used oxygen while she was a resident. Record review of Resident #1's care plan dated 11/12/24 indicated she had and ADL selfcare deficit related to impaired cognition and impaired mobility with interventions for staff to provide supervision and assist resident to the bathroom when needed, provide supervision ad assist with transfers as needed, and provide moderate assistance with showers 3 times a week. During an observation on 06/24/25 at 08:40 AM Resident #1 had hibliclens antiseptic cleanser in her bathroom on the shelf. During an observation on 06/25/25 at 08:15 AM Resident #1 had hibliclens antiseptic cleanser in her bathroom on the shelf. During an observation and interview on 06/25/25 at 03:42 PM Resident #1 had hibliclens antiseptic cleanser in her bathroom on the shelf and LVN L said the hibliclens antiseptic cleanser should not have been in Resident #1's bathroom on the shelf. LVN L threw the hibliclens antiseptic cleanser in the trash and said the failure placed a risk for Resident #1 or any resident drinking the hibliclens antiseptic cleanser. LVN L said the hibliclens antiseptic cleanser should be stored in medication rooms or the medication carts.During an interview on 06/25/25 at 03:55 PM the DON said Resident #1's family had to have brought the hi9bliclens antiseptic cleanser into the facility because they did not have it in the facility. The DON said all staffed nurses, CNAs, and staff who completed rounds to check rooms on that hall were responsible for ensuring medications were not left out in the room. The DON said the failure placed a risk of causing harm to Resident #1 or other residents from ingesting because the hibliclens antiseptic cleanser is something the residents should not have. During an interview on 06/25/25 at 04:05 PM the Administrator said Resident #1 should not have anything like hibliclens antiseptic cleanser in the room. He said any type of medications should be store properly in the medication cart or the medication room. The Administrator said the failure placed a risk for Resident #1 or other residents hurting themselves by ingesting the hibliclens. Record review of the facility policy Med Storage-in the Home dated 12/2017 indicated:POLICYIt is the policy of this home that medications will be stored appropriately as to be secure from tampering, exposure or misuse. PROCEDURE1. The provider pharmacy dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices where applicable. Medications are kept and stored in these containers. Only a pharmacist does transfer of medications from one container to another.2. Only licensed nurses, the consultant pharmacist, and those lawfully authorized to administer medications (i.e., medication aides, etc.) are allowed access to medications. Medication rooms, carts, and medications supplies are locked or attended by persons with authorized access .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review the facility failed to ensure each resident was provided and received food and drink that was palatable, attractive, and at a safe and appetizing temperature for 1 of 1 kitchen reviewed for palatable food. 1.The facility failed to provide meal services in a manner to ensure palatable food served was appetizing to residents.2.The facility failed to provide palatable food served at an appetizing temperature or taste to Residents #60, #66, #58, and other anonymous complaints made during the resident council meeting who complained the food served did not taste good.These failures could place residents at risk of weight loss, altered nutritional status, and diminished quality of life.Findings include:During an interview on 6/23/25 at 10:03 a.m., Resident #60 said the food at the facility was not good. He said he preferred to not eat at the facility. He said he kept snacks in his room so he could get enough to eat since he did not eat much from the kitchen. During an interview on 6/23/25 at 10:15 a.m., Resident #66 said he liked living in the facility , but the food was terrible. He said the variety was fine, it was the taste. He said the flavor could be off. He said it was bland or sometimes overcooked as well as being cold by the time it got to him. During an interview on 6/23/25 at 10:22 a.m., Resident #58 said the food at the facility was just not good. He said the food didn't taste good, and it was bland. He said it came to him cold all the time and sometimes it had weird flavors. During an interview and observation with the Dietary Manager on 6/24/25 at 12:29 PM, a test tray with a regular diet was provided. The state survey team members and dietary manager sampled the test tray she said the sample tray that was tested did not meet her expectations with flavor or temperature. She said the food was bland and did not retain its heat coming out of the kitchen. She said it would help if she had plate warmers to keep the plates warm. She stated the cold plates acted like a heat sink, and it took the heat out of the food after it was plated. During the sampling the lemon butter chicken had a strong taste of lemon and little to no butter flavor. The lemon flavor overpowered all other flavors. The carrots lacked flavor and temperature. The garden rice and peas lacked temperature and flavor as well. The meal was served with vanilla ice-cream and there were no concerns with the ice-cream.During a confidential interview of 5 anonymous residents stated their food was always cold. Residents also stated the timings of lunch and dinners were late. During an interview on 6/25/25 at 3:08 p.m., the Director of Nurses said she ate a test tray randomly but did not eat out of the kitchen regularly. She said she felt the food she tested was fine to her. She said the residents who were not eating or eating less would be placed at risk for malnutrition and weight loss. During an interview on 6/25/25 at 3:16 p.m., the Administrator said he ate out of the kitchen previously, however he ate a carnivore diet and did not eat exactly what the residents ate. He said the residents who disliked the food served from their kitchen could be placed at risk for malnutrition and weight loss by not eating what was served. He said they switched food providers, and it was noticed a decline in appreciation from the residents for the new menus.Record review of the facility's Test Tray Evaluation policy, dated 08/22/2012, indicated: A test tray evaluation will be conducted by the consultant dietitian in accordance with the Quality Assurance Report Schedule or more often if concerns are noted with food temperatures, food quality or resident complaints.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation.1. The facility failed to ensure the pulled pork was properly thawed before cooking.2. The facility failed to ensure the peas, sweet potato fries, cinnamon rolls, and an unknown type of breaded meat were dated and labeled.3. The facility failed to ensure the baking trays were properly stored and not stored in an office between boxes.These deficient practices could place residents at risk for food borne illness.The findings were:Observation during an initial tour of the kitchen on 6/23/25 at 9:20 a.m. revealed 3 packages of pulled pork were frozen, thawing out on a table near a sink. There was no water in the sink and the pork was still solid. The pork was sitting out at room temperature. Several bags of frozen cinnamon rolls and sweet potato fries were in gallon sized freezer bags that were not labeled and dated. Peas and some type of breaded meat were in sealed bags with no date or label. The peas appeared to have frost buildup. Cooking trays and muffin trays were stored in an office between open cardboard boxes. During an interview on 6/24/25 at 2:55 p.m., the Dietician said meat that was being thawed should not be sat out on a table to thaw . She said meat should be underwater with a continuous stream of water flowing to agitate the water. She said all foods in the freezer and refrigerator should be labeled and dated . She said cookware should be properly stored and not stored underneath boxes .During an interview on 6/25/25 at 1:50 p.m., the Dietary Manager said meat should be thawed under running cold water or thawed in the refrigerator. Leaving meat out to thaw on a kitchen prep table was not proper food handling. She stated it should have been under running water if it needed to be thawed quickly and was not thawed in the refrigerator. She said food should be labeled and dated. She said the labels of the foods found with no label or date may have fallen off. She said baking sheets should not be stored in the office. She said they should be stored in a proper location for sheet pans, 6 inches above the ground, and upside down. She said residents could be placed at risk of foodborne illness if food was not stored or handled properly .During an interview on 6/25/25 at 3:16 p.m., the Administrator said it was the responsibility of all staff which included the dietary manager to ensure safe food handling was being followed, foods were thawed properly, food was stored properly, and cooking pans were stored properly. He said the residents could be placed at risk for foodborne illness if eating foods were not handled properly.Record review of the facility's document, dated 12/01/2011, Food Preparation & Handling provided by the Dietary Manager revealed: The consultant dietitian will monitor the preparation and handling of food items to ensure that all food served by the facility is of good quality and safe for consumption according to the state and Federal Food Codes and Hazard Analysis and Critical Control Points guidelines. See Section 6 for Quality Assurance Monitor forms and schedule. The following guidelines should be followed Meat, poultry and fish is thawed in a refrigerator at 41 F. Foods may also be thawed using the following procedures: Completely submerged under cold potable running water with sufficient water velocity to agitate and float off loosened food particles into the overflow: For a period of time that does not allow thawed portions of ready-to-eat food to rise above 41 F; or For a period of time that does not allow thawed portions of a raw animal food requiring cooking to be above 41 F for more than 4 hours including the time the food is exposed to the running water and the time needed for preparation for cooking .Clean, sanitized surfaces, equipment and utensils are used.Record review of the facility's document, dated June 1, 2019, Food Storage provided by the Dietary Manager revealed: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and Hazard Analysis and Critical Control Points guidelines .To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated .

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to conduct and document a facility wide assessment to determine what resources were necessary to care for it's residents competently during both day-to-day operation, including nights and weekend, and emergencies for 1 of 1 facility assessment reviewed for administration and 1 resident who received dialysis (Resident #53).The facility failed to ensure the assessment accurately reflected dialysis patients.This deficient practice could place residents at risk for inadequate care or treatmentsThe findings include:Record review of the Facility assessment dated [DATE] (date of assessments or update) read in part: . Special Treatments and Conditions . dialysis. Number/Average or Range of Residents . 0 . Record review of Resident #53's face sheet, dated 06/25/25, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #53 had diagnoses which included Chronic kidney disease, also called chronic kidney failure (involves a gradual loss of kidney function), malignant neoplasm of kidney (a cancerous tumor in the kidney), diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and high blood pressure.Record review of Resident #53's admission MDS assessment, dated 04/21/25, indicated Resident #53 understood others and was understood by others. The Resident #53 had a BIMS score of 13, which indicated he was cognitively intact. Resident #53 required assistance with bathing, toileting, dressing, bed mobility, personal hygiene, and eating. Resident #53 received dialysis. Record review of Resident #53's care plan, dated 04/21/25, indicated he was scheduled for dialysis on Tuesday, Thursday, and Saturdays. Record review of Resident #53's orders indicated the resident's dialysis order was dated 04/21/25.During an observation and interview on 06/24/25 at 3:30 p.m., the Administrator said he had 1 resident, Resident #53, who received dialysis. He looked at the facility assessment and said Resident #53 should have been on the facility assessment. He said he reviewed the facility assessment on 06/19/25 but did not realize Resident #53 had not been added; he said it was an oversight. He said he just missed the dialysis being documented and it was important to have the facility assessment accurate because it reflected the care they provided to the residents in the facility.During an interview on 07/01/25 at 01:32 PM, the DON said the facility did not have a policy for facility assessment.