STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675837	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kruse Village Senior Living Community	1700 E Stone St Brenham, TX 77833

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs 3 of 7 residents (Residents #39, #44, and #47) reviewed for unnecessary medications. The facility did not have appropriate indications for medications based on Resident #39's diagnoses. The facility did not have parameters to hold blood pressure medication for Resident #39. The facility did not hold blood pressure medications for Residents #44 and #47 when the residents' blood pressure or pulse was outside parameters set by their physician. These failures could place residents at risk of complications related to receiving unnecessary medications. Findings included: 1. Record review of a face sheet dated 01/31/24 indicated Resident #39 was an [AGE] year-old male admitted on [DATE]. His diagnoses included atrial fibrillation (a type of irregular heartbeat), benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland), cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), personal history of other diseases of the blood system, nontraumatic chronic subdural hemorrhage (an old clot of blood on the surface of the brain beneath its outer covering), protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), vascular dementia (stroke related memory loss), metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), zoster (reactivation of the chickenpox virus in the body), personal history of other diseases of urinary system, anemia (lower than normal healthy blood cells), heart failure (a condition that develops when the heart doesn't pump enough blood for the body's needs), acute kidney failure (kidneys suddenly become unable to filter waste products from the blood), and obstructive and reflux uropathy (when urine cannot drain through the urine tubes). (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the MDS dated [DATE] indicated Resident #39 had active diagnoses of anemia, heart failure, renal insufficiency, obstructive uropathy, cerebral vascular accident, non-Alzheimer's dementia, hemiplegia or hemiparesis, malnutrition, zoster, insomnia, metabolic encephalopathy, and atrial fibrillation. Record review of the January 2024 physician orders indicated Resident #39 had: * the same diagnoses as the face sheet, * an order dated 09/26/23 he was to receive atorvastatin for high cholesterol, * an order dated 01/12/24 he was to receive potassium for elevated potassium, and * an order dated 09/27/23 he was to receive levothyroxine for hypothyroidism. During an interview on 01/30/24 at 03:21 p.m., RN D said when a resident was admitted the medications were to be given appropriate diagnoses based on the diagnoses the resident had. She said if there was not a diagnosis for a medication the admitting nurse should check the hospital record for a diagnosis or contact the physician and clarify. During an interview on 01/31/24 at 12:01 p.m., RN E said when a resident was admitted the medications were to be given appropriate diagnoses based on the diagnoses the resident had. She said if there was not a diagnosis for a medication the admitting nurse should contact the physician and clarify. During an interview on 01/31/24 at 12:12 p.m., the Administrator said medications should be given appropriate diagnoses based on the diagnoses the resident had. She said if there was not a diagnosis for a medication the nurse should check the clinical record from the hospital for a diagnosis. She said she was the nurse who transcribed Resident #39's orders and did not realize she had not inputted the appropriate diagnoses or clarified with physician/NP. During an interview on 01/31/24 at 12:45 p.m. the ADON said medications should be given appropriate diagnoses based on the diagnoses the resident had. He said if there was not a diagnosis for a medication the admitting nurse should check the hospital record for a diagnosis or contact the physician and clarify. 2. Record review of a face sheet dated 01/31/24 indicated Resident #39 was an [AGE] year-old male admitted on [DATE]. His diagnoses included atrial fibrillation (a type of irregular heartbeat), cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), and heart failure (a condition that develops when the heart doesn't pump enough blood for the body's needs). Record review of a physician order dated 09/26/23 indicated Resident #39 was to receive nifedipine ER Oral Tablet Extended Release 24 Hour 30 mg (Nifedipine) 1 tablet by mouth one time a day for hypertension with no indications for parameters to hold the medication. Record review of the January 2024 MAR indicated Resident #39's nifedipine was not administered on 01/15 and 01/17 with a code number 5 marked indicating Hold/See Nurse Notes. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Nursing Progress Notes for Resident #39 indicated: *on 01/15/24 an eMAR-Administration Note indicating nifedipine ER Oral Tablet Extended Release 24 Hour 30 mg give 1 tablet by mouth one time a day for hypertension. Medication not given at this time due to BP outside parameters. BP was 99/43. Nurse in charge notified. *on 01/17/24 an eMAR-Administration Note indicating nifedipine ER Oral Tablet Extended Release 24 Hour 30 mg give 1 tablet by mouth one time a day for hypertension. Medication not given at this time due to BP outside parameters. BP was 100/50. Nurse in charge notified. 3. Record review of a face sheet dated 01/30/24 indicated Resident #44 was a [AGE] year-old female readmitted on [DATE]. Her diagnoses included hypertension (condition in which the force of the blood against the artery walls is too high). Record review of the physician orders for January 2024 indicated Resident #44 had an order dated 01/11/24 to receive amlodipine 2.5 mg twice daily with indications to hold the medications if SBP was <110; DBP was <60; or P was <60. Record review of the January 2024 eMAR indicated Resident #44 received amlodipine on 01/28 for the morning dose when her SBP was 108 and she received the medication on 01/28 for the evening dose with code 9. Code 9 was indicated on the eMAR as See Nurse Notes. Record review of the Nursing Progress Note dated 01/28/24 for Resident #44 had no indication the evening dose of the amlodipine was held. During an interview on 01/31/24 at 12:01 p.m., RN E said they checked the vital signs if there was parameters ordered and if the VS were in the parameters to be held then the medications were held. She said she did not realize she checked on the eMAR for Resident # 44's Metoprolol the code 9. She said she did not document in the nursing notes that the medication was held. Record review of the physician orders for January 2024 indicated Resident #44 had an order dated 01/24/24 to receive Metoprolol 25 mg twice daily with indications to hold the medications if SBP was <110, DBP was <60, or P was <60. Record review of the January 2024 eMAR indicated Resident # 44 received Metoprolol on: * 01/15 when her SBP was 101 and DBP was 53; * 01/18 when her DBP was 59; * 01/19 when her SBP was 100; and * 01/28 when her SBP was 108. Record review of a face sheet dated 01/31/24 indicated Resident #47 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the physician orders for January 2024 indicated Resident # 47 had an order dated 01/19/24 for her to receive Toprol XL mg daily and indications to hold the medications if SBP was <110; DBP was <60; or P was <60. Record review of the January 2024 eMAR indicated Resident # 47 received Toprol XL on: *01/09 when her DBP was 51; *01/15 when her DBP was 58 and P was 58. During an interview on 01/30/24 at 04:25 p.m., RN D said they checked the vital signs prior to medication administration. She said if there were parameters ordered and the VS were in the parameters to be held, then they were held. During an interview on 01/31/24 at 01:35 p.m., the ADON said BP medications should be held if they have parameters to hold them. He said if they the medication was held there should be a nursing note also. He said residents given BP medications when they should be held could cause the resident BP to drop and them being sent to the hospital. Record review of an Unnecessary Drugs Policy revised 09/22/17 indicated Policy: Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: .without adequate indications for its use Record review of an Unnecessary Drugs Policy revised 09/22/17 indicated Policy: Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: .In the presence of adverse consequences which indicate the dose should be reduced or discontinued;

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 33460 Based on interview and record review, the facility failed to employ sufficient staff with appropriate competencies and skill sets to carry out the functions of the food and nutrition service for 1 of 1 facility kitchen reviewed for food and nutrition services. The facility failed to designate a person to serve as the dietary manager who met the required qualifications. The facility designated Dietary Supervisor did not have a dietary manager's certification or any other qualifying credentials. This failure could place residents at risk for the spread of foodborne illness and residents not having their nutritional needs met. The findings include: Record review of the personnel file for the Dietary Supervisor indicated no documentation that she had completed the certified Dietary Manager course. She had a date of hire of 12/02/16. During an interview on 01/30/24 at 8:00 a.m., the Dietary Supervisor said she had not completed or started the dietary manager classes. She said she was working as dietary supervisor until the facility could hire a certified dietary manager. During an interview on 01/31/24 at 10:45 a.m., the HR staff said the Dietary Supervisor was not a certified dietary manager and had assumed the position on 01/17/24. He said the facility had tried to hire a certified dietary manager or hire staff and have them become a certified dietary manager since February 2023. During an interview on 01/31/24 at 12:00 p.m., the Administrator said her expectation was for the DM to be certified to over see the dietary services. She said the DM would monitor staff's dietary certifications and ensure diets were followed. Reference obtained from the Texas Food Establishment Rules dated 2015 indicated .Certified Food Protection Manager and Food Handler Requirements. (a) At least one employee that has supervisory and management responsibility and the authority to direct and control food preparation and service shall be a certified food protection manager who has shown proficiency of required information through passing a test that is part of an accredited program. Record review of the Food Service policy dated January 2023 indicated . In addition, a minimum of one person directly responsible food preparation must successfully complete a state approved food protection program by a. Obtaining a certification as a dietary manager; or b. Obtaining a certification as a food protection professional .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 Based on interview and record review, the facility failed to employ staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service for 1 of 10 dietary staff (Dietary Aide B) reviewed for food and nutrition services. The facility failed to ensure Dietary Aide B had a current Food Handler's Certificate while working in the facility's kitchen. This failure could place residents who consumed food prepared in the facility kitchen at risk of foodborne illness due to being served by improperly trained staff. Findings included: Record review of 10 dietary staff food handlers' certificates indicated Dietary Aide B's certificate expired on [DATE]. During an interview on [DATE] at 11:47 a.m., Dietary Aide B said he did not know his food handler's certification had expired last year. He stated, I completed the food handler training and tested last night. During an interview on [DATE] at 12:00 p.m., the Administrator said the Dietary Manager was responsible for monitoring the dietary staff and the food handler certificates. She said the facility did not have a certified dietary manager. She said her expectation was for the dietary staff to have current food handler's certification to prevent food borne illness and the food handler certification was required. Reference obtained from the Texas Food Establishment Rules' dated 2015 indicated .Certified Food Protection Manager and Food Handler Requirements. (e) The food establishment shall maintain on premises a certificate of completion of the food handler training course for each food employee. The requirement to complete a food handler training course shall be effective [DATE]

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 Based on observation, interview, and record review, the facility failed to provide liquids consistent to meet the residents' needs, for one (Resident #43) of 16 residents reviewed for food and nutrition services. The facility did not serve Resident #43 nectar thickened coffee or juice during his breakfast meal on 01/29/24. This failure could place residents who have dysphagia at risk for aspiration. Findings included: Record review of Resident #43's admission record dated 01/29/24 indicated he was [AGE] years old and admitted on [DATE] with aphasia (language disorder) and dysphagia (difficulty swallowing). Record review Resident #43's of the MDS quarterly assessment dated [DATE], indicated Resident #43's BIMS score was 09 indicating moderate impairment with cognition. He was dependent on staff for eating. Resident #43 required mechanically altered diet - required change in texture of food or liquids (thickened liquids) while a resident of this facility and within the last 7 days. Record review of the care plan dated 11/10/2023 indicated Resident #43 was at risk for potential complications with nutrition/hydration. The interventions included diet as ordered, mechanical soft with thickened liquids. Record review of physician orders dated 01/29/24 indicated Resident #43's orders included NAS (No Added Salt) diet mechanical soft texture, mildly thick/nectar thick consistency. During an observation on 01/29/24 at 8:35 a.m., Resident #43 was eating his mechanical soft diet breakfast and drinking his coffee. The coffee and juice on his tray were not thickened. During an observation and interview on 01/29/24 at 8:40 a.m., MA C said Resident #43's coffee and juice were thin consistency, but the liquids should have been thickened. CNA A said Resident #43 drank thin liquids. MA C picked up Resident #43's dietary card on his tray and said the card indicated nectar thickened liquids. During an interview 01/29/24 at 9:05 a.m., the ADON said Resident #43's physician's orders indicated he was to receive a mechanical soft diet with his liquids thickened to nectar consistency. The ADON said the consistency of the resident's liquid was to prevent choking or aspiration. Record review of the policy titled Consistency Altered Diet dated February 2021 indicated Policy To assist in meeting a tenant's/ resident's dietary needs. Consistency altered diets (texture changes and or thickened liquids) are provided as long as these altered diets are adhered to by the tenant /resident, do not jeopardize the tenant's/ resident's health, and are within the capability of the community.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 Based on observation, interview and record review, the facility failed to ensure residents were provided the therapeutic diets as prescribed by the attending physician for 2 of 16 residents (Residents #18 and #40) reviewed for therapeutic dietsfood and nutrition services. The facility failed to ensure Residents #18 and #40 did not received their health shake with the lunch meal on 01/29/24 as ordered by physician. This failure could place residents with diet needs at risk for a decrease in calories and potential weight loss. The findings included: 1. Record review of Resident #18's admission record dated 01/31/24 indicated she was [AGE] years old and admitted on [DATE] with vitamin deficiency and heart disease. Record review of the MDS quarterly assessment dated [DATE], indicated Resident #18's BIMS score was 08 indicating moderate impairment with cognition. She required supervision for eating. No weight loss or gain of 5% or more in the last month or loss of 10% or more in the last 6 months was noted. Record review of the care plan dated 12/08/23 indicated Resident #18 had actual weight loss related to varied intake. The approaches included health shakes with meals. Record review of physician orders dated 01/31/24 indicated Resident #18's orders included orders for health shakes with meals with a start date of 11/11/22 and mechanical soft diet. During an observation on 01/29/24 at 12:15 p.m., Resident #18 was eating her mechanical soft lunch meal, and no health shake was on the tray. During an interview on 01/29/24 at 1:15 p.m., Resident #18 stated I did not get my milk shake at lunch. 2. Record review of admission record dated 01/29/24 indicated Resident #40 was admitted on [DATE] with a stroke, dysphagia (difficulty swallowing) and protein calorie malnutrition (insufficient consumption of protein). Record review of the MDS significant change assessment dated [DATE] indicated Resident #40's BIMS was 14 indicating her cognition was intact. She required supervision or touching assistance as resident completed the activity of eating and assistance could be provided throughout the activity or intermittently. She had a weight gain of 5% or more in the last month or gain of 10% or more in the last 6 months. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the care plan dated 01/18/24 for Resident #40 included she was at risk for complications with nutrition / hydration related to acceptance of supplements, appetite, and meal Intake. The interventions included diet: regular pureed diet, nectar thick liquids and health shakes. Record review of physician's orders dated 01/29/24 indicated Resident #40 diet was on a pureed diet with nectar thick liquids and health shake with meals for weight loss with start date of 01/16/2024 During an observation on 01/29/24 at 12:40 p.m., Resident #40 was sitting in the dining room, and staff was assisting her back to her room. Her plate was empty, and no health shake was on the tray. There was a glass of thickened water half full and thickened juice was almost emptied. During an interview on 01/29/24 at 2:00 p.m., Resident #40 said she did not remember if she had her milk shake at lunch. During an interview on 01/29/24 at 12:45 p.m., CNA A said Residents #18 and #40 did not receive their health shakes with the lunch meal. She said the kitchen did not send them out with lunch trays . She said the nurse in the dining room was responsible for checking the trays and pointed to the DON. During an interview on 01/29/24 at 1:30 p.m., the DON said after surveyor intervention, the staff in the dining room brought Residents #18 and #40 the health shakes. She said the dietary staff had not put them out in the dining room. She said the health shakes were in addition to their meals to prevent weight loss.