STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675870	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindan Park Care Center LP	1510 N Plano Rd Richardson, TX 75081

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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 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 47030 Based on observations, record reviews, and interviews the facility failed to post required postings with the required contact information for the public, residents and family. The facility failed to post required notification to residents or their representatives through prominent postings throughout the facility on how to contact someone to file a complaint. This failure could place 60 of 60 residents at risk for physical and verbal abuse, which could result in decreased self-esteem, reduced quality of life, injury, or decline in condition. Findings included: Observation on 03/05/2025 throughout 10:00AM-3:00PM, revealed the required Adult protective services posting was missing. Interview with the Administrator on 03/05/25 at 3:50PM revealed she confirmed the posting was not posted. The Administrator revealed she is responsible for ensuring the required postings are posted. Facility Surveyor/Liaison emailed the Administrator with a link to order the required posting. The Administrator said she made a sign and posted on the wall

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 47030 Based on observations, interviews, and record review, the facility failed to notify residents or their representatives on how to file a grievance in an anonymous manner for three (Residents #5, #11, #46, #37, #30, and #59) of three residents reviewed for knowledge of how to file a grievance. The facility failed to notify residents or their representatives either individually or through prominent postings throughout the facility on how to file a grievance or complaint in an anonymous manner. These failures could affect 6 of 60 resident's ability to file a grievance without the fear of discrimination, reprisal, retribution, and their right to anonymously file their grievance. Observation on 03/05/25 at 2:45 PM Surveyor attempted to open the frame with many attempts were required. When the frame was opened the 1 grievance printed in small print on blue paper fell out of the frame where the grievances were kept. Interview on 03/04/2025 at 1:30PM with five residents during the confidential Resident Counsel revealed the residents were unaware where grievance forms were located. The residents stated that they did not know how to anonymously file a grievance. Interview on 3/5/25 at 3:00PM with the Activities Director revealed she was unaware of the grievances being kept in the frame hanging on the wall in the hallway around the nursing station. Activities Director was unaware of how to access the grievance forms inside the frame and when she tried to access the frame opening, she had difficulty getting the frame open and the forms fell out when it was opened. Interview with the facility's Administrator on 03/03/25 at 3:50PM revealed there had been no concerns with residents being able to file a grievance as they usually file verbally. Review of the facility's policy titled, Grievances/Complaints, Filing dated March 2017 revealed, The resident and their representatives have the right to file grievances, either orally or in writing to the agency designated to hears grievances (e.g. the State Ombudsman) Review of the Resident's Rights subsection Grievances revealed. The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The facility must make information on how to file a grievance or complaint available to the resident.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for one (Resident #3) of three residents reviewed for abuse. The facility failed to protect Resident #3 from physical abuse when CNA A force fed her on 03/03/25. The resident suffered psychosocial harm. On 03/20/25 at 1:00 PM, an Immediate Jeopardy (IJ) was identified. The IJ template was provided to the facility on [DATE] at 1:15 PM. While the IJ was removed on 03/20/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of choking, aspiration, serious injury, harm, and death. Findings included: Record review of Resident #3's Annual MDS, dated [DATE], reflected she was a [AGE] year-old admitted to the facility on [DATE]. Her cognitive skills for daily decision making were severely impaired. Her diagnoses included aphasia (lack of ability to comprehend or communicate), stroke, non-Alzheimer's dementia, and dysphagia (difficulty swallowing). She was dependent on staff for eating. Record review of Resident #3's Care Plan, dated 01/07/14, reflected: 1. The resident had a nutritional problem related to hypertension. The resident was on a regular diet, pureed texture, and nectar thick/mildly thick liquids. Sometimes the resident refused to eat or drink supplements. Facility interventions included provide and serve diet as ordered. 2. The resident had a swallowing problem related to dysphagia. Facility interventions included follow prescribed diet, and to keep head of bed elevated 90 degrees during meals. 3. The resident had an ADL self-care performance deficit related to dementia, activity intolerance, and limited mobility. Facility interventions included the resident required total assistance to eat. Record review of CNA A's personnel file and background checks reflected no issues. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	An observation on 03/03/25 at 11:47 AM of Resident #3 revealed she was being fed by CNA A. The resident was in her room and the door was slightly open. CNA A forcefully pushed the resident's head back by placing her palm on the resident's forehead and pushing the head back. CNA A forced a large spoonful of food in the resident's mouth very quickly while the resident's head was pushed back. The CNA forcefully fed the resident three times very rapidly. The CNA then picked up a glass of fluids and gave the resident a drink. The resident tried to stop drinking. CNA A kept forcing the resident to drink. The resident began coughing and sputtering. The Surveyor intervened and told the CNA to stop and step away from the resident. Another State Surveyor observed the incident. CNA A said she did not do anything wrong. CNA said she was gently lifting the resident by the side of her side of head to get her to eat. She said she was not forcing her to eat and drink. The State Surveyor asked CNA A to go get the DON. An interview on 03/03/25 at 11:55 AM revealed the DON entered the resident's room. He told CNA A to go to his office. CNA A continued to deny the abuse occurred. The DON told CNA A to go to the Human Resources office. CNA A continued to deny the incident. Resident #3 was non-verbal and did not make any movements to indicate she was still in distress. An interview on 03/03/25 at 11:59 AM revealed the Administrator entered the conference room and said Resident #3 would lean forward and that staff had to place a hand on her and lift her head. State Surveyor informed the Administrator that CNA A was abusive, and force fed the resident. The Administrator said she would self-report the incident. An interview on 03/03/25 at 12:15 PM revealed Resident #3 was in her wheelchair, awake, alert, and non-verbal. The resident was smiling and watching TV. The resident did not respond to questions. The resident did not make any movements to indicate she was still in distress. An interview on 03/03/25 at 1:36 PM with the family member of Resident #3 revealed she was very upset. She said that CNA A was the only staff member who was able to get Resident #3 to eat and meet her needs. The family member said the required technique to feed Resident #3 was a little aggressive. The family member said Resident #3 could speak and she wanted to be present for an interview to show the State Surveyor that the resident could say she was not abused by CNA A. An interview on 03/03/25 at 2:20 PM with the DON revealed the facility was able to meet Resident #3's needs without CNA A. The DON said feeding the resident was not an aggressive technique and the only requirement was to gently hold up the resident's head if it dropped down. An observation and interview on 03/04/25 at 12:07 PM with Resident #3 revealed her family member and the Administrator was in the room. Another State Surveyor was present as a witness. The resident spoke a few words to the family member and smiled. The resident was awake and alert. The resident was asked if she remembered eating lunch on 03/03/25 and if she felt CNA A was abusive during the lunch. The resident did not answer. The family member asked the resident if CNA A was mean to her, and the resident said yes. The family member asked the resident if she was mean to the resident and the resident said yes. The resident was asked if the Administrator was mean, and the resident said no. The family member asked the resident if CNA A ever forced her to do anything. The resident became upset and said yeah. The interview was ended, and the resident was thanked for talking to the State Surveyor. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	An interview on 03/04/25 at 3:56 PM with the Rehabilitation Director revealed Resident #3 did not require any aggressive or special techniques for feeding. She said Resident #3 had poor trunk control and cervical neck issues. The Rehabilitation Doctor said Resident #3 was usually able to keep her head neutral and that if she leaned to the side, the staff could use their fingertips to gently position her head back up and give her a bite. The Rehabilitation Director said the family member rarely came to visit. The Rehabilitation Director said a CNA should never force feed a resident and that there should be nothing aggressive about feeding Resident #3. The Rehabilitation Director said she never saw CNA A feed Resident #3. An observation on 03/04/25 at 4:41 PM revealed Resident #3 was being fed by LVN B. The resident was sitting up in a wheelchair in the dining room. LVN B offered appropriately sized-bites and the resident swallowed well. Resident #3 drank fluids with no issues. LVN B encouraged the resident to hold her head up and she did so without difficulty. LVN B did not use any abusive or aggressive techniques to feed Resident #3. An interview on 03/05/25 at 1:44 PM with the DON revealed he said the charge nurses were responsible for ensuring residents were fed correctly. The DON said the only resident that CNA A fed on 03/03/25 was Resident #3. The DON said he saw CNA A feed residents with no issues. He said he and Administration did random observations to observe CNAs feed residents. He said Resident #3 did not require any special technique to be fed and would droop her head. The DON said it was easily fixed by placing a towel under her neck to help her sit up more. He said that if a resident was forcefully fed; they were at risk for choking and injury. He said Resident #3 was assessed after the incident and did not have any harm. The DON said CNA A was terminated from employment. An interview on 03/05/25 at 3:48 PM with the Administrator revealed CNA A was terminated from employment. Additionally, the facility conducted in-services with staff for abuse. Record review of the facility policy, Abuse, Neglect, and Exploitation, dated January 2012, reflected: Policy It is the policy of this facility to provide protections for the health, welfare and rights of each resident . This was determined to be an IJ on 03/20/25 at 1:00 PM. The Administrator and the DON were notified. The Administrator was provided with the IJ template on 03/20/25 at 1:15 PM. The following Plan of Removal was submitted by the facility and was accepted on 03/20/25 at 3:20 PM and reflected the following: 1. Identification of Residents Affected or Likely to be Affected: The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. (Completion Date: 3/3/25) (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The Administrator or designee immediately ensured the safety and well-being of the residents who alleged abuse by removing the accused staff member, CNA A, from the facility. They were suspended pending investigation. The Administrator or designee immediately initiated abuse investigation into Resident #3's abuse allegation. Physical assessment was completed on Resident #3 to identify any injuries of unknown origin and/or evidence of abuse or neglect. No concerns were identified. Medical Director and resident's Attending Physician were both notified of the issue. 2. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: 3/4/25) Disciplinary action was taken with staff member accused of abuse (CNA A was immediately terminated from her position and never returned to the facility). All Federal and State protocols were followed in investigating and reporting the abuse allegation (Facility immediately completed a Self-Report to Health and human Services. Residents with BIMS scores of 8 or higher were interviewed/assessed to identify if they felt safe and if they had ever experienced abuse while living at the facility. Concerns were not identified. All staff received education on facility abuse policies. All staff received education on abuse prevention and reporting. Facility abuse policies and procedures were reviewed with any staff prior to their shift. Staff members were not permitted to work a shift until education had been completed. The Administrator and DON received education from corporate consultant team member on timely and thorough abuse investigations. The regional/corporate/hired consultant team member will visit the facility twice per week to provide oversight, audits, and additional training as needed. The Activities Director held a Resident Council meeting in which the residents were educated on the facility's abuse policies and procedures. The Social Services Director began discussing facility abuse policies with residents and families at the initial care plan conference. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The Administrator or designee will continue to interview residents with BIMS scores of 8 or higher on a monthly basis to ensure they have not experienced abuse. The findings of these interviews will be presented to the Quality Assurance/Performance Improvement (QAPI) Committee as a PIP project. Monitoring of the facility's Plan of Removal included the following: Record review of Resident #3's clinical records revealed the resident had been assessed by nursing after the incident on 03/03/25 and did not have any injuries. Record review of the facility in-services revealed all staff were trained. Interviews were conducted on 03/20/25 from 3:26 PM to 4:05 PM with staff from various shifts. The staff included LVN D, CNA E, LVN F, LVN H, CNA I, LVN J, and CNA K. All staff were able to identify: What abuse was and the different types of abuse. The staff understood that a resident could not be force fed. Observations and interviews with residents on 03/20/25 from 2:50 PM to 3:15 PM revealed they felt safe and were not force fed. An interview on 03/20/25 at 4:00 PM with the DON revealed his roles in the facility plan of removal included: Assisting the Administrator with continued training of staff. He said he would be doing monitoring to ensure residents were fed appropriately. He said that all staff were in-serviced on 03/03/25. An interview on 01/05/25 at 4:05 PM with the Administrator revealed he would be making sure in-services and monitoring were completed to prevent abuse from happening again. He said the issues would continue to be discussed in QAPI. The Administrator and DON were informed the Immediate Jeopardy was removed on 03/20/25 at 4:20 PM. On 03/20/25 at 1:00 PM, an IJ was identified. While the IJ was removed on 03/20/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on interviews and record review, the facility failed to refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review for one (Resident #29) of five residents reviewed for PASARR services. The facility failed to ensure Resident #29 was properly screened for PASARR services This failure could place residents at risk of not receiving specialized PASARR services which would enhance their highest level of functioning and could contribute to residents decline in physical, mental, and psychosocial well-being. Findings included: Record review of Resident #29's quarterly MDS Assessment, dated 02/17/25, revealed she was an [AGE] year-old-female admitted to the facility on [DATE] with diagnoses including depression, schizophrenia, and post-traumatic disorder. Resident #29's BIMs score of 3 indicated the resident's cognition was severely impaired. Record review of Resident #29's PASARR Level I screening, dated 04/01/23, reflected the resident did not have a history of mental illness. Record review of Resident #29's Care Plans, dated 03/26/23, reflected: The resident had an ADL self-care performance deficit related to dementia, PTSD, and Schizophrenia. Facility interventions included assist resident with ADLs. An observation on 03/03/25 at 10:43 AM with Resident #29 revealed she was awake, alert, and confused. An interview on 03/05/25 at 10:02 AM with the MDS Nurse revealed she was responsible for entering PASARR information. She said she did not double-check the PL-1 for Resident #29 for accuracy. She said she received the PL-1 for Resident #29 from another facility and documented the information as it was. The MDS Nurse said the resident did not receive an evaluation or PL-2 screening. The MDS Nurse said that no one oversaw her work. She said the resident was at risk of not receiving PASARR services if her PL-1 was incorrect. An interview on 03/05/25 at 1:42 PM with the DON revealed Resident #29 admitted with a negative PL-1. He said the MDS Nurse was responsible for PASARR screenings. He said he did not know if there was a process in place to double check PL-1's. He said the resident was at risk to miss out on PASARR services if her PL-1 was incorrect. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy and procedure, PASRR Requirements Level I & Level II, not dated, reflected: Preadmission screening will be conducted prior to admission as the PASRR process is a federally mandated pre-admission screening program (see 42 CFR S 483.100) required to be performed on all individuals prior to admission to a Nursing Home. The screening is reviewed by Admissions for suspicion of serious mental illness & intellectual disability to ensure appropriate placement in the least restrictive environment and to identify the need to provide applicants with needed specialized services. PASRR screening applies to all new admissions into a Medicaid certified nursing facility & includes private pay, Medicare, & Medicaid admissions regardless of payer source.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45053 Based on interviews and record review, the facility failed to complete a discharge summary that included but was not limited to, (i) A recapitulation of the resident's stay that includes, but was not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results; (ii) A final summary of the resident's status; (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter) for two (Resident #58, Resident #59) of two residents reviewed for discharge planning. 1. The facility failed to complete a discharge summary and a reconciliation of medications for Resident #58 for his planned discharge home on 12/13/24. 2. The facility failed to complete a discharge summary and a reconciliation of medications for Resident #59 for his planned discharge to the hospital on 02/26/25. These failures could place residents at risk of a recapitulation of the stay being unavailable to help ensure continuity of care once they went back home and/or discharged from the facility. Findings included: Record Review of Resident #58's admission face sheet dated 03/05/25 reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Resident #58's active diagnoses included dementia (without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety), hypertension, chronic obstructive pulmonary disease, chronic Stage 4 kidney disease, history of transient ischemic attack (a temporary blockage of blood flow to the brain and cerebral infraction without residual deficits), restlessness, and agitation. Record review of Resident #58's Entry MDS assessment dated [DATE], reflected she was admitted to the facility from a Short-Term General Hospital on 11/30/24. Record review of Resident #58's Admission MDS assessment dated [DATE] reflected a BIMS score was a 13, which indicated she was cognitively intact meaning she was able to recall information immediately, orient herself to time and place, and retain information for a short period. Record review of Resident #58's Discharge MDS assessment dated [DATE], reflected she had a planned discharge home. Record review of Resident #58's Care Plan dated 11/30/2023 reflected, Focus: CANCELLED: I plan on discharging Home. Date Initiated: 12/13/2024 (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Revision on: 12/18/2024 Cancelled Date: 12/18/2024 Goals: CANCELLED: I will safely discharge home (specify). Date Initiated: 12/13/2024 Revision on: 12/18/2024 Target Date: 12/13/2024 Cancelled Date: 12/18/2024 Interventions/Tasks: CANCELLED: Assure continuity of care with home health. Date Initiated: 12/13/2024 Revision on: 12/18/2024 Cancelled Date: 12/18/2024 o CANCELLED: Assure that all equipment required is available. Date Initiated: 12/13/2024 Record review of Resident #58's Nursing Progress Note dated 12/09/2023 reflected, The resident discharged home via Transport x 2 Transport Drivers at this time. The resident's medications were sent with the resident . Record Review of Resident #59's admission face sheet dated 03/05/25 reflected that he was a [AGE] year-old male initially admitted to the facility on [DATE] with a readmitted [DATE]. Resident #59's active diagnoses included dementia (without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety), secondary hypertension, atherosclerotic heart disease (buildup of fats, cholesterol, and other substances in and on the artery walls including the heart), sepsis (a life-threatening medical emergency resulting from the body's extreme response to an infection, potentially leading to organ damage and death if not treated promptly), and cerebral infraction (condition where brain tissue dies due to a blockage or severe restriction of blood flow, depriving brain cells of oxygen and nutrients). The resident was discharged from the facility on to an Acute Care Hospital on 02/26/25. Record review of Resident #59's Entry MDS assessment dated [DATE], reflected the residents BIMS score was a 1, which indicated he had severe cognitive impairment. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #59's Death MDS assessment dated [DATE], reflected that he passed away at the facility on 02/26/25. Record review of Resident #59's Record of Death Notice dated 02/26/25, reflected he passed away at the facility on 02/26/25 at 6:58 AM. Record review of Resident #59's Care Plan dated 11/30/2023 reflected: Focus: Discharge Planning Date Initiated: 06/11/2023 Revision on: 02/26/2025 Cancelled Date: 02/26/2025 Goal: CANCELLED: Resident Will Attain Their Highest Quality of Life at Discharge. Date Initiated: 06/11/2023 Revision on: 02/26/2025 Target Date: 02/27/2025 Cancelled Date: 02/26/2025 o CANCELLED: Resident Will Be Prepared to Return to Community Upon Discharge. Date Initiated: 06/11/2023 Revision on: 02/26/2025 CANCELLED: CM and interdisciplinary team to determine the next most appropriate setting of care and expected discharge interval. Date Initiated: 06/11/2023 Revision on: 02/26/2025 Cancelled Date: 02/26/2025 o CANCELLED: Coordinate, facilitate and communicate all plans for follow-up and future care needs. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindan Park Care Center LP	1510 N Plano Rd Richardson, TX 75081

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date Initiated: 06/11/2023 Revision on: 02/26/2025 Cancelled Date: 02/26/2025 o CANCELLED: Determine Resident / Representative's goals for discharge. Date Initiated: 06/11/2023 Revision on: 02/26/2025 Interventions/Tasks: Target Date: 02/27/2025 Cancelled Date: 02/26/2025 Cancelled Date: 02/26/2025 o CANCELLED: Identify necessary home modification. Date Initiated: 06/11/2023 Revision on: 02/26/2025 Cancelled Date: 02/26/2025 o CANCELLED: Identify need for home or community resources. Date Initiated: 06/11/2023 Revision on: 02/26/2025 Cancelled Date: 02/26/2025 o CANCELLED: Include Resident / Representative / interdisciplinary team in discharge planning process. Date Initiated: 06/11/2023 Revision on: 02/26/2025 Cancelled Date: 02/26/2025 o CANCELLED: Perform medication reconciliation of all prescribed and nonprescribed Medications. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date Initiated: 06/11/2023 Revision on: 02/26/2025 Cancelled Date: 02/26/2025 o CANCELLED: Prepare and provide Resident with a discharge summary document upon discharge from facility. Date Initiated: 06/11/2023 Revision on: 02/26/2025 Cancelled Date: 02/26/2025 o CANCELLED: Upon admission, evaluate Resident / Representative's desire to return to the community. Date Initiated: 06/11/2023 Revision on: 02/26/2025 Cancelled Date: 02/26/2025 Record review of Resident #58 and Resident #59's Clinical Records reflected no discharge summary and reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter). In an interview with the MDS Nurse on 03/05/25 at 10:04 AM, she stated she could not locate a Discharge Summary for Resident #58 and Resident #59. She reported that the Social Worker was responsible for completing the Discharge Summaries for discharged residents. She stated the facility has hired a new Social Worker, but she has not started working at the facility . In an interview with the DON on 03/05/25 at 11:15 AM, he acknowledged that discharge summaries should be completed for each resident that discharges from the facility. He stated there was not a Discharge Summary for Resident #58 and Resident #59. He stated the facility's Social Worker was responsible for completing the Discharge Summaries for residents. He stated the facility has been without a Social Worker for about 2 months. He stated since the facility has been without a Social Worker, he believed the Discharge Summaries for discharged residents were being completed by the Charge Nurses, who have been doing some of the Discharge Summaries since the Social Worker position has been vacant. The DON stated there was a risk to residents being discharged from the facility without a Discharge Summary. He stated without a Discharge Summary, the discharge residents would not be able to meet with the staff to discuss their reconciliation of medications and their discharge plans such as home health and care responsibilities. He stated if a resident did not have a Discharge Summary, there was potential for there being a gap of follow-up appointments for medical needs. The DON stated if there was not a Discharge Summary for discharged residents, they would miss the opportunity for any continuous care and appointments. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the previous Social Worker on 03/05/25 at 3:04 PM, she reported she was employed at the facility as the Social Worker from October 2024 - November 2024. She stated on her first day of employment, she was told by the Administrator that she would have to complete the Discharge Summaries for residents who discharged from the facility. She stated she later learned the previous Social Worker did not complete the Discharge Summaries for discharged residents and was advised by the Administrator that she needed to complete the Discharge Summaries that were outstanding including the current Discharge Summaries for discharged residents. She stated there have been several Social Workers employed at the facility throughout the year and the facility has not been completing the Discharge Summaries for discharged residents and expected her to get the facility caught up with their incomplete Discharge Summaries which was a daunting task . In an interview with the Administrator on 03/05/2024 at 3:48 PM, she acknowledged that discharge summaries should be completed for each resident that discharged from the facility. She stated the Social Worker was responsible for completing the Discharge Summaries for residents who discharged from the facility. She stated the facility has not had a Social Worker since the beginning of November. She stated the facility hired a Social Worker, but she had not begun working at the facility. The Administrator stated she was not familiar with the Discharge Planning process and the Discharge Summary because the process was done by the Social Worker. She stated she knew before a resident was discharged from the facility, there was a note done in the PCC . If the resident was discharging home, the staff would speak with the family and a doctor to ensure the resident was being sent home with some instructions regarding the care that would be needed at home. She stated different Nursing Staff Managers have been assigned to the task of ensuring the Discharge Summaries for discharging or discharged residents had been completed. She stated there was not anyone overseeing that Nursing Staff Managers to ensure the Discharge Summaries were being completed. She stated she felt the staff at the facility did their due diligence when a resident was being discharged home, and the staff would write a detailed progress note in their file on PCC. She stated that families, including the residents (if they are alert and oriented) were talked to before they were discharged home to ensure that follow-up appointments would be done. She stated she felt the facility had done good with safe discharges for residents. The Administrator stated she did not know if there was any risk or harm that can be caused to a resident if they were discharged home without a Discharge Summary. Record review of the Social Worker Job Description dated 11/11/24 revealed, Reports to: Social Services Director, Administrator Classification: Position Purpose: Provide support to residents and their families in coping with placement in a long-term care facility. Be the understanding, helpful and caring person they turn to at this difficult time. Perform assessment at admission; update as needed. Essential Functions of Position: *Work with the resident, family, and other team members to plan discharge. Record review of the facility's policy titled, Discharge Summary and Plan, reviewed December 2024, reflected, Policy Statement: (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. Policy Interpretation and Implementation 1. When the facility anticipates a resident's discharge to a private residence, another nursing care facility (i.e. , skilled, intermediate care, ICF/IID, etc.), a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment. 2. The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's: a. Current diagnosis; b. Medical history (including any history of mental disorders and intellectual disabilities); c. Course of illness, treatment and/or therapy since entering the facility; d. Current laboratory, radiology, consultation, and diagnostic test results; Physical and mental functional status; f. Ability to perform activities of daily living including: (1) bathing, dressing and grooming, transferring and ambulating, toilet use, eating, and using speech, language, and other communication systems; (2) the need for staff assistance and assistive devices or equipment to maintain or improve functional abilities; and (3) the ability to form relationships, make decisions including healthcare decisions, and participate (to the extent physically able) in the day-to-day activities of the facility. g. Sensory and physical impairments (neurological, or muscular deficits; for example, a decrease in vision and hearing, paralysis, and bladder incontinence); - h. Nutritional status and requirements: (1) weight and height; (2) nutritional intake; and (3) eating habits, preferences, and dietary restrictions. i. Special treatments or procedures (treatments and procedures that are not part of basic services (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided); j. Mental and psychosocial status (ability to deal with life, interpersonal relationships and goals, make health care decisions, and indicators of resident behavior and mood); k. Discharge potential (the expectation of discharging the resident from the facility within the next three months); l. Dental condition (the condition of the teeth, gums, and other structures of the oral cavity that may affect a resident's nutritional status, communications abilities, quality of life, and the need for and use of dentures or other dental appliances); m. Activities potential (the ability and desire to take part in activity pursuits which maintain or improve physical, mental, and psychosocial well-being); n. Rehabilitation potential (the ability to improve independence in functional status through restorative care programs); o. Cognitive status (the ability to problem solve, decide, remember, and be aware of and respond to safety hazards); and p. Medication therapy (all prescription and over-the-counter medications taken by the resident including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident). 3. As part of the discharge summary, the nurse will reconcile all pre-discharge medication with the resident's post-discharge medications. The medication reconciliation will be documented. 4. Every resident will be evaluated for his or her discharge needs and will have an individualized post discharge plan. 5. The post-discharge plan will be developed by the Care Planning Interdisciplinary Team with the assistance of the resident and his or her family and will include: a. Where the individual plans to reside; b. Arrangements that have been made for follow-up care and services; c. A description of the resident's stated discharge goals; d. The degree of caregiver/support person availability, capacity and capability to perform required care; e. How the IDT will support the resident or representative in the transition to post-discharge care; f. What factors may make the resident vulnerable to preventable readmission; and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45053 Based on observations, interviews, 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 safety. 1. The facility failed to ensure food in the facility's dry storage, and refrigerator areas were labeled and dated according to guidelines. 2. The facility failed to seal open items in plastic bags in the dry storage pantry and the refrigerator areas. 3. The facility failed to ensure that expired items in the dry storage pantry and the refrigerator areas were removed. 4. The facility failed to ensure that 1 dented can was removed from the shelf in the dry pantry area. These deficient practices could affect residents who received meals and/or snacks from the main kitchen and place them at risk for cross contamination and other air-borne illnesses. Findings Included: Observation of the kitchen during the brief initial tour of the kitchen on [DATE] at 9:20 AM, revealed the following: Dry storage area contained: *1 dented can of 105 fl. oz. of [NAME] Monte Lite Diced Pears, *1 unsealed bag of 160 fl. oz. [NAME] Noodle, *1 unsealed bag of 21 lb. Sysco Classic Confectioners [NAME] Sugar, *1 bag of 21 lb. Sysco Classic Confectioners [NAME] Sugar with a sticker labeled [DATE] with an expiration date on the package of [DATE], *1 unsealed bag of 32 oz. Sysco Classic Light [NAME] Sugar, *1 package of 15 oz. Lawry's Sloppy [NAME] Seasoning Mix with an expiration date of [DATE], *3 unsealed bags of 11.3 oz. Imperial Turkey Gravy Mix without an expiration date, *2 unsealed bags of Ms. Baird's Wheat Bread, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*1 unsealed clear plastic container with a blue lid labeled cornmeal, *1 unsealed clear plastic container with a blue lid labeled flour, Refrigerator area contained: *1 metal pan of unsealed red Jello with 4 puncture marks on the foil without an expiration date, *1 white plate with unsealed plastic wrap labeled Burger Setup, which included 4 pickles, brown lettuce, and sliced tomatoes, *1 unsealed bag of 5 lb. Arrezzio Parmesan Cheese with an expiration date of [DATE], *1 unsealed plastic container with a green lid with 3 packages of unsealed mixed vegetables with a sticker labeled, ,d+[DATE] and use by ,d+[DATE], *1 unsealed plastic container with a green lid with 1 container of pears with a sticker labeled, [DATE] without a use by date, *1 container of caramel with a sticker labeled [DATE] without a use by date, * 1 unsealed package of Driscoll's strawberries, * 4 stacked pans of bacon with unsealed parchment paper cover each pan of bacon dated [DATE] without a use by date, * 3 red juices without sealed lids, *4 orange juices without sealed lids, and *6 cups of tea without sealed lids. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview with the Dietary Manager on [DATE] at 10:05 AM, she stated she has been employed at the facility as the Dietary Manager for 1 year. She was shown the items that were found in the dry pantry and refrigerator areas. She stated she would correct everything that was found and would do an in-service training with her staff regarding food storage and labeling and checking for expired items throughout the kitchen including the dry pantry, refrigerator, and freezer areas. She stated all staff were responsible for ensuring items in the kitchen's dry pantry, refrigerator, and freezer areas were not expired and unsealed. She stated staff were to notify her if they find anything in the dry pantry, refrigerator, or freezers areas that was expired, unsealed, and undated. She stated her expectation was for staff to throw away any items that were expired or opened in the kitchen's dry pantry, refrigerator, and freezer areas and notify herself or the Dietician of their findings. She stated that on a daily basis she would check the inventory in the dry pantry, refrigerator, and dry pantry areas to ensure that everything was sealed, labeled, dated, and not expired. She stated that the items found in the dry pantry and refrigerator areas on [DATE] was an oversight and she missed or overlooked the items in both areas of concern. She stated she would throw away all expired items in the kitchen and the unsealed items as well. She stated she and the kitchen staff would do a walkthrough of the dry pantry, refrigerator, and freezer areas to ensure that nothing was overlooked. She stated the kitchen staff have received several in-services relating to food preparation, storage, labeling, and immediately removing expired items. She stated staff have been trained and educated when they were restocking to place the items already on the shelf in the front and the new items behind the items that were already shelved. She stated she would throw away the expired items in the kitchen and retrain and reeducate the staff via in-service trainings . She stated that the risk of residents eating anything from the kitchen that is expired, unsealed items, and dented cans could result in anyone that eats the food from the facility's kitchen can make them sick and they could experience illnesses such as vomiting and diarrhea. In an interview with [NAME] C on [DATE] at 10:40 AM, she stated that she had been employed at the facility for [AGE] years. She stated she was unaware that there were expired and unsealed items in the dry storage, and refrigerator areas. She stated all the staff were responsible for storing the items on the shelf and checking the expiration dates on everything in the kitchen. She stated that the Dietary Manager was responsible for ensuring the items in the dry storage, and refrigerator areas were sealed, labeled, and dated. She stated she had taken in-service trainings on food preparation and storage, and she was unable to provide a timeframe when she had taken her last in-service training. She stated if a staff member sees an item(s) that were expired, the staff member was to throw the item away in the trash can and then inform the Dietary Manager what they threw away. She stated everything in the dry storage, freezer, and refrigerator should be labeled and dated per her in-service trainings. [NAME] A stated if any residents were given food from the kitchen's dry pantry, freezer, and refrigerated that was unsealed or expired, they would ingest food that had been cross-contaminated. She stated that if a resident eats any food that has been cross contaminated, they can become very sick and have a stomachache, vomit, and diarrhea. She stated that with food in the dry pantry, refrigerator, and freezer areas being unsealed and expired, the items could cause anyone who ingested the food to have a foodborne illness and become sick and cause them harm. (continued on next page)

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