STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675927	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Crane	699 Campus Dr Crane, TX 79731

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 Based on interview and record review, the facility failed to ensure that residents had the right to choose their schedule for 2 of 6 residents (Residents #12 and #63) reviewed for self-determination preferences. The facility failed to allow Resident's #12 and #63 to smoke more than one cigarette while on their smoke break. This failure could place residents at risk of diminished feeling of self-worth, depression, and or diminished quality of life. Findings include: Resident #12 Record Review of Resident #12's Face Sheet dated 04/24/2024, revealed he was a [AGE] year-old Male, admitted to the facility on [DATE], with a Diagnoses of muscle weakness and wasting, difficulty walking, depression and tobacco use and heart disease. Resident #12's MDS, dated [DATE], Section C revealed a BIMS score of 11 (moderately impaired cognition). Resident #12's Care Plan dated 10/10/2023 revealed: Focus- The resident has coronary artery disease related to Hypertension, lifestyle choices, Smoking. Goal-The resident will be free from/sx (signs) of complications of cardiac problems through the review date. Interventions-Educate the resident/family/caregivers about: factors which might precipitate irregular heart rate: Alcohol, Caffeine, Stress, Activity. Encourage compliance to treatment regimen and follow up with physician. Encourage resident to refrain from smoking. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #12's smoking assessment dated [DATE] revealed, he can independently light smoking materials safely dispose of ashes and other tobacco-related residue appropriately. Resident #12 can also extinguish smoking materials completely in an appropriate receptacle. Resident #12 orders revealed no evidence of having only one cigarette during the 15-minute break. Interviews during a confidential meeting on 04/22/2024 at 10:02 AM, Resident #12 wanted to know if there were a policy that stated he can only have 1 cigarette during smoke breaks for himself and other smoking residents. During an interview on 04/24/24 at 11:23 AM, Resident # 12 voiced that he was upset that he was only allowed 1 cigarette per smoke break. He stated that he had smoked 2 packs prior to admission and does not feel that 1 cigarette was enough. He voiced that he would have no problem smoking 2-3 cigarettes in the 15 minutes that were allotted to him during the smoke breaks provided. Resident #63 Record Review of the resident #63's Face Sheet dated 04/25/2024, revealed he was a 63 yr. old male, admitted to the facility on [DATE], with a Diagnoses of Major Depressive Disorder, Anxiety Disorder, tobacco use and insomnia. Resident 63's MDS, dated [DATE], Section C revealed a BIMS score of 11 (moderately impaired). Resident #63's Care Plan dated 08/10/2023 revealed: Focus-The resident is a smoker. Goal-The resident will not smoke without supervision through the review date. Interventions-Instruct resident about smoking risks and hazards and about smoking cessation aids that are available. Observe clothing and skin for signs of cigarette burns. Resident #63's smoking assessment dated [DATE] revealed, he can independently light smoking materials safely and can the resident dispose of ashes and other tobacco-related residue appropriately. Resident #63's Orders revealed no evidence of having only one cigarette during the 15-minute break. During an interview on 04/23/24 at 11:30 AM, HK-J stated that she had worked there since 2021. She stated that she performed the smoke breaks on the days she worked approximately 3-4 days a week. She stated she took the resident's out to smoke on those days. She stated the rules were for residents to have only 1 cigarette during a 15-minute smoke break. HK-J stated she did not know what the policy was about smoking. She stated at one time they had a red box with a sign that had said, only one cigarette a break. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/25/2024 at 11:15 AM, the SW stated the residents were only allowed to have 1 cigarette per smoke break every three hours. She stated there were two safe smokers that had been given smoke breaks at night due to these two residents only able to have one cigarette throughout the day with each smoke break. The SW stated in doing that, it had helped them sleep but inconvenient for them as it was at 12:30 AM and 3:30 AM. She stated even at those times, Resident #12 and Resident #63 were still to only have one cigarette. The SW stated the rules were in the corporate facility policy. She stated the department heads had a meeting with the smokers about what the violations would be if they did not adhere to those rules. The SW stated she was unaware the facility policy showed no evidence that the residents could only have one cigarette. She stated she had previously been told that it was the way it had always been done the past three years. The SW stated the residents received $60 a month and stated that was another reason they ration the residents cigarettes. During an interview on 04/25/2024 at 11:35 AM, the ADMN stated there was a limit to only one cigarette while the residents were out on smoke break. She stated it was corporate policy and the Department Heads (ADMN, DON, and AD), had a smoking RC meeting as well, to let the residents know what the rules were. The ADMN stated the residents were told that if they violated the smoking policy, they would get written up with a smoking violation. The ADMN stated it was the Department Heads that had that specific RC so they (Dept. Heads and smoking Residents) would be on the same page. She stated once having read the smoking policy at that time, there was no mention of residents only could have one cigarette per smoke break. She stated the Department Heads had decided it kept the residents on their budget as well as not having residents stealing cigarettes from other residents who smoked. The ADMN stated it would also prevent them from running out of money at the end of each month. She stated, it was not fair to the residents, but it kept them on the same level and in reality, it was not fair, but the one cigarette is in all fairness to all who smoke. The ADMN stated she made the determination across the board with that being the best for the community. She stated she thought it was fair to make a blanket rule. She stated if someone asked her if they could have another cigarette with plenty of time left in that smoke break, she would have always told them No because it was based on the situational needs of all residents. She stated the failure was that the residents did not like to be monitored and was the reason that certain residents had brought it up. The ADMN stated she thought the negative impact were the residents health if they smoke more than one. The ADMN stated her expectations were for the residents on only have one cigarette per break. She stated that ultimately it was her decision. During an interview on 04/25/2024 at 2:34 PM, the RRN stated she was unaware the residents were being told they could only smoke 1 cigarette. She stated it was not in their facility policy that the residents could only have 1 cigarette during their 15-minute scheduled smoking times. She stated they had the right to smoke as many as they wanted if it were during that scheduled time. Review of facility Resident Smoking Council Meeting Minutes, dated 02/16/2024 revealed no evidence of advising residents they could have only one cigarette during their 15-minute break. Review of facility's policy titled Risk Management, Smoking Policy, dated 06/11/2018 revealed .Standard of Practice Explanation and Compliance Guidelines Self Determination the Resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to a. The resident has a right to choose activities, schedules (including sleeping and waking times) . (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy showed no evidence the residents could have only one cigarette during their 15-minute smoke break. Review of facility's policy titled Resident Rights, dated 08/2009 revealed; Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: 1.k. Retain and use personal possessions to the maximum extent that space and safety permit; 2. Residents are entitled to exercise their rights and privileges to the fullest extent possible. 3. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity 48883

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 48883 Based on observation, interview, and record review, the facility failed to maintain a safe, clean, and homelike environment for 3 of 17 (Resident #4, #22, and #32) resident rooms reviewed for resident rights. 1. The facility failed to ensure the hot water faucet worked in Resident #4's and #22's rooms. 2. The facility failed to ensure hot water in room was above 100? in Resident #32's room sink. 3.The facility failed to ensure hand washing sink drained water without resident holding up drain with hand by reaching into used water in Resident #32's room. 4. The facility failed to ensure closets had doors that would enclose resident's clothing. These failures could place residents at risk for infection and diminished clean, homelike environment. Findings included: Resident #4 Record review of Resident #4's face sheet dated 04/24/2024 revealed he was a [AGE] year-old male admitted to the facility on [DATE], with a diagnosis of chronic obstructive pulmonary disease (lung disease interfering with airflow), dementia, major depressive disorder, anxiety, tobacco use, diabetes, and acquired absence of right and left leg (leg amputations). Record Review of Resident #4's quarterly MDS assessment dated [DATE], Section C - Cognitive Patterns revealed a BIMS score of 09 (moderate cognitive impairment); Section GG- Functional Abilities and Goals revealed resident needed setup or cleanup assistance with eating, needed supervision with oral hygiene, toilet hygiene, upper body dressing, lower body dressing, and personal hygiene, and needed partial assistance with bathing. During an observation and interview on 04/21/2024 at 3:53 p.m., the sink in Resident #4's room, hot water faucet, would not turn on and left closet door not present leaving resident's clothing exposed. Resident #4 stated that he would like to have warm or hot water available in his room. He voiced he washed his hands and face with the water from sink. He stated that he had told staff his hot water did not work, and nothing had been done about it. Resident #22 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #22's face sheet dated 04/24/2024 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of seizures, diabetes, morbid obesity, muscle weakness, and lack of coordination. Record review of Resident #22's admission MDS dated [DATE] Section C - Cognitive Patters revealed a BIMS score of 12 (moderate cognitive impairment); Section GG- Functional abilities and Goals revealed resident needed setup or cleanup assistance with eating and oral hygiene, needed supervision with upper body dressing, and needed partial assistance with toileting hygiene, bathing, lower body dressing, putting on or taking off footwear and personal hygiene. During an observation and interview on 04/24/2024 at 12:19 p.m., the sink in Resident #22's room only had cold water. Resident #22 stated she would like to have warm or hot water in her room and had not had it since she moved into the facility. Resident #32 Record review of Resident #32's face sheet dated 04/24/2024 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of encephalopathy (damage or disease that effects the brain), dementia, unsteadiness of feet, hypertension (high blood pressure), and lack of coordination. Record review of Resident #32's quarterly MDS dated [DATE], Section C revealed a BIMS score of 10 (moderate cognitive impairment); Section GG- Functional abilities and Goals revealed resident needed setup assistance with eating, supervision with bathing, and was independent with oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on and taking off footwear, and personal hygiene. During an observation and interview on 04/21/2024 at 10:48 a.m., the sink in Resident #32's room would not drain water without resident putting hand down in used water and holding up the drain plug. Hot water temperature obtained with thermometer, read 92.4 ?. Resident stated that she did not mind water not being hot. She stated she was not sure how long the drain had not functioned without her holding the plug up. Record review of resident council minutes from January and February of 2024 revealed concerns with hot water on 500 hall. Record review of maintenance log on 04/21/2024 revealed no evidence that 500 hall's hot water concerns were addressed or that Resident #32's drain not draining. During an interview on 04/23/2024 at 10:39 a.m., AD stated she was who made notes in the resident council minutes. She stated hot water concern on 500 hall meant some sinks did not have hot enough water or no hot water at all. During an observation on 04/24/2024 at 3:33 p.m., room [ROOM NUMBER] right closet door missing leaving resident's clothing exposed. During an observation on 04/24/2024 at 12:19 p.m., room [ROOM NUMBER] had only cold water available in the only sink in the room and closet doors leaving resident's clothing exposed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 04/21/2024 at 11:45 a.m., room [ROOM NUMBER] had left closet door sitting on floor on A side of room and lying against the wall. Left closet clothing left exposed. During a follow up interview on 04/25/2024 at 8:33 a.m., the AD stated when a concern was brought up in resident council then she would take the concern to the responsible department head for that concern. She stated DPP would be notified if there were issues with maintenance such as plumbing. She stated that she was unsure if the current DPP worked in January or February of 2024 and was unsure who concern was brought up to during that time. She stated the facility discussed concerns during their scheduled QAPI meetings also. She was not able to state whether the hot water concern was corrected. During an interview on 04/25/2024 at 8:38 a.m., the ADMN stated it was her expectation that resident rooms had working water. She did not voice any negative outcome to residents when faucets and drains were not in working order. She would not state her expectation about closet doors adding that some people would not mind having no closet doors. She did not voice any negative outcome to residents. She stated DPP was responsible for monitoring that items in the room were working. ADMN stated verbal discussions were made when items needed to be fixed. She did not provide any evidence that verbal communication had occurred. During an interview on 04/25/2024 at 10:20 a.m., the DPP stated he had ordered parts to fix hot water faucets in the sinks that he knew were not working. He stated it was hard to obtain parts due to facility's location and no stores close by, so he had to have parts shipped. He stated that he did not have computer access to order supplies until two to three weeks ago which delayed his ability to correct issues. He stated he had been attempting to find [NAME] brackets to fix closet doors, but they were no longer available to order. He stated he had been verbally told about some items not working but felt that he forgot some of the items that were told to him when he became busy during his workday. Review of facility's policy titled Maintenance Service dated December 2009 revealed: The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .Functions of maintenance personnel include but are not limited to .maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order. Review of facility's policy titled Work Orders, Maintenance revised in April 2010 revealed: Maintenance work orders shall be completed in order to establish a priority of maintenance service .In order to establish a priority of maintenance service, work orders must be filled out and forwarded to the Maintenance Director .It shall be the responsibility of the department directors to fill out and forward such work orders to the Maintenance Director .A supply of work orders is maintained at each nurses' station .Work order requests should be placed in the appropriate file basket at the nurses' station. Work orders are picked up daily . Emergency requests will be given priority in making necessary repairs. Review of facility's policy titled Quality of Life - Homelike Environment revised in May 2017 revealed: Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences .The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include Clean, sanitary and orderly environment.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 Based on observations, interview, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 3 of 4 halls (Hall 300, Hall 400, and Hall 500) reviewed for accidents and supervision. 1. The temperature reading for Hall 300 shower room sink was 119 F. 2. The temperature reading for Hall 400 shower room sink was 141.3 F and for the shower itself was 137.9 F. 3. The temperature for Hall 500 shower was 136 F. 4. The temperature readings for Hall 500 resident sinks were in temperature ranges from 130 F to 135 5. The temperature of Hall 500 hot water heater was 140 F. An Immediate Jeopardy (IJ) situation was identified on 04/22/2024. While the IJ was lowered on 04/23/2024 at 3:00 PM, the facility remained out of compliance at a severity level of no actual harm with a potential for more than minimal harm, with a scope of a pattern, due to the facility's need to evaluate the effectiveness of their corrective actions. This failure could place residents at risk for 3rd degree burns causing serious injury, serious harm, hospitalization s, impairment and/or death. Findings include: Resident #51 Record Review of the Resident #51's Face Sheet dated 04/24/2024, revealed he was a [AGE] year-old male, admitted to the facility on [DATE] with initial admission on 01/20/2022. He had a Diagnoses of Schizophrenia, dementia, anxiety disorder, and depression. Record Review of Resident #51's MDS assessment, dated 03/14/2024, revealed a BIMS score of 06 (severely impaired cognition). During an interview on 04/21/24 at 12:54 PM Resident #51 stated he used the shower on Hall 500 and the showers were too hot when being showered. He stated he would complain to the CNA that showered him but in doing so, it had not lowered the temperatures of the water for future showering. Resident #12 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review of the resident #12's Face Sheet dated 04/24/2024, revealed he was a [AGE] year-old-male, admitted to the facility on [DATE], with diagnoses of muscle weakness and wasting, difficulty walking, depression, and tobacco use and heart disease. Resident #12's MDS, dated [DATE], revealed a BIMS score of 11 (moderately impaired). Review of Resident #12's Care Plan dated 10/10/2023 revealed: Focus-The resident has coronary artery disease (CAD) r/t Hypertension . Goal-The resident will be free from/sx of complications of cardiac problems through the review date. Interventions-Educate the resident/family/caregivers about: factors which might precipitate irregular heart rate: Stress, Activity. Focus- I have an ADL self-care performance deficit r/t disease process. Impaired balance and Limited Mobility. Goal-The resident will show appropriate self-care progress by review date. Interventions-BATHING/SHOWERING: The resident requires limited staff assistance with bathing. During an interview on 04/21/24 at 4:18 PM, Resident #12 statedhe used the shower on Hall 500 and that he felt as if the water was too hot in the shower and would burn someone if they were not careful. An observation made by the surveyors on 04/21/2024 between 5:05 PM and 5:25 PM, with [NAME] Model 884ON Digital Thermometer, revealed; 1. The temperature reading for Hall 300 shower room sink was 119 F. 2. The temperature reading for Hall 400 shower room sink was 141.3 F and for the shower itself was 137.9 F. 3. The temperature for Hall 500 shower was 136 F. 4. The temperature readings for Hall 500 resident sinks were in temperature ranges from 130 F to 135 5. The temperature of Hall 500 hot water heater was 140 F. During an interview on 04/21/24 at 5:22 PM, the DON was present during 400 hall temp. She voiced that she felt the water could have burnt residents. During an interview on 04/21/2024 at 5:30 PM, CNA-F stated she did not know what the water temperature should be. She stated that having water too hot could lead to residents being burned because the residents with memory difficulty would not know to turn on the cold water and feel pain differently. During an observation on 04/21/2024 at 7:18pm, Hall 400 water heater revealed temperature of 140 F. The DON then lowered the temperature to below 130 F (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on 04/21/2024 at 7:21pm, Hall 300 water heater revealed temperature of 120 F. The DON was unable to lower the temperature due to the gauge being locked. During an observation on 04/21/2024 at 7:22pm, Hall 200 water heater revealed temperature of 120 F. The DON then lowered the temperature to 110 F During an observation on 04/21/2024 at 7:32pm, Hall 500 water heater revealed temperature of 140 F. The DON turned the hot water off due to inability to lower the temperatures. During an interview on 04/21/2024 at 7:45 PM, the DPP stated he checked the water temperatures using a General 8:1 Non-Contact Infrared Thermometer. He stated the thermometer he was told to use had no probe to insert into running water but had checked the temperatures weekly. He also stated that the only policy the facility used for water checking the water temperatures were regarding monitoring for Legionella's and not specifically maintaining water temperatures. During an observation on 04/21/2024 at 8:07 PM, the facility temperature of the Hall 200 shower measured, by DPP, at 81 F with the General 8:1Non-Contact Infrared Thermometer. The survey teams measured temperature, with a [NAME] Model 884ON Digital Thermometer, was 106.3 F, a 25.3 difference. During an observation on 04/21/2024 at 8:12pm, the facility temperature of Hall 500 shower measured, by DPP, was 80 F with the General 8:1 Non-Contact Infrared Thermometer. The survey team temperature with a [NAME] Model 884ON Digital Thermometer was 104.9 F. a 24.9 difference. During an interview on 04/21/2024 at 12:06 PM, the ADMN stated that the DPP had monitored the water temperatures for the showers and resident rooms. She stated she was supposed to had monitored the DPP but had assumed they were correct as the numbers were between 100-110 degrees F but not knowing his infrared thermometer was inaccurate. The ADMN stated the negative impact to residents could have possibly been burned, as well as cause rashes since they have sensitive skin. She stated the failure occurred with faulty equipment. The ADMN stated her expectations were to monitor and regulate the water temperatures to stay between 100-110. Record Review of facility's undated policy titled FACP (Focused Acute Care Partners), revealed: Components: 3B. Temperature checks will be performed in each zone via showers, sink faucets at least weekly; information will be entered into the life safety logs for monitoring of changes. Water temperature must be between 100-110 at the point of use for resident areas .temperatures will be adjusted if temperature is out of range. If unable to correct the temperature the Executive Director of operations will be notified for further interventions. Review of US Consumer Product Safety Commission Avoiding Tap Water Scalds accessed on 05/09/2024 at http://efaidnbmnnnibpcajpcglclefindmkaj/https://www.cpsc.gov/s3fs-public/5098.pdf revealed: Most adults will suffer third-degree burns if exposed to 150 degree water for two seconds. Burns will also occur with a six-second exposure to 140 degree water or with a thirty second exposure to 130 degree water. Even if the temperature is 120 degrees, a five minute exposure could result in third-degree burns. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	This was determined to be an Immediate Jeopardy (IJ) on 04/22/2024. The Administrator was notified on 04/22/2024 at 2:36 pm that an Immediate Jeopardy was identified, was requested at that time. The Administrator was provided with the IJ template on 04/22/2024 at 2:36 pm. The following Plan of Removal was accepted on 04/23/2024 at 8:10 pm and included: The facility failed to maintain an environment that was free from accidents and hazards for 3 of 4 (300, 400, and 500) halls and failed to maintain hot water temperatures below 110 F. This had the potential to affect 50 residents that were dependent on water in resident rooms and shower rooms on 3 of 4 halls that could put residents at risk for severe injury, serious harm, hospitalization , impairment and/or death. The medical director was notified of the immediate jeopardy related to hot water on 04/22/2024 at 4:09 p.m. As of 4/22/2024 the facility has achieved temperatures below 110 degrees Fahrenheit on hall 300, 400 and 500. Facility will maintain hot water temperatures below 110 F on 300, 400, and 500 and will be checked three times daily for 7 days, twice daily for 30 and then once daily thereafter. Implemented 4/22/24. An ongoing in-service will be done until all staff has been in-service. The Corporate Physical Plant Director will Inservice the Executive Director of Operation (EDO), Director of Physical Plant (DPP), Director of Clinical Operations (DCO) and Assistant Director of Clinical Operations, (ADCO) via spoken in- service/demonstration: Checking water temperatures and the ranges to be within 100-110. A sign in sheet will reflect an indication of understanding. Completed 4/22/24. The EDO and DPP will in-service all staff to include administration (IDT team), dietary, housekeeping, laundry and clinical (nurses and nurse aides) via spoken in- service/demonstration prior to the start of their next shift: Checking water temperatures and the ranges to be within 100-110 degrees Fahrenheit using probe style thermometer. A sign in sheet will reflect an indication of understanding. Completed 4/22/24. ALL newly hired and agency staff will be trained in Checking water temperatures and the ranges to be within 100-110 degrees Fahrenheit using probe style thermometer. A sign in sheet will reflect an indication of understanding. If shower is outside of the acceptable range the temperatures the shower will be put OUT OF ORDER until the acceptable temperature can be obtained. The facility will provide in-service documents, temp logs and signature pages. New thermometers have been purchased and will be used within the manufacturer's limits. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Skin sweeps by ADCO and DCO will be conducted on 50 out of 70 residents to ensure residents are free from burn marks. Any findings of burn marks will be addressed with pertinent first aid and physician notification protocol. An incident report will be completed along with family notification. Completed 4/22/24. Focused Partner Rounds to be done daily by IDT team to address any issues or concerns with water temperature during showers. If residents voice any concerns with water temperature immediate testing will be conducted to ensure water is within appropriate ranges. Implemented 4/23/24. This practice will be reviewed monthly with the QA committee to ensure we comply with hot water temperatures. Responsible: Corporate Director of Physical Plant, EDO, DPP, DCO Surveyors monitored the facility's Plan of Removal and confirmed it was sufficient to remove the IJ through observations, interview, and record reviews from 04/23/2024 at 9:15 a.m. to 04/23/2024 at 3:00 p.m. as follows: During an interview on 4/23/2024 at 9:56 a.m., the EDO stated she had been in-serviced by the corporate PPD. She stated she understood the education and that water temperatures needed to be maintained between 100 F and 110 F. During an interview on 4/23/2024 at 9:58 a.m., the DPP stated he had been in-serviced by the corporate PPD. He stated he understood the education and that water temperatures needed to be maintained between 100 F and 110 F. During an interview on 4/23/2024 at 9:59 a.m., the DCO stated she had been in-serviced by the corporate PPD. She stated she understood the education and that water temperatures needed to be maintained between 100 F and 110 F. During an interview on 4/23/2024 at 10:00 a.m., the ADCO stated she had been in-serviced by the corporate PPD. She stated she understood the education and that water temperatures needed to be maintained between 100 F and 110 F. During a phone interview on 4/23/2024 at 10:08 a.m., CNA-D stated she had been in-serviced by the DCO. She stated that she worked on the night shift. She stated she understood the education and that water temperatures needed to be maintained between 100 F and 110 F. During a phone interview on 4/23/2024 at 10:12 a.m., LVN-H stated she had been in-serviced by the DCO. She stated that she worked on the day shift. She stated she understood the education and that water temperatures needed to be maintained between 100 F and 110 F. During a phone interview on 4/23/2024 at 10:14 a.m., LVN-I stated she had been in-serviced by the DCO. She stated that she worked on the night shift. She stated she understood the education and that water temperatures needed to be maintained between 100 F and 110 F. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a phone interview on 4/23/2024 at 10:16 a.m., CNA-C stated she had been in-serviced by the DCO. She stated that she worked on the night shift. She stated she understood the education and that water temperatures needed to be maintained between 100 F and 110 F. During a phone interview on 4/23/2024 at 10:17 a.m., HK-K stated she had been in-serviced by the DCO. She stated that she worked on the night shift. She stated she understood the education and that water temperatures needed to be maintained between 100 F and 110 F. During a phone interview on 4/23/2024 at 10:19 a.m., Laundry stated she had been in-serviced by the DCO. She stated that she worked on the night shift. She stated she understood the education and that water temperatures needed to be maintained between 100 F and 110 F. During a phone interview on 4/23/2024 at 10:25 a.m., the DM stated she had been in-serviced by the DCO. She stated that she worked on the night shift. She stated she understood the education and that water temperatures needed to be maintained between 100 F and 110 F. During an interview on 04/23/2024 at 10:30 a.m., the EDO stated that the facility had not hired any new staff since the IJ was called on 04/22/2024. She stated that the facility had one agency staff who was in-serviced and would provide proof of in-service on document sign-in sheet. Record review of the in-service signature sheets were verified of the agency staff signature. During an interview on 04/23/24 at 11:53 AM, the ADON (ADCO) and DON (DCO) verified that they both performed skin sweeps to all the residents. The DON stated that it was during the smoking break and some of the 400 hall residents were outside, but they came back and performed the skin assessments for them later. Both stated that they would verify that they observed each other performing. Reviewed list of residents with skin assessments performed. Verified skin assessments were documented in the electronic charts for all 70 residents. Random interviews with 6 residents who verified their skin was assessed the night of 04/22/2024. Reviewed in-service titled: Water temperatures dated 04/22/2024 revealed the administration (IDT team), dietary, housekeeping, laundry and clinical (nurses and nurse aides). The education included: Facility water temperatures should be between 100-110 degrees Fahrenheit in resident use areas. Reviewed in-service information and signature sheets for in-service reading dated 04/22/2024: Facility water temperatures must be between 100-110 degrees Fahrenheit in resident use areas. Water temperatures must be checked three times daily for 7 days, twice daily for 30 days and then once daily thereafter. Water temperatures must be checked with a calibrated probe style thermometer. Verified EDO, DPP, DON (DCO), and ADON (ADCO) signatures. Reviewed in-service information and signature sheets for in-services titled Temperatures of Showers dated 04/22/2024 revealed: Temperatures of Showers should be between 100-110 degrees Fahrenheit. If the resident states it is too hot, stop and report to DON/ADMN. We check the temperature with a temperature probe, report broken/hot water or sinks in maintenance log. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Comparison of schedule from 04/22/2024- 04/23/2024 including day and night shift revealed all scheduled staff were educated prior to working their next shift. Reviewed water temperature logs that included temperature checks for hall 200, 300, 400, 500 sinks and shower. Those checks were performed on 04/22/2024 at 8:00 AM, 12:45 PM, 3:10 PM, and 7:00 PM, with all temperatures in range. Further review revealed temperature checks on 04/23/24 at 8:00 AM and were within range between 100-110 degrees F. During an observation on 04/23/24 at 11:00 AM, temperature checks were performed on showers and sinks on hall 200, 300, 400, and 500 by Maintenance DPP. Temperatures checked correctly with a new probe thermometer. During an observation on 04/23/24 12:35 PM, temperature checks were performed on showers and sinks on hall 200, 300, 400, and 500 by Maintenance DPP. Temperatures checked correctly with a new probe thermometer. During an observation on 04/23/24 at 1:35 PM, DPP performed water temperature checks using a new thermometer with a probe on Hall 100 sink and shower due to them being too low before. The sink reading was 104 degrees, and the shower reading was 104 degrees. During an interview with the ADMN, she stated the IDT team had not started focused partner rounds to address water temperatures during showers due to not being able to use showers until the immediate jeopardy was lowered. The ADMN provided the check sheet the facility intended to use once they began rounds. An Immediate Jeopardy was identified on 04/22/2024. While the Immediate Jeopardy was removed on 04/23/2024, the facility remained out of compliance at a level of no actual harm with a potential for more than minimal harm and a scope of pattern, due to the facility monitoring the effectiveness of their Plan of Removal. The ADMN, DON, and RRN were informed of the Immediate Jeopardy was removed on 04/23/2024 at 3:10 p.m.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on observations, interviews, and record reviews, the facility failed to provide appropriate treatment and services to prevent urinary tract infections for residents who are incontinent of bladder, for 2 of 18 (Resident #17 and Resident #38) residents reviewed for incontinent care. The facility failed to ensure no cross-contamination occurred when CNA B failed to wash hands prior to, during, or after performing peri-care and failed to follow peri-care standards of practice when wiping in a zig-zag motion instead of front to back and when going from dirty to clean for Resident #17. The facility failed to ensure no cross-contamination occurred when CNA C failed to wash hands prior to, during, or after performing peri-care and failed to follow peri-care standards of practice when wiping in a zig-zag motion instead of front to back and when going from dirty to clean for Resident #38. These failures could place residents at risk of development and transmission of communicable diseases and infections. Findings included: Resident #17 Review of Resident #17's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: major depression, dementia, and psychotic disorder. Record review of Resident #17's Quarterly MDS assessment dated [DATE] revealed: BIMS score of 05 which indicated severe cognitive impairment. Further review of the MDS Section GG Self-Care revealed toileting hygiene of substantial/maximal assistance. Further review of the MDS Section H Bladder and bowel revealed frequently incontinent of bladder and always incontinent of bowel. Record review of Resident #17's Care plan revised on 10/17/2023 revealed: Focus: The resident has mixed bladder incontinence and is at risk for skin breakdown r/t incontinence of urine r/t Dementia, Impaired Mobility. Goal: The resident will remain free from skin breakdown due to incontinence and brief use through the review date. The resident's risk for septicemia will be minimized/prevented via prompt recognition and treatment of symptoms of UTI through the review date. Interventions: Clean peri-area with each incontinence episode. Establish voiding patterns. Monitor/document/report PRN any possible causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, Stroke, medication side effects. Resident #38 Review of Resident #38's electronic face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: dementia, pain, Alzheimer's, and fatigue. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #38's Significant Change MDS dated [DATE] revealed: BIMS not completed. Further review of the MDS Section GG Self-Care revealed toileting hygiene of dependent. Further review of the MDS Section H Bladder and Bowel revealed always incontinent of bowel and bladder. Record review of Resident #38's Care plan revised on 02/05/20 revealed: Focus: The resident has bladder incontinence and is at risk for skin breakdown r/t incontinence of urine dx of Alzheimer's. Goal: The resident will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions: Clean peri-area with each incontinence episode. Encourage fluids during the day to promote prompted voiding responses. Ensure the resident has unobstructed path to the bathroom. Establish voiding patterns. Limit fluids 2-3 hours prior to bedtime. Monitor and document intake and output as per facility policy. During observation on 04/21/24 at 11:31 AM, CNA B performed peri-care on Resident #38 with the assist of CNA C. CNA B did not wash her hands prior to beginning. CNA B wiped perineal area in a zig-zag motion with one wipe. CNA B did not separate the labia and clean that area. CNA B did not change gloves or sanitize between removing dirty brief and applying clean brief. CNA B finished peri-care, removed gloves, and did not wash hands. CNA C assisted with turning of resident. CNA C then performed peri-care on Resident #17 with the assist of CNA B for turning. Neither CNA C nor CNA B washed their hands. CNA C wiped perineal area in a zig-zag motion with one wipe. CNA C did not separate the labia and clean that area. CNA C did not change gloves or sanitize between removing dirty brief and applying clean brief. CNA C finished peri-care, removed gloves, and did not wash hands. During an interview on 04/21/24 at 1:15 pm, CNA C stated she should have washed her hands prior to peri-care and after peri-care. She stated she was just nervous. CNA C stated she did not know she should have changed gloves between dirty and clean. She stated she had not been trained or checked off on peri-care since she had worked at the facility. During an interview on 04/21/24 at 1:30 pm, CNA B stated she did not wash her hands because the resident bathrooms were either too full to get into or they do not have hot water. She stated she felt that she cleaned the resident thoroughly. CNA B stated she had not performed any skills competencies. Record review of personnel files showed no evidence of skill competency checkoffs or peri-care training for CNA B hired on 12/12/2023. Record review of personnel files showed no evidence of skill competency checkoffs or peri-care training for CNA C hired on 01/13/2020. During an interview on 04/25/24 at 2:00 PM, the DON stated hands should be washed before, during, and after peri-care. She stated the perineal should be cleaned from front to back not a zig-zag motion and a new wipe should be used after each swipe. DON stated the labia should be separated and cleaned thoroughly. The DON stated she had not performed any staff competencies since she had been DON starting in February 2024. She stated she had called the previous DON to see if she had record of competencies but at that time, she had no record of when competencies were last performed. She stated she did not know how often staff performance should be evaluated or anything about their required annual training. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's policy titled Perineal Care not dated revealed: Steps in Procedure: .2. Wash and dry your hands thoroughly .6. Put on gloves 8. For a female resident a. use wipes and apply skin cleansing agent. B. wash perineal area, wiping from front to back. 1. Separate labia and wash area downward from front to back. (Note: If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on observation, interview, and record review, the facility failed to attempt to use alternatives prior to installing a side or bed rail and assess the resident for risk of entrapment from bed rails prior to installation for 3 of 3 residents (Resident #26, Resident #59, and Resident #68) reviewed for bed rails. 1. The facility failed to assess residents for entrapment risks and attempt less restrictive measures prior to installing bed rails. 2. The facility failed to obtain informed consent prior to installation of bed rails. These failures could place residents at risk for injury and restricted movement. The findings include: Resident #26 Record review of Resident #26's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: Alzheimer's, dementia, and depression. Record review of Resident #26's quarterly MDS assessment dated [DATE] revealed: BIMS score of 06 which indicated severe cognitive impairment. Further review of the MDS Section P Restraints and Alarms revealed no bed rails used and Section GG- Functional Abilities and Goals revealed resident needed partial assistance with rolling left and right in the bed, ability to move from sitting to lying, ability to move from lying on the back to sitting on the side of the bed, and ability to move from bed to chair. Record review of Resident #26's care plan initiated on 03/07/2024 revealed no evidence of side rails. Record review of Resident #26's electronic physicians Orders revealed no evidence of order for side rails. Record review of Resident #26's electronic medical record revealed no evidence that risk for entrapment was performed, less restrictive measures were attempted, or informed consent was obtained prior to installation of bed rails. During an observation on 04/25/24 at 1:53 p.m., Resident #26 was resting in bed with bilateral half side rails up. Resident was not able to be interviewed or answer questions. Resident #59 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #59's electronic face sheet dated 04/24/2024 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: major depressive disorder, dementia, insomnia, muscle weakness, psychotic disorder with delusions, and anxiety. Record review of Resident #59's quarterly MDS dated [DATE] revealed: BIMS score of 02 which indicated severe cognitive impairment. Further review of the MDS Section P Restraints and Alarms revealed no bed rails used and Section GG- Functional Abilities and Goals revealed resident needed substantial assistance to roll left and right in the bed, and helped does all of the effort with ability to move from sitting to lying, ability to move from lying on the back to sitting on the side of the bed, and ability to move from bed to chair. Record review of Resident #59's Care plan initiated on 01/04/2024 revealed: Focus: Resident requires the use of 1/2 side rails to assist with bed mobility. Goal: Dignity will be maintained, and no occurrence of injury will occur throughout the review date. Interventions: Evaluate and Re-evaluate for 1/2 side rail use quarterly and PRN. Explain reason and risks of 1/2 side rails using terms the resident and responsible party can understand. Monitor for proper positioning and circulatory concerns report any significant changes to MD promptly. Record review of Resident #59's electronic physicians orders revealed no evidence of an order for side rails. Record review of Resident #59's electronic medical record revealed no evidence that risk for entrapment was performed, less restrictive measures were attempted, or informed consent was obtained prior to installation of bed rails. During an observation on 04/21/2024 at 11:15 a.m., Resident #59 was sitting in the dining area of the secured unit. Resident 59's room [ROOM NUMBER]-A had bilateral half side rails present and the left side was in the up position. Attempted phone interview on 04/21/2024 at 6:20 p.m. with Resident #59's responsible party who refused interview at this time. Resident #68 Review of Resident #68's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: blindness, depression, autistic disorder, and Down's syndrome. Record review of Resident #68's admission MDS dated [DATE] revealed: BIMS not completed that indicated resident was unable to complete related to resident is rarely or never understood. Further review of the MDS Section P Restraints and Alarms revealed no bed rails used, and Section GG- Functional Abilities and Goals revealed partial assistance needed for resident to roll left and right in the bed and ability to move from sitting to lying and needed substantial assistance with ability to move from lying on the back to sitting on the side of the bed, and ability to move from bed to chair. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #68's Care plan initiated on 03/04/2024 revealed: Focus: Resident requires the use of 1/2 side rails to assist with bed mobility. Goal: Dignity will be maintained, and no occurrence of injury will occur throughout the review date. Interventions: Evaluate and Re-evaluate for 1/2 side rail use quarterly and PRN. Explain reason and risks of 1/2 side rails using terms the resident and responsible party can understand. Monitor for proper positioning and circulatory concerns report any significant changes to MD promptly. Record review of Resident #68's electronic physicians orders revealed: MAY USE SIDE RAILS FOR POSITIONING, dated 03/04/2024. Record review of Resident #68's electronic medical record revealed no evidence that risk for entrapment was performed, less restrictive measures were attempted, or informed consent was obtained prior to installation of bed rails. During an observation on 04/25/2024 at 01:59 p.m. Resident #68 was lying in bed with bilateral half rails in the up position. Resident unable to be interviewed or answer questions. During an interview on 04/25/2024 at 12:03 p.m., LVN I stated the facility did not use bed rails to keep residents in their beds but used them as mobility aides. She stated that a consent should be obtained, and a physician's order was needed prior to bed rails being installed. She stated that she would perform a mobility device assessment in the electronic medical record when a resident had bed rails and would know to perform when UDA (un-documented assessments) triggered. She was unsure who scheduled out the assessment on the UDA. LVN I stated the effect of placing bed rails on a resident's bed that did not have orders, consent, or appropriate assessment could cause resident to potentially fall or get caught in the rail. During an interview on 04/25/2024 at 12:05 p.m., CNA F stated the facility did not use bed rails to keep residents in their beds but for mobility. She stated that Resident #59 had recently moved into room [ROOM NUMBER] and felt that the bed may have had rail prior to her being in the room. During an observation and interview on 04/25/2024 at 1:10 p.m., Resident #59's bed had bilateral half rails with left rail (closest to the wall) in the up position. The ADON stated that facility did not use bed rails to keep residents in their beds. She stated that she did not know the facility's policy on bed rails. During an interview on 04/25/2024 at 1:15 p.m., the DON stated her expectation would be for physician orders to be obtained and consent obtained prior to installing bed rails on a resident's bed. She felt that the failure had occurred due to Resident #59 had recently changed rooms and bed rails being present prior to room change. She stated that she and the RRN were responsible for monitoring that proper items were in place prior to bed rails being installed on the beds. She was not aware of any assessment that needed to be performed for bed rails. She stated that the effect to the resident could be having an injury from a fall. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/25/2024 at 1:18 p.m., the RRN stated she expected for a physician's order, informed consent, an entrapment risk assessment, and an assessment of bed to make sure bed rail fit properly prior to bed rails being used. She stated that both her and the DON were responsible to make sure those tasks were performed. During a follow up interview on 04/25/2024 at 1:37 p.m., the DON stated the assessment that should have been performed was titled Bed Rail Entrapment Assessment and the DPP should have been performing. She stated that the DPP would be in-serviced then he could start to perform assessments. Review of facility's policy titled Bed Safety dated 04/2021 revealed: Focused Communities will strive to provide a safe sleeping environment for the resident. Procedure 1. The resident's sleeping environment shall be assessed by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from resident and family regarding previous sleeping habits and bed environment. 2. To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches: a. An inspection should be done by the Director of Plant Operations at installation/before use and quarterly thereafter of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks; b. Review that gaps within the bed system are within the dimensions established by the FDA (Note: The review shall consider situations that could be caused by the resident's weight, movement, or bed position. c. Ensure that when bed system components are worn and need to be replaced, they are replaced with compatible components that meet manufacturer's specifications; d. Ensure that bed side rails are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard, etc.); and e. Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g., altered mental status, restlessness, etc.). 3. The Director of Plant Operations shall provide a copy of inspections to the Executive Director of Operations and report results to the QA Committee recommendations shall be maintained by the Executive Director of Operations and/or Safety Committee. 4. The facility's education and training activities will include instruction about risk factors for resident injury due to beds, and strategies for reducing risk factors for injury, including entrapment. 5. If side rails are used, there shall be an interdisciplinary assessment of the resident, consultation with the Attending Physician, and input from the resident and/or legal representative. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. The staff shall obtain consent for the use of side rails from the resident or the resident's legal representative prior to their use. 7. After appropriate review and consent as specified above, side rails may be used at the resident's request to increase the resident's sense of security (e.g., if he/she has a fear of falling, his/her movement is compromised, or he/she is used to sleeping in a larger bed). 8. Side rails may be used if assessment and consultation with the Attending Physician has determined that they are needed to help manage a medical symptom or condition, or to help the resident reposition or move in bed and transfer, and no other reasonable alternatives can be identified. 9. Before using side rails for any reason, the staff shall inform the resident and family about the benefits and potential hazards associated with side rails. 10. When using side rails for any reason, the staff shall take measures to reduce related risks. 11. Side rails shall not be used as protective restraints. Should a protective restraint be used, communities' protocol for the use of restraints shall be followed. 12. The use of physical restraints on individuals in bed shall be limited to situations where they are needed to treat a resident's medical symptoms, and only after being reviewed by authorized individuals. 13. The staff shall report to the Director of Clinical Operations and Executive Director of Operations any deaths, serious illnesses and/or injuries resulting from a problem associated with a bed and related equipment including the bed frame, bed side rails, and mattresses. The Executive Director of Operations shall ensure that reports are made to the Food and Drug Administration or other appropriate agencies, in accordance with pertinent laws and regulations including the Safe Medical Device Act. 48883

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 44728 Based on interview and record review, the facility failed to review the work of each Certified Nurse Aid (CNA) every 12 months for 4 (CNA-D, CNA-E, CNA-F and CNA G) of 5 CNAs reviewed for nursing services. The facility failed to provide CNA competency evaluations at least every 12 months after hire. This failure could result in inadequate CNA performance while providing care for residents. Findings include: Record Review of Personnel Files revealed: - Employee record for CNA-D revealed a hire date of 10/04/2021 and had no evidence of a competency evaluation at least every 12 months after hire. - Employee record for CNA-E revealed a hire date of 10/19/2021 and had no evidence of a competency evaluation at least every 12 months after hire. - Employee record for CNA-F revealed a hire date of 11/15/2021 and had no evidence of a competency evaluation at least every 12 months after hire. - Employee record for CNA-G revealed a hire date of 10/14/2021 and had no evidence of a competency evaluation at least every 12 months after hire. During an interview on 04/25/2024 at 2:00 PM, the DON stated she had not performed any staff competencies since she had been hired as DON, February 2024. She stated she had called the previous DON to see if she had the records of CNA competencies, but she had no records. She stated she did not know how often staff performances should have been evaluated or their required annual training. The DON stated she was supposed to have monitored the CNA competency trainings. She stated the negative impact to residents could have been them not performing their duties correctly and possibly not giving them the proper care they deserved. She stated the failure was that she had not followed up with making sure the CNA's had all been trained correctly with documentation. The DON stated her expectations were for them to have had all of the competencies they needed and have the proper training and to take care of the residents as required. Record Review of the facility's policy titled Nurse Aide Education, dated 08/16/17, revealed the following: - Competency will be evaluated initially and annually. - Facility will conduct a performance review of each nurse aide at least once every 12 months. 45732

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on observation, interview, and record review, the facility failed to ensure residents with PRN orders for psychotropic drugs were limited to 14 days for 6 (Resident #45, Resident #10, Resident #18, Resident #58, Resident #2, and Resident #52) of 11 residents reviewed for pharmacy services. The facility failed to ensure Resident #45, Resident #10, Resident #18, Resident #58, Resident #2, and Resident #52 had stop dates for PRN Lorazepam (medicine used to treat the symptoms of anxiety). This failure could place residents at risk for psychotropic medication side effects, adverse consequences, decreased quality of life and dependence on unnecessary medications. Resident #45 Review of Resident #45's electronic face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: anxiety, diabetes, depression, dementia, and Alzheimer's. Record review of Resident #45's Quarterly MDS assessment dated [DATE] revealed: BIMS score of 04 which indicated severe cognitive impairment. Further review of the MDS Section N Medications revealed antianxiety medications taken in the last 7 days during the look back period (assessment period). Record review of Resident #45's Care plan revised on 10/24/2023 revealed: Focus: The resident uses antianxiety Medication. Goal: The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. Interventions: Administer ANTI-ANXIETY medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms. Monitor/document/report PRN any adverse reactions to ANTI-ANXIETY therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, Slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. UNEXPECTED SIDE EFFECTS: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations. Monitor/record occurrence of for target behavior symptoms (SPECIFY pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. Record review of Resident #45's electronic Physicians Orders revealed: Lorazepam Concentrate 2 MG/ML Give 0.5 ml sublingually every 4 hours as needed for restlessness/agitation/anxiety, dated 02/11/2022 with no stop date. Record review of Resident #45's MAR, dated April 2024, revealed no evidence of Lorazepam being administered. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #45's physician progress notes from January 2024- April 2024 revealed no documented rationale for the continued provision of lorazepam. Resident #10 Review of Resident #10's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: bipolar disorder, difficulty swallowing, and anxiety. Record review of Resident #10's Significant Change MDS dated [DATE] revealed: BIMS score not completed. Further review of the MDS Section N Medications revealed antianxiety medication taken in the last 7 days during the look back period (assessment period). Record review of Resident #10's Care plan revised on 10/17/2023 revealed: Focus: The resident uses antianxiety Medication. Goal: The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. Interventions: Administer ANTI-ANXIETY medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Monitor/document/report PRN any adverse reactions to ANTI-ANXIETY therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, Slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. UNEXPECTED SIDE EFFECTS: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations. Record review of Resident #10's electronic Physicians Orders revealed: Lorazepam Intensol Oral Concentrate 2 MG/ML Give 0.5 ml by mouth every 4 hours as needed for restlessness/agitation/anxiety, dated 02/06/2024 with no stop date. Record review of Resident #10's MAR, dated April 2024, revealed Lorazepam was administered on 04/23/24 at 11:53 am and 04/24/24 at 11:49 am. Review of Resident #10's physician progress notes from January 2024- April 2024 revealed no documented rationale for the continued provision of lorazepam. Resident #18 Review of Resident #18's electronic face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: paralysis, diabetes, irregular heartbeat, and difficulty swallowing. Record review of Resident #18's Quarterly MDS dated [DATE] revealed: BIMS score 00 which indicated severe cognitive impairment. Further review of the MDS Section N Medications revealed antianxiety medication taken in the last 7 days during the look back period (assessment period). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #18's Care plan revised on 12/20/2023 revealed: Focus: The resident uses antianxiety Medication. Goal: The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. Interventions: Administer ANTI-ANXIETY medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Monitor/document/report PRN any adverse reactions to ANTI-ANXIETY therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, Slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. UNEXPECTED SIDE EFFECTS: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations. Record review of Resident #18's electronic Physicians Orders revealed: Lorazepam Injection Solution 2 MG/ML (Lorazepam) Give 0.5 ml sublingually every 4 hours as needed for restlessness/agitation/anxiety, dated 12/29/2023 with no stop date. Record review of Resident #18's MAR, dated April 2024, revealed no Lorazepam had been administered. Review of Resident #18's physician progress notes from January 2024- April 2024 revealed no documented rationale for the continued provision of lorazepam. Resident #58 Review of Resident #58's electronic face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include: diabetes, liver failure, and high blood pressure. Record review of Resident #58's Quarterly MDS dated [DATE] revealed: BIMS score 10 which indicated moderate cognitive impairment. Further review of the MDS Section N Medications revealed no antianxiety medications taken in the last 7 days during the look back period (assessment period). Record review of Resident #58's Care plan revised on 12/20/2023 revealed: Focus: The resident uses antianxiety Medication. Goal: The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. Interventions: Administer ANTI-ANXIETY medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Monitor/document/report PRN any adverse reactions to ANTI-ANXIETY therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, Slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. UNEXPECTED SIDE EFFECTS: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations. Record review of Resident #58's electronic Physicians Orders revealed: Lorazepam Solution 2 MG/ML (Lorazepam) Give 0.5 ml by mouth every 4 hours as needed for restlessness/agitation/anxiety, dated 12/15/2022 with no stop date. Record review of Resident #58's MAR, dated April 2024, revealed no Lorazepam had been administered. Review of Resident #58's physician progress notes from January 2024- April 2024 revealed no documented rationale for the continued provision of lorazepam. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2 Review of Resident #2's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: depression, anxiety, brain bleed, and Parkinson's disease. Record review of Resident #2's Quarterly MDS dated [DATE] revealed: BIMS score 10 which indicated moderate cognitive impairment. Further review of the MDS Section N Medications revealed no antianxiety medication taken in the last 7 days during the look back period (assessment period). Record review of Resident #2's Care plan revised on 12/20/2023 revealed: Focus: The resident uses antianxiety Medication. Goal: The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. Interventions: Administer ANTI-ANXIETY medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Monitor/document/report PRN any adverse reactions to ANTI-ANXIETY therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, Slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. UNEXPECTED SIDE EFFECTS: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations. Record review of Resident #2's electronic Physicians Orders revealed: Lorazepam Solution 2 MG/ML (Lorazepam) Give 0.5 ml by mouth every 4 hours as needed for restlessness/agitation/anxiety, dated 12/15/2022 with no stop date. Record review of Resident #2's MAR, dated April 2024, revealed no Lorazepam had been administered. Review of Resident #2's physician progress notes from January 2024- April 2024 revealed no documented rationale for the continued provision of lorazepam. Resident #52 Review of Resident #52's electronic face sheet revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include: prostate cancer, anxiety, and respiratory failure. Record review of Resident #52's Admission MDS dated [DATE] revealed: BIMS score 08 which indicated moderate cognitive impairment. Further review of the MDS Section N Medications revealed antianxiety medication taken in the last 7 days during the look back period (assessment period). Record review of Resident #52's Care plan revised on 03/22/2024 revealed: Focus: The resident uses antianxiety Medication. Goal: The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. Interventions: Administer ANTI-ANXIETY medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Monitor/document/report PRN any adverse reactions to ANTI-ANXIETY therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, Slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. UNEXPECTED SIDE EFFECTS: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #52's electronic Physicians Orders revealed: Lorazepam Intensol Oral Concentrate 2 MG/ML Give 0.5 ml by mouth every 1 hours as needed for Anxiety/Agitation/Restless, ordered 03/22/2024 with no stop date. Record review of Resident #52's MAR, dated April 2024, revealed: lorazepam was administered on 04/21/2024 at 2:59 am and 6:48 am, 04/23/2023 at 1:00 pm and 2:42 pm, and 04/24/2024 at 4:12 am, 10:10 am, 11:53 am, and 7:14 pm. Review of Resident #52's physician progress notes from January 2024- April 2024 revealed no documented rationale for the continued provision of lorazepam. During an interview on 04/24/2024 at 10:45 AM, the DON stated she was aware of the regulation on PRN psychotropic medications. She stated it was her responsibility to monitor and ensure all PRN psychotropic medications had a stop date no longer than 14 days. The DON stated she had been the DON since February and had been very busy and she just missed the orders. She stated she did not know the possible negative outcome other than not following the regulation. Review of facility policy titled, Psychotropic Medication Review not dated revealed: Policy: IDT will emphasize the importance of seeking an appropriate dose and duration of each psychotropic medication, with careful assessment as to whether the medication is necessary and pharmacologically appropriate. Standards: 1. The community will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications, to include regular review for continued need, appropriate dosage, side effects, risks and/or benefits. 2. The community supports the appropriate use of psychopharmacologic medications that are therapeutic and enabling for residents suffering from mental illness. 3. The community supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, mental, and/or behavioral interventions, as well as psychopharmacological medications can be utilized to meet the needs of the individual resident. 4. Efforts to reduce dosage or discontinue of psychopharmacological medications will be ongoing, as appropriate, for the clinical situation. 5. Psychopharmacological medications will never be used for purpose of discipline or convenience. Procedures: 1. Monitors psychotropic drug use noting any adverse effects. 2. Reviews of the use of the medications with IDT on monthly basis, during Standard of Care Meeting to determine the continued presence of target behaviors and or the presence of any adverse effects of the medications. 3. Monitors psychotropic drug use to ensure that medications are not used in excessive doses or for excessive duration. 4. Monitor psychotropic drug use for gradual dose reduction (GDR) potential. 5. Monitor GDR for success or failure, related to targeted behaviors. Review of Drugs.com for Lorazepam accessed on 04/29/2024 at https://www.drugs.com/lorazepam.html revealed: Lorazepam belongs to a class of medications called benzodiazepines. It is thought that benzodiazepines work by enhancing the activity of certain neurotransmitters in the brain. Lorazepam is used in adults and children at least [AGE] years old to treat anxiety disorders. 48883

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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. 48883 Based observations, interviews, and record reviews, the facility failed to store all drugs and biologicals in locked compartments for 1 of 4 medication carts reviewed for label and storage of drugs and biologicals. The facility failed to ensure 1 medication cart (used by nurse for treatments performed on 200 and 400 halls was locked when unattended. This failure could place residents at risk of having access to unauthorized medications, wound care, and medical supplies leading to possible harm or drug diversions. Findings included: During an observation on 04/23/2024 at 6:23 p.m., an unlocked medication cart seen unattended by the nurses' station in between 200 and 400 halls with one resident approximately 6 feet away. There were medications including Nystatin (prescription anti-yeast) powders, Voltaren and hydrocortisone (over the counter topical) creams. Over the counter medication bottles including Aspirin, Tylenol, and colace (stool softener). Prescription medications including Zoloft (anti-depressant), trazodone (anti-depressant), Singulair (anti-inflammatory), Buspar (anti-anxiety), Baclofen (muscle relaxant), Keppra (anti-seizure), lactulose (anti-constipation), Sinemet (dopamine precursor), and Megace (appetite stimulant) in the cart. During an interview on 04/23/2024 at 6:25 p.m., RN A stated that she was responsible for the unlocked medication cart. She stated she had left it unlocked since counting medications during shift change. She stated that being nervous and distracted led to her not locking cart. RN A stated that she knew medication carts were to be locked when left unattended. She stated that she had not taken any in-services with the facility but had education through her agency as she was an agency nurse. She stated that the negative impact of leaving the cart unlocked could be possible adverse reactions leading to death if a resident were to take some medication out of cart. She stated the failure was the locking mechanism not being pushed in that would have locked the cart. During an interview on 04/23/2024 at 6:30 p.m. the DON stated medication carts should always be locked when unattended. She stated the negative impact would be residents could possibly have an allergic reaction and/or death if they took medications out of the medication cart. The DON stated all nursing staff should monitor the medication carts to make sure they are always locked. She stated she had not done any in-services herself, but had found in-services of June 2023, prior to her hire date. She stated the failure occurred when the nurse left the cart unlocked with her expectations being keeping all carts locked and to follow protocol. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled Storage of Medications revised on 08/2020 revealed Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .Medication rooms, carts, and medication supplies are locked when they are not attended by persons with authorized access.

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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** 44728 Based on observation, 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 food and nutrition services in that: The facility failed to ensure the dry food storage was not past their use by dates. This failure placed residents at risk for food borne illnesses. Findings include: During an observation on [DATE] at 9:45 AM, the dry storage pantry revealed: 1. 6 packages of 16 oz. sealed marshmallows in the original packaging with an use by date of [DATE]. 2. 1 opened box of shredded coconut with the in date of [DATE] and an opened date of [DATE]. 3. 1 sealed 20 lb. box of black-eyed peas with an use by date of [DATE]. During an interview on [DATE] at 10:44 AM, the DM stated there should have been no expired food in the pantry. She stated the product dates should have been checked on a weekly basis as well as when the truck came in with products. She stated she had previously given in-services for food safety to her kitchen staff on [DATE]. She stated she should have monitored the stored food as well as what came in on the trucks to the kitchen more closely. The DM stated the failure occurred with the kitchen department head and having not paid attention to the expired products and dates. She stated the negative impact was it could have possibly made residents sick, and her expectations would have been that all products were checked correctly daily. During an interview on [DATE] at 11:45 AM, the ADMN stated the expiration dates on food products should have been checked every day and updated weekly as well as rotating food products. She stated she would only go into the kitchen when she needed to. She stated she the DM monitored products to make sure there were no outdated products, but that ultimately the ADMN monitored the DM. The ADMN stated the negative impact to residents were that they could get sick. She stated the failure occurred with the chain of command with trainings not being adhered to. She stated her expectations were that the products be labeled and dated as they come in off the truck and rotating and using the oldest dated products before their expired date. Record review of facility's food manager training, Food Safety Articles, First In, First Out (FIFO), undated, revealed; FIFO organizes food by expiration or use-by date (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the FDA Food Code 2022 https://www.fda.gov/food/retail-food-protection/fda-food-code accessed [DATE] revealed: ,d+[DATE].11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement; (2) If made from two or more ingredients, a list of ingredients and sub-ingredients in descending order of predominance by weight, including a declaration of artificial colors, artificial flavors and chemical preservatives, if contained in the FOOD; (3) An accurate declaration of the net quantity of contents; (4) The name and place of business of the manufacturer, [NAME], or distributor; and (5) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or usual name of the respective ingredient. Pf (6) Except as exempted in the Federal Food, Drug, and Cosmetic Act S 403(q)(3) - (5), nutrition labeling as specified in 21 CFR 101 - Food Labeling and 9 CFR 317 Subpart B Nutrition Labeling. (7) For any salmonid FISH containing canthaxanthin or astaxanthin as a COLOR ADDITIVE, the labeling of the bulk FISH container, including a list of ingredients, displayed on the retail container or by other written means, such as a counter card, that discloses the use of canthaxanthin or astaxanthin.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on interview and record review, the facility failed to ensure resident records were maintained with accepted professional standards and practices for completeness and accurately documented for 1 of 17 residents (Resident #64) reviewed for resident records. The facility failed to obtain physician's order prior to placing Resident #64 in secure unit. The facility failed to obtain consent from resident or representative prior to placing Resident #64 in secure unit. These failures could place residents at risk of being separated against their will , without orders or the representative's consent. Findings include: Record review of the Resident #64's face sheet dated 04/21/2024 revealed she was a [AGE] year-old female admitted to the facility initially on 03/06/2024 and most recently on 03/30/2024 with a diagnosis of acute posthemorrhagic anemia (low iron from blood loss), unspecified dementia (brain disorder that interferes with memory with unknown severity), anxiety, and diabetes. Record review of Resident #64's quarterly MDS dated [DATE], revealed: Section C - Cognitive Patterns a BIMS score of 05 (severe cognitive impairment); Section P- Restraints and Alarms revealed no restraint use; Section E- Behavior revealed she had wandering and rejection of care behaviors. Record review of Resident #64's care plan dated 03/31/2024 revealed she had impaired cognitive function and impaired decision-making abilities but no evidence of residing on secure unit. Record review of Resident #64's physician orders dated 04/21/2024 revealed quetiapine/Seroquel (antipsychotic medication) 25mg give 1 tablet by mouth one time a day for preventative; quetiapine/Seroquel (antipsychotic medication) 25 mg give 2 tablets by mouth one time a day for preventative; quetiapine/Seroquel (antipsychotic medication) 25mg give 3 tablets by mouth at bedtime for preventative, but no orders to be placed on secured unit at this facility. During an interview on 04/24/2024 at 10:46 a.m., the DON stated residents needed to have a physician's order and consent prior to being admitted into the locked unit. She stated she was unsure why physician's order was not obtained but felt that consent was obtained on paper. She was not able to locate where the paper form would have been stored and stated she would prefer those consents be uploaded into resident's electronic record. She stated that she monitored consents and orders were obtained. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/24/2024 at 11:11 a.m., the RRN stated her expectation would be for physician's order and consent obtained from the resident or their representative, prior to resident admitting into the secure unit. She stated she felt consent was obtained and paper lost. She stated she did not know why physician's order was not obtained. She stated that the DON and ultimately herself monitors those consents and physician orders were obtained. She stated the effect not having would have on the resident was possible involuntary seclusion of the resident. Review of facility's policy titled Admission Screening for Placement on Memory Care Unit and Consent for Placement on Memory Care Unit last revision date on 05/25/2021 revealed Pre-Admission: Identification of the individuals whose needs necessitate placement on the Memory Care Unit prior to their admission to the facility requires the following: 1. Assessment of the potential resident by admission staff and DCO (director of clinical operations) is required prior to admission to the nursing facility to determine if the potential resident exhibits the flags listed in section (3) a,b,c,d,e,f,g. 2. If yes, upon admission of the Resident to the facility, admission member will Complete the Admission Screening for Placement on Memory Care Unit. Meet with the responsible party to complete the Consent for Placement on Memory Care Unit. Admission Screening form and consent for placement will be generated in Document Manager in Point Click Care. Social worker will prepare a care plan to reflect the need for placement on the Memory Care Unit and follow up with the resident to assess psychosocial well-being for adjustment issues. Charge nurse will notify the physician to obtain an order for placement on the Memory Care Unit.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44728 45732 Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician and others participating in the provision of care for 11 (Resident #45, Resident #10, Resident #18, Resident #58, Resident #2, Resident #52, Resident #26, Resident #19, Resident #21, Resident #35, and Resident #34) of 11 residents reviewed for hospice services. The facility failed to maintain required hospice forms and documentation, that included the hospice plan of care and certificate of terminal illness to ensure Resident #45, Resident #10, Resident #18, Resident #58, Resident #2, Resident #52, Resident #26, Resident #19, Resident #21, Resident #35, and Resident #34 received adequate end-of-life care. The facility failed to have physicians' orders for Hospice Care for Resident #10, Resident #58, Resident #2, Resident #52, Resident #21, and Resident #35. This failure could place the residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. The findings included: Resident #45 Review of Resident #45's electronic face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: anxiety, diabetes, depression, dementia, and Alzheimer's. Record review of Resident #45's Quarterly MDS assessment dated [DATE] revealed: BIMS score of 04 which indicated severe cognitive impairment. Further review of the MDS Section O Special Treatments, Procedures, and Programs revealed Hospice Care. Record review of Resident #45's Care plan revised on 09/01/2023 revealed: Focus: The resident has a terminal prognosis r/t Alzheimer's Disease. On Hospice Services. Goal: The resident's comfort will be maintained through the review date. Interventions: Assess resident coping strategies and respect resident wishes. Consult with physician and Social Services to have Hospice care for resident in the facility. Encourage resident to express feelings, listen with non-judgmental acceptance, compassion. Encourage support system of family and friends. Keep the environment quiet and calm. Keep linens clean, dry and wrinkle free. Keep lighting low and familiar objects near. Record review of Resident #45's electronic Physicians Orders revealed: Admit to Hospice, dated 02/11/2022. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No evidence of a binder that contained the required hospice forms and documentation, that included the hospice plan of care and certificate of terminal illness for Resident #45. Resident #10 Review of Resident #10's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: bipolar disorder, difficulty swallowing, and anxiety. Record review of Resident #10's Significant Change MDS dated [DATE] revealed: BIMS score not completed. Further review of the MDS Section O Special Treatments, Procedures, and Programs revealed Hospice Care. Record review of Resident #10's Care plan revised on 02/07/2024 revealed: Focus: The resident has a terminal prognosis r/t DX: Huntington's. On hospice Services. Goal: The resident's dignity and autonomy will be maintained at highest level through the review date. The resident's comfort will be maintained through the review date. Interventions: Adjust provision of ADLS to compensate for resident's changing abilities. Encourage participation to the extent the resident wishes to participate. Keep the environment quiet and calm. Keep linens clean, dry and wrinkle free. Keep lighting low and familiar objects near. Observe resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain. Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Record review of Resident #10's electronic Physicians Orders revealed no evidence of an order for Hospice Care. No evidence of a binder that contained the required hospice forms and documentation, that included the hospice plan of care and certificate of terminal illness for Resident #10. Resident #18 Review of Resident #18's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: paralysis, diabetes, irregular heartbeat, and difficulty swallowing. Record review of Resident #18's Quarterly MDS dated [DATE] revealed: BIMS score 00 which indicated severe cognitive impairment. Further review of the MDS Section O Special Treatments, Procedures, and Programs revealed Hospice Care. Record review of Resident #18's Care plan revised on 12/20/2023 revealed: Focus: The resident has a terminal prognosis HEMIPLEGIA AND HEMIPARESIS FOLLOWING CEREBRAL INFARCTION AFFECTING RIGHT DOMINANT SIDE. On Hospice services. Goal: The resident will be free of depression and anxiety through the review date. The resident's comfort will be maintained through the review date. Interventions: May oral suction PRN. Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Work with nursing staff to provide maximum comfort for the resident. Record review of Resident #18's electronic Physicians Orders revealed: Admit to Hospice ., dated 12/29/23. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No evidence of a binder that contained the required hospice forms and documentation, that included the hospice plan of care and certificate of terminal illness for Resident #18. Resident #58 Review of Resident #58's electronic face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include: diabetes, liver failure, and high blood pressure. Record review of Resident #58's Quarterly MDS dated [DATE] revealed: BIMS score 10 which indicated moderate cognitive impairment. Further review of the MDS Section O Special Treatments, Procedures, and Programs revealed Hospice Care. Record review of Resident #58's Care plan revised on 09/29/2023 revealed: Focus: The resident has a terminal prognosis r/t liver failure. HOSPICE. Goal: The resident's comfort will be maintained through the review date. Interventions: Adjust provision of ADLS to compensate for resident's changing abilities. Encourage participation to the extent the resident wishes to participate. Assess resident coping strategies and respect resident wishes. Consult with physician and Social Services to have Hospice care for resident in the facility. Encourage support system of family and friends. Observe resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain. Review resident's living will and ensure it is followed. Involve family in discussion. Work with nursing staff to provide maximum comfort for the resident. Record review of Resident #58's electronic Physicians Orders revealed no evidence of an order for Hospice Care. No evidence of a binder that contained the required hospice forms and documentation, that included the hospice plan of care and certificate of terminal illness for Resident #58. Resident #2 Review of Resident #2's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: depression, anxiety, brain bleed, and Parkinson's disease. Record review of Resident #2's Quarterly MDS dated [DATE] revealed: BIMS score 10 which indicated moderate cognitive impairment. Further review of the MDS Section O Special Treatments, Procedures, and Programs revealed Hospice Care. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's Care plan revised on 09/29/2023 revealed: Focus: The resident has a terminal prognosis r/t liver failure. HOSPICE. Goal: The resident's comfort will be maintained through the review date. Interventions: Adjust provision of ADLS to compensate for resident's changing abilities. Encourage participation to the extent the resident wishes to participate. Assess resident coping strategies and respect resident wishes. Consult with physician and Social Services to have Hospice care for resident in the facility. Encourage support system of family and friends. Observe resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain. Review resident's living will and ensure it is followed. Involve family in discussion. Work with nursing staff to provide maximum comfort for the resident. Record review of Resident #2's electronic Physicians Orders revealed no evidence of an order for Hospice Care. No evidence of a binder that contained the required hospice forms and documentation, that included the hospice plan of care and certificate of terminal illness for Resident #2. Resident #52 Review of Resident #52's electronic face sheet revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include: prostate cancer, anxiety, and respiratory failure. Record review of Resident #52's Admission MDS dated [DATE] revealed: BIMS score 08 which indicated moderate cognitive impairment. Further review of the MDS Section O Special Treatments, Procedures, and Programs revealed Hospice Care. Record review of Resident #52's Care plan revised on 03/22/2024 revealed: Focus: The resident has a terminal prognosis r/t DX: C61 Malignant neoplasm of prostate. On Hospice Services. Goal: The resident will be free of depression and anxiety through the review date. The resident's comfort will be maintained through the review date. Interventions: Adjust provision of ADLS to compensate for resident's changing abilities. Encourage participation to the extent the resident wishes to participate. Encourage resident to express feelings, listen with non-judgmental acceptance, compassion. Keep the environment quiet and calm. Keep linens clean, dry and wrinkle free. Keep lighting low and familiar objects near. Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Record review of Resident #52's electronic Physicians Orders revealed no evidence of an order for Hospice Care. No evidence of a binder that contained the required hospice forms and documentation, that included the hospice plan of care and certificate of terminal illness for Resident #52. Resident #26 Review of Resident #26's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: Alzheimer's, dementia, and depression. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #26's Quarterly MDS dated [DATE] revealed: BIMS score 06 which indicated severe cognitive impairment. Further review of the MDS Section P Restraints and Alarms revealed no bed rails used. Further review of MDS Section O Special Treatments, Procedures, and Programs revealed hospice care. Record review of Resident #26's Care plan initiated on 03/07/2024 revealed: Focus: The resident has a terminal prognosis r/t DX: Alzheimer's. On hospice services. Goal: The resident will be free of depression and anxiety through the review date. The resident's comfort will be maintained through the review date. Interventions: Assess resident coping strategies and respect resident wishes. Encourage resident to express feelings, listen with non-judgmental acceptance, compassion. Keep the environment quiet and calm. Keep linens clean, dry and wrinkle free. Keep lighting low and familiar objects near. Record review of Resident #26's electronic Physicians Orders revealed: May admit to hospice ., dated 03/07/24. No evidence of a binder that contained the required hospice forms and documentation, that included the hospice plan of care and certificate of terminal illness for Resident #26. Resident #19 Review of Resident #19's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: pneumonia, diabetes, and dementia. Record review of Resident #19's Quarterly MDS dated [DATE] revealed: BIMS score not completed. Further review of MDS Section O Special Treatments, Procedures, and Programs revealed hospice care. Record review of Resident #19's Care plan revised on 03/28/2024 revealed: Focus: The resident has a terminal prognosis r/t DYSPHAGIA FOLLOWING CEREBRAL INFARCTION. On hospice services. Goal: The resident will be free of depression and anxiety through the review date. The resident's comfort will be maintained through the review date. Interventions: Adjust provision of ADLS to compensate for resident's changing abilities. Encourage participation to the extent the resident wishes to participate. Encourage support system of family and friends. Keep the environment quiet and calm. Keep linens clean, dry and wrinkle free. Keep lighting low and familiar objects near. Suction as needed due to excess secretions. Record review of Resident #19's electronic Physicians Orders revealed: May admit to hospice ., dated 11/21/23. No evidence of a binder that contained the required hospice forms and documentation, that included the hospice plan of care and certificate of terminal illness for Resident #19. Resident #21 Review of Resident #21's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: anxiety, dementia, and bipolar disorder. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #21's Quarterly MDS dated [DATE] revealed: BIMS score not completed. Further review of MDS Section O Special Treatments, Procedures, and Programs revealed hospice care. Record review of Resident #21's Care plan initiated on 02/02/2024 revealed: Focus: The resident has a terminal prognosis r/t DX: Huntington's Disease. admitted to Hospice. Goal: The resident's dignity and autonomy will be maintained at highest level through the review date. The resident's comfort will be maintained through the review date. Interventions: Keep the environment quiet and calm. Keep linens clean, dry and wrinkle free. Keep lighting low and familiar objects near. Observe resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain. Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Record review of Resident #21's electronic Physicians Orders revealed no evidence of orders for hospice care. No evidence of a binder that contained the required hospice forms and documentation, that included the hospice plan of care and certificate of terminal illness for Resident #21. Resident #35 Review of Resident #35's electronic face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include: Alzheimer's, depression, anxiety, and dementia. Record review of Resident #35's Significant Change MDS dated [DATE] revealed: BIMS score 05 which indicated severe cognitive impairment. Further review of MDS Section O Special Treatments, Procedures, and Programs revealed hospice care. Record review of Resident #35's Care plan initiated on 04/20/2024 revealed: Focus: The resident has a terminal prognosis r/t DX: ALZHEIMER'S DISEASE WITH LATE ONSET On hospice services. Goal: The resident will be free of depression and anxiety through the review date. The resident's comfort will be maintained through the review date. Interventions: Adjust provision of ADLS to compensate for resident's changing abilities. Encourage participation to the extent the resident wishes to participate. Observe resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain. Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Record review of Resident #35's electronic Physicians Orders revealed no evidence of orders for hospice care. No evidence of a binder that contained the required hospice forms and documentation, that included the hospice plan of care and certificate of terminal illness for Resident #35. Resident #34 Review of Resident #34's electronic face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include: heart failure, dementia, and back fracture. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #34's Quarterly MDS dated [DATE] revealed: BIMS score 06 which indicated severe cognitive impairment. Further review of MDS Section O Special Treatments, Procedures, and Programs revealed hospice care not claimed. Record review of Resident #34's Care plan initiated on 04/20/2024 revealed: Focus: The resident has a terminal prognosis r/t DX: Heart failure, unspecified. On Hospice Services. Goal: The resident will be free of depression and anxiety through the review date. The resident's comfort will be maintained through the review date. Interventions: Adjust provision of ADLS to compensate for resident's changing abilities. Encourage participation to the extent the resident wishes to participate. Encourage resident to express feelings, listen with non-judgmental acceptance, compassion. Encourage support system of family and friends. Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Record review of Resident #34's electronic Physicians Orders revealed: ADMIT TO HOSPICE ., dated 11/29/2023. No evidence of a binder that contained the required hospice forms and documentation, that included the hospice plan of care and certificate of terminal illness for Resident #34. During an interview on 04/24/2024 at 10:46 AM, the DON stated that hospice communicated with the facility by writing orders. She stated she could not find the binder or any hospice information for any residents on hospice services. She stated that she did not know that hospice was supposed to provide information to the facility. During an interview on 04/24/24 at 10:49 AM, the RRN stated that she expected for facility to have hospice documentation either in a binder or in the medical record that included the hospice plan of care and certificate of terminal illness. She stated that facility did have hospice contact information and she called one of the hospice agencies and asked them to send over the binder with required information. She stated that she did not know why the facility did not have that information. She stated that the effect of not having the information could cause the resident to not get the care they needed because of not having continuity of care. During an interview on 04/24/24 at 11:16 AM, the SSD voiced that the 2 hospice charts at the nurses' station were for resident's that are no longer in the facility. She voiced that she did not find any hospice binders at the nurses' station for any of the current residents on hospice. Record review of the facility's Hospice Services Agreement dated effective November 27, 2023, between the nursing facility and Hospice revealed: .4. Hospice Services A. Hospice will: .6. Provide the facility with the following: 1. The most recent Hospice Plan of Care; 2. The Hospice election form and any advance directives specific to each Patient; 3. Physician certification and recertification of the Terminal , Illness specific to each Patient; 4. Names and contact information for Hospice personnel involved in the delivery of Hospice Services for each Patient; 5. Instructions on how to access Hospice's twenty-four hour on- call system; 6. Hospice medication information for each Patient; and 7. Hospice physician and Attending Physician, if any, orders for each Patient .8. Medical Records: a. Facility and Hospice will prepare and maintain medical records for each Hospice Patient. Such records will be prepared and maintained in conformity with federal and state law, rules, regulations, procedures, policies, guidelines, and generally accepted medical record practices . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675927	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Crane	699 Campus Dr Crane, TX 79731

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48883

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675927	A. Building B. Wing	04/25/2024

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Focused Care at Crane	699 Campus Dr Crane, TX 79731

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 44728 Based on interview and record review, the facility failed to ensure 4 of 5 (CNA-D, CNA-E, CNA-F, CNA-G) employees whose in-service records were reviewed had received the required minimum 12 hours annual in-service. The facility failed to provide the required annual performance care training to CNA-D, CNA-E, CNA-F, and CNA-G. This failure placed residents at risk for unmet needs due to untrained staff. Findings include: Record review of Personnel Files revealed: - Employee record for CNA-D revealed a hire date of 10/04/2021 and had no evidence of the required minimum 12 hours annual in-service. - Employee record for CNA-E revealed a hire date of 10/19/2021 and had no evidence of the required minimum 12 hours annual in-service. - Employee record for CNA-F revealed a hire date of 11/15/2021 and had no evidence of the required minimum 12 hours annual in-service. - Employee record for CNA-G revealed a hire date of 10/14/2021 and had no evidence of the required minimum 12 hours annual in-service. During an interview on 04/25/2024 at 2:00 PM, the DON stated she was responsible for nursing staff competencies and she had not performed any staff in-service competencies since she had been hired as DON, February 2024. She stated she had called the previous DON to see if she had the records of CNA required in-services, but she had no record. She stated she did not know how often staff in-service competencies should have been evaluated or their required annual training. The DON stated she was supposed to have monitored the CNA competency trainings. She stated the negative impact to residents could have been them not performing their duties correctly and possibly not giving them the proper care they deserved. She stated the failure was that she had not followed up with making sure the CNA's had all been trained correctly with documentation. The DON stated her expectations were for them to have had all of the competencies they needed and have the proper training and to take care of the residents as required. Record Review of the facility policy titled Nurse Aide Education, dated 08/16/17, revealed the following: - Competency will be evaluated initially and annually. - Facility will conduct a performance review of each nurse aide at least once every 12 months. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675927	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Crane	699 Campus Dr Crane, TX 79731

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	45732