STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675963	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Pointe Nursing and Rehabilitation	7804 Virgil Anthony Blvd Watauga, TX 76148

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for one of 18 residents (Resident #36) reviewed for resident rights. The facility failed to ensure Resident #36 was treated with dignity and respect when she asked CNA C to dress her. The noncompliance was identified as past noncompliance (PNC). The noncompliance began on 03/05/25 and ended on 03/06/25. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk for abuse and psychological harm. Findings included: Record review of Resident #36's Quarterly MDS Assessment, dated 04/2/25, reflected the resident was a [AGE] year-old female who initially admitted on [DATE] and readmitted on [DATE]. Resident #36's diagnoses of hemiplegia or hemiparesis (paralysis or weakness to one side of the body), diabetes mellitus (disease that results in too much blood sugar in the blood), cerebrovascular accident, transient ischemic attack, or stroke (damage to the brain from interruption of its blood supply). Resident #36 also had a BIMS score of fifteen meaning the resident was cognitively intact. Resident #36's Quarterly MDS Assessment reflected the resident required dependent assistance (helper does all of the effort and resident does none of the effort) with lower body dressing and substantial/maximal assistance (helper does more than half the effort) with upper body dressing. Record review of Resident #36's Care Plan, dated 03/31/25, reflected Resident #36 had an ADL self-care performance deficit and required assist with ADLs relating to impaired mobility/hemiplegia and cognitive deficits. Record review of Resident #36's Care Plan also reflected the resident will be provided assist with ADLs through the review date to maintain current ability and clean appearance. Resident #36's Care Plan Interventions reflected the resident was a two person staff participation to dress and to dress the resident according to resident comfort/season. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Provider Investigation Report dated 03/12/25 reflected, Upon review of video footage provided by resident's daughter, it was determined that the CNA did not act professionally. She was observed on video speaking unprofessionally and loudly to resident. The Provider Investigation Report also reflected that the Wound Care Nurse, .completed head to toe assessment with no negative findings. Resident denied any mental, physical or emotional abuse. No injuries noted. No changes in behavior noted. The Provider Investigation Report also reflected that the result of the investigation was inconclusive, but CNA C was terminated. Record review of the Resident's Statement, dated 03/06/25, of the previous day's event, reflected that sometime before lunch, the resident asked CNA C to change her clothes and then she became irritated. CNA C was unclear why she acted that way. The resident stated she needed her shirt changed and her pajama pants put on so she could get up for lunch. The resident stated she told CNA C she was being bossy. The resident denied being fearful or scared but stated she did not like the way CNA C was speaking to her. The resident denied any mental, physical, or emotional abuse. The resident did, however, state she did not want CNA C to provide any further care to her. Record review of CNA's personnel file on 04/17/25 at 2:51 PM reflected CNA C was suspended on 03/06/25 and terminated on 03/07/25. Interview on 04/15/25 at 10:42 AM with Resident #36 revealed the resident, on 03/05/25, asked CNA C to assist her in dressing in pajama pants and a top so she could go to the dining room. Resident #36 said CNA C was very rude and disrespectful to her in her response and told her to put the pajama pants on herself twice. Resident #36 stated she did not feel CNA C was abusive, but she was verbally rude in her tone. Resident #36 also said the CNA did not physically harm her. Resident #36 concluded by stating she was never afraid, scared, or sad; she only felt disrespected by CNA C. The resident revealed she was not afraid of anyone in the facility, and she felt safe. Interview on 04/17/25 at 12:33 PM with the Wound Care Nurse revealed Resident #36 was not in fear or scared when she made her assessment, but the resident could have feelings of depression or isolation if CNA C continued providing care after the initial incident. She stated there was no skin breakage nor bruises. She stated the resident denied pain or soreness during the assessment. She said she had not heard of any abuse by the aide previous to this event. Interview on 04/17/25 at 12:45 PM with the ADON revealed the facility suspended CNA C immediately following the allegation of verbal abuse. The ADON also stated CNA C was later terminated at the conclusion of the investigation. The ADON revealed they educated staff on abuse/neglect. The ADON also stated the Social Worker completed safe surveys and determined no one else was verbally or physically abused. Interview on 04/17/25 at 12:40 PM with the Social Worker revealed the Resident's daughter called the Administrator and told her an Aide had verbally abused her mother. The Social Worker said she recalled Resident #36 stating CNA C was rude but was not physically abusive to her. The Social Worker could not recall further details about the incident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/17/25 at 4:32 PM with the Administrator revealed Resident #36's Responsible Party sent a video of an interaction with an aide and Resident #36 to the facility that she received. The Administrator stated she viewed the video and suspended CNA C based on a poor customer service tone. The Administrator revealed they later terminated CNA C based on the video viewed. The Administrator said the facility completed safe surveys, interviewed staff, and interviewed residents. The Administrator revealed the facility in-serviced the staff on abuse/neglect, customer service, and resident rights. Record review of the facility's Abuse/Neglect policy, revised on 09/09/24, reflected: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility Verbal Abuse: Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability . Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again, etc. The Incident/Accident log was reviewed with no issues noted. The Resident Council minutes were reviewed with no issues noted. Grievances were reviewed with no issues noted. Safe surveys were completed with eleven residents with no issues noted. An Ad Hoc QAPI was conducted with the recommended following items below completed during a 4-week period: Ask 15-20 staff members per week, situational questions related to abuse. Document date and time, the staff member's name, if they responded correctly, and any corrective action if needed. Ask about 5 residents per week how staff is treating them. Document date/time, the resident's name, if there was any negative response, and any corrective action if needed. During incident/event review in standup, the DON and the Admin will monitor for potential abuse in the event Reports. During facility rounds, there were not any signs of staff acting rudely or inappropriate with residents. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prior to the HHSC investigation, the facility took the following actions to correct the noncompliance: In-Service with staff on Abuse/Neglect on 03/05/25, Code of Conduct, Customer Service, and Resident Rights on 03/10/25 initiated from the Administrator to all facility staff and completed. Interview on 04/17/25 at 12:50 PM with MA F revealed she recalled the in-services given by the facility following the suspension of CNA C. MA F stated three types of abuse were physical, mental, and financial. MA F said three signs of abuse yelling, anger, and withdrawing from care. MA revealed she would report signs of abuse to the Administrator, the abuse coordinator. MA stated the facility was also in-serviced on abuse about two days ago. Interview on 04/17/25 at 2:32 PM with CNA H revealed she recalled the facility in-serviced all the staff on four topics including abuse/neglect, customer service, code of conduct, and resident rights. CNA H stated types of abuse were physical, mental, financial, and verbal. CNA H said three signs of abuse occurred when the resident avoided eye contact, bruises, and the resident withdrew from care. CNA H revealed she would report these and other signs to the Abuse Coordinator, the Administrator, immediately if she saw any of these signs. Interview on 04/17/25 at 2:40 PM with the Activity Aide revealed she knew three types of abuse were mental, physical, and financial. The Activity Aide stated three signs of abuse were bruises, behavior changes, and crying. The Activity Aide said that she would report signs of abuse to the abuse coordinator, the Administrator as soon as she was made aware of an abuse allegation. Interview on 04/17/25 at 2:56 PM with LVN D revealed she recalled the in-service on abuse. LVN D stated types of abuse were physical, sexual, financial, and verbal. LVN D also said that bruises, changes in behaviors, and refusal of care were types of abuse. LVN D stated that she would report any type of abuse or abuse allegation to the Administrator, the abuse coordinator immediately. LVN D said that she was in-serviced on abuse about a week ago. Interview on 04/17/25 at 3:23 PM with CNA E revealed she was in-serviced on all four in-services immediately following CNA's C suspension. CNA E stated she had been employed at the facility for approximately three years. CNA E also said that three types of abuse were verbal, sexual, and neglect. CNA E stated that three signs of abuse were bruises, skin tears, and crying. CNA E revealed that she would report any signs of abuse or allegations of abuse to the abuse coordinator, the Administrator immediately. CNA E stated she was in-serviced on abuse yesterday also. Interview on 04/17/25 at 3:14 PM with RN I revealed she recalled being in-serviced on a group of topics the first week of March. RN I stated three types of abuses are physical, sexual, and verbal. RN I said that signs of abuse could be bruising, scratches and anger. RN I stated she would report any signs of abuse to the abuse Administrator and the DON. RN I concluded by stating she was in-serviced last month on abuse. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/17/25 at 4:32 PM with the Administrator revealed Resident #36's Responsible Party notified her a staff member verbally abused her mother, and she had it on video. The Administrator received the video the following day and viewed it. The Administrator interviewed Resident #36, and Resident #36 stated CNA C was bossy, but was not fearful. The Administrator said she suspended the staff member immediately. The Administrator revealed she believed CNA C gave poor customer service based on her tone and it was inappropriate, and therefore terminated her employment. The Administrator stated the facility completed safe surveys, interviewed staff, and interviewed residents. The Administrator revealed she in-serviced the staff on abuse/neglect, customer service, code of conduct, and resident rights as well.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive person-centered care plans for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 1 (Resident ##9) reviewed for comprehensive care plans. The facility failed to develop a care plan for Resident #9's compression stockings. This failure placed resident at risk of not receiving appropriate care. Findings included: Record review of Resident #9's quarterly MDS assessment, dated 03/27/25, revealed Resident #9 was an [AGE] year-old male with an admitted [DATE] and readmitted [DATE] with diagnoses which included edema and high blood pressure, and he had a BIMS score of 05, which indicated his cognition was severely impaired. Record review of Resident #9's care plan, dated 03/31/25, did not address edema and compression stockings. Interview on 04/17/25 at 10:34 AM with the ADON revealed Resident #9 was supposed to be care planned for edema and compression stockings. She stated it was her responsibility and the DON's to update the care plan when they received a new order, but she missed the orders. She stated failure to update or have a care plan would lead to not taking the appropriate measures to address the edema and risk of fluid overload. Interview on 04/17/25 at 12:47 PM with the Corporate Nurse who was acting as Interim DON, she stated it was the responsibility of the nursing management team to care plan for edema and compression stockings. She stated she noticed there was no care plan for Resident#9's compression stockings and edema, and she would update the care plan. She stated she did not see any risk if the care plan was not updated as long as the nurses were following the doctor's orders. Review of the facility's current, undated, Comprehensive Care Planning policy reflected the following: Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 3 of 18 residents (Residents #5, #20, and #34) reviewed for ADLs. 1. The facility failed to ensure Resident #20 and Resident #5's fingernails were cleaned and cut. 2. The facility failed to ensure Resident #34 received regular oral care. This failure had the potential to affect residents by placing them at risk for poor personal hygiene, decreased self-esteem, and a decline in their quality of life. Findings included: 1. Record review of Resident #20's Face sheet, dated 04/17/25, revealed the resident was a [AGE] year-old female with an admitted [DATE] and readmitted on [DATE]. Record review of Resident #20's quarterly MDS assessment dated [DATE] reflected her diagnoses included atherosclerotic heart disease, dysphagia, chronic pain, and essential hypertension (high blood pressure). Resident #20's BIMS score was 08, which indicated moderate cognitive impairment. The MDS further revealed Section G: Activities of Daily Living Assistance revealed Resident #20 required extensive assistance for ADLs. Record review of Resident #20's Care Plan, revised 01/09/25, reflected Focus: [Resident #20] has an ADL Self Care Performance Deficit. Goal: [Resident #20] will maintain or improve current level of function in (Specify Bed Mobility, Transfers, Eating, Dressing, Toilet Use, and Personal Hygiene; ADL Score) through the review date. Interventions: Assist with personal hygiene as required: hair, shaving, oral care as needed Observation on 04/15/25 at 10:20 AM of Resident #20 in bed sleeping. Observed Resident #20's fingernails to be long, approximately close to an inch long and had yellow build-up underneath her nails. In an interview on 04/17/25 at 10:20 AM, Resident #20 stated she was doing well. Resident #20 was unable to answer further questions regarding her fingernails. In an interview and observation on 04/17/25 at 10:30 AM, CNA J revealed she was the CNA assigned to Resident #20. CNA J looked at Resident #20's fingernails, and she stated the resident's nails were long. She stated the resident's fingernails should be cut by the nurses. She was unaware of how long Resident #20's fingernails were. She stated she did not usually work with Resident #20. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 04/17/25 at 10:48 AM, RN I stated she was the nurse assigned to Resident #20. She stated residents, who were diabetic, had their fingernails cut by the nurses, and the podiatrist cut their toenails. She stated CNAs and nurses were responsible for cutting the fingernails of non-diabetic residents. RN I looked Resident #20's fingernails. She stated she was unaware of how long Resident #20's fingernails were. She stated fingernails were about 1/2 inch or inch long. She stated she was unsure if the resident refused for her nails to be cut. She stated the potential risk of not cutting or trimming fingernails would be infections or the resident scratching herself. Record review of Resident #5's Face sheet, dated 04/17/25, revealed the resident was a [AGE] year-old female with an admitted [DATE]. Record review of Resident #5's annual MDS assessment dated [DATE] reflected her diagnoses included unspecified dementia, contracture, left hand, and essential hypertension (high blood pressure). Resident #10's BIMS score was 08 which indicated moderate cognition impairment. The MDS further revealed Section G: Activities of Daily Living Assistance revealed Resident #5 required extensive assistance for ADLs. Record review of Resident #5's Care Plan, revised 01/09/25, reflected Focus: [Resident #5] has an ADL Self Care Performance Deficit. Goal: [Resident #5] will maintain or improve current level of function in (Specify Bed Mobility, Transfers, Eating, Dressing, Toilet Use, and Personal Hygiene; ADL Score) through the review date. Interventions: Assist with personal hygiene as required: hair, shaving, oral care as needed. BATHING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. If diabetic, the nurse will provide toenail care. Record review of Resident #5's Kardex, dated 04/17/25, revealed: Resident Care: Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. In an interview and observation on 04/17/25 at 10:58 AM, Resident #5 revealed she wanted her fingernails cut. Resident #5's left hand was contracted, and the resident was able to open her hand. The resident's fingernails were long and had build-up underneath. Resident #5 stated she could not recall when the last time was her fingernails on her left hand were cut. Resident #5 stated her middle fingernail was the longest, and it was starting to bother her. In an interview and observation on 04/17/25 at 12:03 PM, CNA J revealed she was the CNA assigned to Resident #5. She observed Resident #5's left hand fingernails and stated the resident's nails needed to be cut and cleaned. She stated it was the responsibility of the nurses to cut fingernails and the responsibility of the CNAs to clean residents' hands and underneath her fingernails. She stated the risk of not trimming residents' fingernails was it could cause infections and skin breakdown if the hand was contracted. In an interview and observation on 04/17/25 at 1:00 PM, RN I stated she was the nurse assigned to Resident #20. RN I assisted Resident #20 with opening her left hand. RN I observed Resident #20's fingernails and stated her fingernails were long. Resident #20 asked RN I to please cut her fingernails. RN I stated Resident #20's fingernails were longer than Resident #5's. RN I stated it was the responsibility of the nurses and CNAs to cut fingernails and clean them. She stated the potential risk of not cutting fingernails was it could cause residents to scratch themselves and bacteria build-up. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/17/25 at 1:30 PM, the ADON stated the CNAs were responsible for cutting residents fingernails unless the residents were diabetic, then the nurses were responsible for cutting them. She stated if the residents refuse fingernails to be cut it should be documented and care planned. She stated Resident #5 had some fingernails she did not allow to be trimmed; however, staff should still ask them if she wanted them cut. She stated fingernails should be cleaned during showers or in between meals. She stated the potential risk of not cleaning, cutting, or trimming fingernails could lead to infections or skin tears. Interview on 04/17/25 at 2:28 PM, the Interim DON revealed the expectations were for CNAs to provide hand hygiene to residents during showers, before and after meals. She stated CNAs and Nurses should complete weekly skin assessments and need to ensure fingernails were clipped. She stated if residents refuse, it should be documented. She stated the potential risk of not cutting/trimming fingernails was it could cause skin breakdown if contracted or the resident could scratch themselves. 2. Record Review of Resident #34's quarterly MDS, dated [DATE], reflected the resident was an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. The MDS reflected the resident's diagnoses included hemiplegia or hemiparesis (paralysis or weakness to one side of the body), chronic kidney disease, stage 3 unspecified (longstanding disease of the kidneys leading to renal failure), seizure disorder or epilepsy (disorder in which nerve cell activity in the brain is disturbed, causing seizures), difficulty in walking, contracture left hand, and age-related physical debility. The MDS further reflected the resident had a BIMS of 10, meaning moderate cognitive impairment. The MDS also reflected Resident #34 required partial/moderate assistance (helper does less than half the effort and lifts, holds or supports trunk or limbs, but provides less than half the effort). Record review of Resident #34's care plan, revised on 02/11/25, reflected the following: Focus: Resident had an ADL self-care performance deficit relating to: mobility/hemiplegia, cognitive deficits, contracture. Goal: The resident will maintain current level of ADL abilities and will receive the necessary assistance to maintain a clean and neat appearance through the review date. Interventions: .Personal hygiene/oral care: the resident requires X1 staff participation with personal hygiene and oral care by CNA staff. In an observation and interview on 04/15/25 at 11:01 AM with Resident #34 revealed the resident had white build-up on her teeth, and it appeared her teeth had not been brushed. Resident #34 stated her teeth were last brushed about two weeks ago. Resident #34 said she would like her teeth brushed regularly. Resident #34 said she did not feel clean without her teeth brushed regularly. In an observation and interview on 04/16/25 at 1:44 PM with CNA A revealed Resident #34's teeth had not been brushed regularly. CNA A stated Resident #34's teeth appeared to not have been brushed that day, and she had not brushed them. CNA A said the residents' teeth were supposed to be brushed by the CNA when ADLs were performed each morning. CNA A revealed if a resident received poor oral hygiene, it could affect their self-esteem because they would have bad breath and would not want to be around other individuals. CNA A also revealed if a resident refused to have their teeth brushed, the CNA should report the refusal to their nurse. CNA A then stated if the nurse did not follow-up on the refusal, the CNA should report the refusal to the ADON. The CNA was not aware of the last in-service on ADLs because the CNA had been employed less than one month. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/16/25 at 2:11 PM with LVN B revealed teeth should be brushed daily in the morning and in the evening before bed by anyone assisting the resident, but usually the Resident's CNA. LVN B stated if residents did not receive oral care regularly, residents could get infections, cavities, and lose weight because they could not chew. LVN B said if a resident refused oral care, the CNA should notify the resident's nurse. LVN B revealed the CNA should document the resident's refusal of oral care. LVN B stated the Resident's nurse should encourage and educate the resident on the importance of oral care. LVN B said if the resident continued refusing oral care, the nurse should notify the responsible party, the primary care physician, the ADON, and the DON. LVN B also stated the resident's care plan should be updated to reflect the resident's continued oral care refusal. LVN B said she was last in-serviced approximately one month ago. Interview on 04/17/25 at 10:02 AM with the ADON revealed the CNAs should perform oral care on residents daily when they dressed residents in the morning. The ADON stated if the resident refused, the CNA should attempt three times during their shift. The ADON continued and said if the resident still refused on the third attempt, the CNA should notify the nurse. The ADON revealed the nurse should attempt to discuss the reason for the refusal and accommodate the resident. The ADON stated if refusal continued, the nurse should notify the ADON, the DON, the Responsible Party, and the primary care physician. The ADON revealed poor oral care could lead to infections which could then lead to the resident not eating and possible weight loss. The ADON stated the staff were in-serviced on ADLs last month at the all-staff in-service. Interview on 04/17/25 at 10:16 AM with the Interim DON revealed that teeth brushing was part of the morning routine. The Interim DON stated oral care could be difficult for some residents with cognitive deficits. The Interim DON stated the CNAs should attempt oral care with residents once per day. The Interim DON said if the resident refused oral care by their CNA, the CNA should notify their charge nurse and document the refusal on the ADL sheet. The Interim DON revealed if the charge nurse did not follow up with the resident, the CNA should follow the chain of command until the resident's oral care was addressed. The Interim DON stated the nurse should contact the responsible party and notify them the resident was refusing oral care. The Interim DON stated the risk to the resident of not receiving proper oral care depended on the resident's cognitive status. Record review of the facility's current, undate Nail Care policy reflected the following: Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticle are and is usually done during the bath. 1. Nail care will be performed regularly and safely. 2. The resident will free from abnormal nail conditions 3. The resident will be free from infection. Record review of the facility's Teeth Care/ Oral Hygiene policy, dated 06/29/05, reflected the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.It includes procedures such as brushing and flossing, gum massage, and mouth rinsing. It is performed in the morning or at bedtime, and after meals depending on individual needs. The procedures can be done independently or with assistance in those with impaired ability to use the hands and arms. The resident will receive mouth care at lease daily. 48236

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 2 of 2 residents (Resident #9 and #29) reviewed for quality of care. The facility failed to ensure Resident #9 and #29 wore their compression stockings, used to prevent swelling and blood clots, as ordered by the physician. This failure placed residents at risk of not receiving appropriate care and worsening of their conditions. Findings included: 1. Record review of Resident #9's quarterly MDS assessment, dated 03/27/25, revealed Resident #9 was an [AGE] year-old male with an admitted [DATE] and readmitted [DATE] with diagnoses which included edema and high blood pressure, and he had a BIMS score of 05, which indicated his cognition was severely impaired. Record review of Resident #9's care plan, dated 03/31/25, did not address edema and compression stockings. Record review of Resident #9's physician orders, dated 04/2/25, reflected: Compression stockings to BLE on am [morning] and off pm [evening] for edema. Observation and interview on 04/15/25 at 12:27 PM of Resident #9 revealed Resident #9 sitting on his chair. Resident #9's legs (lower extremities) were observed with edema and had no compression stocking. Resident #9 stated staff [NAME] the regular socks on him. Observation on 04/15/25 at 2:37 PM revealed Resident #9 wheeling himself in the hallway. The resident did not have the compression stockings on his legs. Observation and interview on 04/16/25 at 12:10 PM revealed Resident #9 was on his wheelchair in the hallway. Resident #9 stated he did not have any compression stockings on his legs. Resident #9 stated staff did not put the compression stockings on him. He could not recall the last time he had compression stocking on. 2. Record review of Resident #29's quarterly MDS assessment, dated 03/18/25, revealed Resident #29 was a [AGE] year-old male with an admitted [DATE] and readmitted [DATE] with diagnoses which included edema and cellulitis, and he had a BIMS score of 14, which indicated his cognition was Intact. Record review of Resident #29's care plan, dated 12/30/24, revealed Focus: Resident #29 was on diuretic therapy rule out bilateral lower extremities Edema. Goal: He will be free of any discomfort or adverse side effects of diuretic therapy through the next review date. Interventions: Administer medication as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #29's physician orders, dated 11/23/2023, reflected: Compression stockings to BLE on am and off pm for edema. Observation and interview on 04/15/25 at 11:35 AM of Resident #29 revealed Resident #29 sitting on his wheelchair in the dining area. Resident #29's legs (lower extremities) were observed with edema and had no compression stockings on. Resident #29 stated staff did not put compression stockings on him, and they only applied cream on his legs. Observation on 04/15/25 at 2:15 PM revealed Resident #29 in his room. The resident did not have the compression stockings on his legs. Observation and interview on 04/16/25 at 10:47 AM revealed Resident #29 was seated in his wheelchair in his room watching television. Resident #29 stated he did not have any compression stockings on his legs. Resident #9 stated staff did not put compression stockings on him. He could not recall the last time he had stockings on. Interview on 04/16/25 at 1:20 PM with CNA G revealed Residents #9 and #29 were her assigned residents. She stated she got report from the nurse when she reported on duty. She stated she was not aware Residents #9 and #29 were supposed to have compression stockings on both their legs. CNA G stated it was the nurse's responsibility to put on Resident #9 and #29's compression stockings. Interview on 04/16/25 at 1:33 PM with LVN D revealed she was the nurse for Resident #9 and #29. LVN D stated she worked the 6:00 AM-2:00 PM shift. LVN D stated Residents #9 and #29 had orders for compression stockings due to edema. She stated she was aware both residents were supposed to have compression stockings put on in the morning but every time she wanted to put the stockings on, something would distract her from getting the stockings from the central supply, since they did not have any in their rooms. LVN D stated the risk of not using the compression stockings as ordered could cause circulation issues and the edema would increase. She stated she had not done an in-service on compression stockings. Interview on 04/17/25 at 10:34 AM with the ADON revealed the nurses were responsible for putting compression stockings on residents and to follow physician orders. The ADON stated Residents #9 and #29 had orders for compression stockings due to their bilateral legs swelling. The ADON stated staff should be documenting on the MAR/TAR if residents refused treatment and when they had put compression stockings on and off. The ADON stated she had noticed Resident #9 and #29 without compression stockings on Monday 04/14/25, and she talked about it with LVN D. She stated LVN D notified her both residents did not have compression stockings in their rooms. LVN D did not know where to find the compression stockings in the central supply. The ADON stated she gave the nurse the compression stockings for both Residents #9 and #29, and she was not aware LVN D was not using them on Resident#9 and #29. The ADON stated the risk of not putting compression stockings on Resident #9 and #29 would be lack of circulation and increase in edema. She stated she had not done an in-service on compression stockings with staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/17/25 at 10:34 AM with the Corporate Nurse, who was acting as Interim DON, revealed nurses were responsible for ensuring compression stockings were put on Residents #9 and #29 in the morning and off at night. She stated the nurse should not be signing off in the residents' EHRs that the compression stockings were on when they had not put the compression stockings on the residents. She stated failure to put compression stockings on Residents #9 and #29 would cause their edema to worsen. She stated they had not done an in-service on compression stockings, but they would be starting one. Record review of the facility's TED Hose [compression stockings] policy, dated 02/13/07, reflected the following: Antiembolism hose are elastic stockings (TEDS) applied to an extremity to promote venous return and prevent pooling of blood in the leg(s). PURPOSE 1. To provide support for lower extremities. 2. To aid return circulation from lower extremities. 3. To prevent embolus formation. 4. To reduce pain. The facility did not have a specific policy related to following these physician orders.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observation, interview, and record review, the facility failed to ensure residents received proper treatment and care to maintain good foot health by providing foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition for 1 of 18 residents (Resident #34) reviewed for foot care. The facility failed to ensure foot care, specifically trimming of toenails, was provided for Resident #34. This failure could result in residents developing fungal infections or other podiatric problems. Findings included: Record review of Resident #34's quarterly MDS, dated [DATE], reflected the resident was an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. The MDS reflected the resident's diagnoses included hemiplegia or hemiparesis (paralysis or weakness to one side of the body), chronic kidney disease, stage 3 unspecified (longstanding disease of the kidneys leading to renal failure), seizure disorder or epilepsy (disorder in which nerve cell activity in the brain is disturbed, causing seizures), difficulty in walking, contracture left hand, and age-related physical debility. The MDS further reflected the resident had moderate cognitive impairment. The MDS also reflected Resident #34 required partial/moderate assistance (helper does less than half the effort and lifts, holds or supports trunk or limbs, but provides less than half the effort). Record review of Resident #34's care plan, revised on 02/11/25, reflected the following: Focus: Resident had an ADL self-care performance deficit relating to: mobility/hemiplegia, cognitive deficits, contracture to left hand. Goal: The resident will maintain current level of ADL abilities and will receive the necessary assistance to maintain a clean and neat appearance through the review date. Interventions: .Personal hygiene/oral care: the resident requires X1 staff participation with personal hygiene and oral care by CNA staff (toenail trimming was not addressed). Record review of Resident #34's Physician's Orders revealed Resident #34 had no referral to a podiatrist. Observation and interview on 04/15/25 at 11:01 AM with Resident #34 revealed she would like her toenails trimmed. Resident #34 stated no one had offered to trim her toenails since her re-admission on 09/18/24. Resident #34 said she had not asked a staff member to trim her toenails. The resident's toenails appeared approximately 1/4 of an inch long, clean, thin, needed to be trimmed. The resident did not express pain. Observation and interview on 04/16/25 at 1:44 PM with Resident #34 revealed the resident's toenails still had not been trimmed since 04/15/25 at 11:01 AM. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/16/25 at 1:45 PM with CNA A revealed Resident #34's toenails needed to be trimmed. CNA A stated Resident #34 could scratch herself which could lead to an infection. CNA A said long toenails were painful. CNA A stated she had been employed at the facility approximately two weeks. CNA A revealed it was all staff's responsibility to trim toenails if the resident was not diabetic. CNA stated if a resident was diabetic, the nurse or physician should trim the resident's toenails. CNA A explained if the resident would not allow the aide to trim the toenails, the aide should report it to the nurse. CNA A stated toenails should be examined in the morning when completing ADLs. Interview on 04/16/25 at 2:01 PM with LVN B revealed it was the nurses' responsibility to trim toenails. And if a resident was diabetic, the nurse should not trim the resident's toenails and should ask the doctor for a referral to a podiatrist. LVN B stated it was the aide's responsibility to notify their nurse if a resident's toenails needed to be trimmed. LVN B said if a resident's toenails were too long, the toenail could snag on clothes, bedding, etc. resulting in injury or infection. LVN B revealed she was in-serviced within the last month on ADLs. Interview on 04/17/25 at 10:02 AM with the ADON revealed the CNA should notify the nurse if a resident's toenails should be trimmed. The ADON stated if the resident was diabetic, the nurse should notify the social worker to add the resident to the podiatry list. The ADON also revealed if the resident was not diabetic and refused to have their toenails trimmed, the nurse should also notify the social worker to add the resident to the podiatry list. The ADON said that if a resident continued to refuse toenail care, the resident's care plan would reflect the continued refusal. The ADON revealed residents could receive skin tears resulting in infection if the toenails were not kept trimmed. The ADON concluded by stating administration in-serviced all staff last month on ADLs. Interview on 04/17/25 at 10:16 AM with the Interim DON revealed a resident's aide should notify the nurse if a resident's toenails should be trimmed. The Interim DON also stated the wound care nurse upon weekly skin inspections should notify the nurse. The Interim DON said if a resident was diabetic or had thick toenails, the nurse should refer them to podiatry. The interim DON stated if the resident's toenails were thin and normal, the resident's nurse could trim them. The Interim DON explained the facility had to receive an order from the physician for the podiatrist and written approval by the responsible party before the resident could be seen by the podiatrist. Upon receipt of the written approval and referral, the Social Worker would put them on the podiatry list. The Interim DON stated there was not a big risk to the resident unless the resident was complaining of pain. Interview on 04/17/25 at 10:43 AM with the facility Social Worker revealed the nurse should obtain an order for the podiatrist if a resident had a cause to be seen by the podiatrist. The Social Worker stated she would next request permission from the family for the resident to be seen by the podiatrist. The Social Worker said Resident #34 was not on her podiatrist list and a referral had not been made. The Social Worker revealed the risk to the resident for untrimmed toenails was she was uncomfortable, they could catch on the sheets, etc. Record review of the facility's Foot Care policy, revised 2003, reflected the following: Foot management is the daily assessment, bathing, lubrication, and protection of the feet. It is done to promote cleanliness and peripheral circulation of the feet. Foot care is especially important in those residents with diabetes mellitus or peripheral circulatory conditions because of their susceptibility to infection and skin breakdown. If required, trimming of the toenails is performed by a podiatrist. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goals 1. The resident will maintain intact skin integrity. 2. The resident will be free from infection. 3. The resident will remain free from injury to the fact.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards for 1 of 2 residents (Resident #105) reviewed for intravenous fluids. The facility failed to ensure Resident #105's intravenous tubing was labeled with the date and initials. The failures could affect residents by placing them at risk for infections. Findings included: Record review of Resident #105's admission MDS Assessment, dated 04/11/25, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Her BIMS was not completed due to resident was newly admitted . Her diagnoses included cerebral infarction (stroke), and gastrostomy status (surgical opening into the stomach). Record review of Resident #105's care plan, dated 04/14/25, reflected the following: Focus: Resident #105 has potential fluid deficit rule out Dysphagia (difficulty swallowing) and g-tube status. Goal: Resident will be free of symptoms of dehydration and maintain moist mucous membranes, and good skin turgor through the next review date. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Record review of Resident #105's April 2025 physician orders dated 04/14/25 and 04/15/25 reflected the following: Sodium Chloride Intravenous Solution 0.45 % (Sodium Chloride) Use 80 ml/hr. intravenously one time a day for Increased Sodium Level until 04/15/2025 17:30 2nd bag 80ml/hr. x 13 hours total of 1000ml. Sodium Chloride Intravenous Solution 0.45 % (Sodium Chloride) Use 80 ml/hr. intravenously one time a day for Increased Sodium Level until 04/15/2025 04:00 80ml/hr. x 13 hours total 1000ml. Observation on 04/14/25 at 10:25 AM revealed Resident #105 was in her room, lying in bed. She was observed to have a PICC line dressing dated 04/12/25 and was intact. The intravenous medication bottle was hanging on the pole. The IV tubing was not labeled with the date, time, and initials to indicate when it was last changed. Observation and interview on 04/15/25 at 12:09 PM with LVN D revealed the IV tubing was supposed to have the correct, date, and initials of the nurse administering the medications. She stated she was not the one that hung the bag, she came on for the 6-2 shift. She was aware she was supposed to check whether the tubing was labeled because the tubing was good for only 24 hours, but she missed checking when taking over the shift. She stated the failure to label the tubing could lead to infection. LVN D stated she had had done training on intravenous medication administration. IV certification dated 1/06/25 was provided. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/17/25 at 10:46 AM with the ADON revealed she expected staff to date and initial tubing when administering intravenous medications or fluids. She also expected staff to check on all equipment's status when taking over a shift. She stated she had also checked on 04/15/25 and noticed the tubing was not labeled. She stated it was the responsibility of the DON and the ADON to check after the nurses and ensure IV bags and tubing were labeled with date, time, and initials. She stated tubing was good for 24 hours. She stated the failure to label the tubing put residents at risk for infection and if the tubing was used for more than 24 hours it affected the flow rate by making it slow and the resident might not get the expected therapy. She stated she had done training with staff on intravenous therapy. No training records were provided. Interview on 04/17/25 at 12:53 PM with the Interim DON revealed she expected staff to date and initial intravenous bags and tubing when administering intravenous to prevent infection. She stated it was the responsibility of the DON and the ADON to check after the nurses and ensure labelling was being done. She stated the facility had done training with staff on intravenous therapy. Interview on 04/15/25 at 12:09 PM with LVN E revealed she was the nurse that hung the IV fluids. She stated she was aware she was supposed to date and initial the bag and the tubing, but she forgot since the fluids were supposed to run for 48 hrs. She stated the tubing was good for 24 hours. She stated the failure to label the tubing could lead to infection. LVN E stated she had had done training on intravenous medication administration. Record review of the facility's training records reflected LVN D was IV certified. Review of the facility's current, Intravenous fluid management policy dated 2003, reflected the following: .2. Label the bag or bottle and IV line using tape, as the ink can absorb into the solution. On the label list the date that it was placed into use as well as the nurse's initials

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observations, interviews, and record review, the facility failed to ensure it was free of a medication error rate of five percent (5%) or greater, 3 errors of 33 opportunities for errors leading to 9.09% medication error rates, for two of four staff (LVN D and MA F) observed for medication pass. The facility failed to ensure MA F administered the correct dose of 500mgs vitamin B12 for Resident #19. The facility failed to ensure LVN D administered all the crushed medication in the medication cups without leaving residue for Resident #105. These failures resulted in a 9.09% medication error rate and could put residents at risk who received medications via g-tube for tube occlusion, not receiving the correct dose of medication, and those that took orally not getting intended therapy. Findings included: 1. Record review of Resident #19's quarterly MDS Assessment, dated 03/26/25, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE] and readmission on 03/07/25. Her BIMS score was 11, revealing her cognition was moderately impaired. Her diagnoses included anemia (a condition where the blood doesn't have enough healthy red blood cells, or the red blood cells don't function properly, leading to a reduced ability to carry oxygen). Record review of Resident #19's care plan, dated 12/28/24, reflected the following: Focus: Resident #19 has anemia rule out vit B12 deficiency. Goal: Resident will remain free of complications related to anemia through review date. Interventions: Administer medications as ordered. Monitor for side effects, and effectiveness. Record review of Resident #19's April 2025 physician orders reflected the following: Cyanocobalamin Tablet 1000 Mcg. Give 0.5 tablet by mouth one time a day for Vitamin b 12 deficiency. Observation on 04/16/25 at 08:13 AM revealed MA F prepared the following medication: Cyanocobalamin Tablet 1000 MCG 1 tablet in a cup. She went to Resident#19's room and administered it to her. Interview on 04/16/25 at 10:46 AM with MA F revealed she was aware she was supposed to review Resident #19's physician orders prior to administering her medications. MA reviewed Resident #19's physician order and stated she was not aware the resident had an order to administer 0.5 tablet of 1000mcg and she has been administering 1000mcg daily. She stated the failure to administer the correct dosage to Resident #19 would lead to a medication error and not getting the right therapy. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #105's admission MDS Assessment, dated 04/11/25, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE], her BIMS was not completed due to the resident was newly admitted . Her diagnoses included cerebral infarction (stroke), and gastrostomy status (surgical opening into the stomach). Record review of Resident #105's care plan, dated 04/14/25, reflected the following: Focus: Resident #105 requires tube feeding rule out Dysphagia (difficulty swallowing). Goal: Resident will remain free of side effects or complications related to tube feeding through the next review date. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Record review of Resident #105's April 2025 physician orders reflected the following: - Enteral Feed Order every shift May crush meds or open capsules unless contraindicated. Do not mix together. - Enteral Feed Order every shift Flush enteral tube with 60ml water pre/post medication administration and 5-10 ml water between each medication. - Amlodipine Besylate Oral Tablet 5 MG. Give 5 mg via G-Tube one time a day related to essential (primary) hypertension Hold for SBP less than 115 and DPB less than 70. Start Date 04/12/25 - Ascorbic Acid Oral Tablet 500 MG Give 500 mg via G-Tube one time a day related to unspecified protein calorie malnutrition- start date 04/12/25. - Aspirin 81 Oral Tablet Chewable (Aspirin). Give 81 mg via G-Tube one time a day for preventive- Start Date 04/12/25. - Multivitamin-Minerals Oral Tablet (Multiple Vitamins w/ Minerals) give 1 tablet via G-Tube one time a day for unspecified protein calorie malnutrition. -Metformin HCl Oral Tablet 500 MG. Give 500 mg via G-Tube two times a day for diabetes mellitus related to type 2 diabetes mellitus without complications. Observation on 04/16/25 at 08:33 AM revealed LVN D prepared the following medication, crushed them, and placed them in separate cups: - Vitamin C tablet 500mgs 1 tablet via g-tube - Aspirin 81mgs 1 tablet via g-tube - Amlodipine 5mgs 1 tablet via g-tube - Metformin 500mgs 1 tablet via g-tube - Multivitamin 1 tablet via -g-tube LVN D dissolved the medication prior to administering to Resident #105. LVN D went to Resident #105's (continued on next page)

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	675963	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Pointe Nursing and Rehabilitation	7804 Virgil Anthony Blvd Watauga, TX 76148

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room, positioned the resident, checked for the g-tube placement and residual, and flushed the g-tube with 10 ml of water. LVN D poured the crushed medication, each cup at a time and flush with 5-10mls of water. She then flushed with 20mls of water. Two cups were noted to have scanty medication residue remaining in the cups. Interview on 04/16/25 at 09:01 AM with LVN D revealed she did not review Resident #105's physician orders prior to administering her medications via gastronomy tubes. LVN D reviewed Resident #105's physician order and stated she was not aware the resident had an order to flush 60 ml of water before and after medication administration.Not considered because all was included on medication administration error . LVN D stated she did not flush the gastronomy tube with the prescribed amount. LVN D stated she was aware medication residual remained in the cups. She stated she was supposed to give all the contents in the cup for Resident #105 to get the full dose of those medications. She stated the failure to administer the full doses to Resident #105 would lead to the resident having not getting the therapy needed. Interview on 04/17/25 at 10:15 AM with the ADON revealed her expectation was with medication administration through the g-tube, nurses should try to give as much as possible of all the contents in the cups. She also stated the nurse should ensure they were flushing the gastronomy tube with the prescribed water to prevent gastronomy tubes from getting clogged. The ADON stated when administering medication. the nurses and the MA were expected to check the physician order before they pop the medications. She stated the failure to administer the full dose leads to resident medications not to be as effective and also the failure to administer the right dose would lead to overdose or a low dose and which could cause the medications to not be as effective. The ADON stated it was her responsibility to ensure the staff were doing the right thing, ensure the orders were in place for all the residents, and they were being followed. She stated the facility had done training of medication administration and g-tube medication administration. No training records were provided. Interview on 04/17/25 at 12:30 PM with the Interim DON revealed her expectation was with medication administration through the g-tube, nurses should try to give as much as possible of all the contents in the cups. The Interim DON stated when administering medication via g-tube, nurses were expected to check the order, and flush the g-tube with the right orders. The Interim DON stated the MA F was supposed to follow the physician orders. She stated the failure to administer the full dose would lead to resident medications not being effective. The Interim DON stated the failure to follow the physician orders could also lead to an overdose. The Interim DON stated it was the ADON's responsibility to ensure the staff were doing the right thing and ensure the orders were in place and being followed. Record review of the facility's Enteral Medication Administration policy, revised 01/25/13, reflected the following: 7. Flush the tube with 30ml water or according to physician order. 8. Administer one medication at a time with a flush of 5-10 ml water or the amount ordered by the physician, between each medication and after the final medication is administered. Verify that medication cups are clear of any remnants of crushed pills or liquid medication. Alternate fluid may be used if the facility policy and diet orders permit. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Once all medications have been administered, flush the tube with 30ml water or according to physician order. Record review of the facility's Medication Administration Procedures policy, revised 10/25/17, reflected the following: 20. The 10 rights of medication should always be adhered to 1. Right patient 2. Right medication

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview, and record review the facility failed to ensure all drugs and biologicals were stored securely for 1 of 18 residents (Resident #10) on one hall reviewed for storage of medications. The facility failed to ensure an Amoxicillin tablet (an antibiotic) was not left at Resident #10's bed side unsupervised on 04/15/25. This failure could place residents at risk of consuming unsafe medications. Findings included: Record review of Resident #10's face sheet, dated 04/17/25, revealed the resident was a [AGE] year-old male with an admitted [DATE] and readmitted on [DATE]. Record review of Resident #10's annual MDS assessment dated [DATE] reflected his diagnoses included unspecified dementia, depression, essential hypertension, and acute respiratory failure with hypoxia. Resident #10's BIMS score was 15 which indicated cognition was intact. Record review of Resident #10's physician order dated 04/11/25, revealed he had an order for Amoxicillin-Pot Clavulanate Tablet 875-125 MG Give 1 tablet by mouth every 12 hours for UTI for 10 Days. Observation and interview on 04/15/25 at 10:56 AM revealed Resident #10 was in his room, on his bed. There was a clear cup on the bedside table with 1 tablet in it. Resident #10 stated the nurse dropped it off not long ago, he stated he was going to take it but fell asleep. Resident #10 stated the nurse dropped it off about 15-20 minutes ago, he stated he could not recall the nurse's name. Observation and interview on 04/15/25 at 11:08 AM with LVN D revealed she was the nurse assigned to Resident #10. LVN D observed the medication on Resident #10's bedside table. She stated it was his amoxicillin medication. LVN D stated she provided the medication about 5 minutes ago. LVN D stated she had to step out to assist staff with another resident and she was supposed to come back to the room. She stated the risk of leaving medication unattended was it could cause another resident to take it. Interview on 04/17/25 at 11:28 AM with the ADON revealed her expectations were for the nurses to follow physician orders and to see the residents take their medications before they left the room. She said she was informed Resident #10 had a pill on his bedside table. The ADON stated LVN D made a mistake by leaving the medications in the room. She stated the risk of leaving medication in rooms could lead to another resident taking it or the resident not taking the medication. Record review of facility's Medication Administration Procedures policy, dated 10/25/17, revealed the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. All medications are administered by licensed medical or nursing personnel. 2. Medications are to be poured, administered, and charted by the same licensed person.

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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** 42859 Based on observation, interview, and record review, the facility failed to ensure maintain medical records on each resident that are complete and accurately documented for 1 of 1 residents (Resident #105) reviewed for respiratory care. The facility failed to document on Resident #105's MAR/TAR showing that the resident's oxygen tubing was changed on Sunday as ordered by the physician. This failure could affect residents with respiratory therapy and could lead them to lack of care including possible infection by not following the physician orders. Findings included: Record review of Resident #105's admission MDS Assessment, dated 04/11/25, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE], her BIMS was not completed due to resident was newly admitted . Her diagnoses included cerebral infarction (stroke), and tracheostomy status (a surgical procedure where an opening is created in the trachea to allow for breathing). Record review of Resident #105's care plan, dated 04/14/25, reflected the following: Focus: Resident #105 requires has Tracheostomy rule out impaired gas exchange. Goal: Resident will have clear and equal breath sounds bilaterally through the review. The resident will have no signs and symptom of infection through the review date. Interventions: tube out procedures: Keep extra trach tube at bedside. If tube cannot be reinserted, monitor/document for signs of respiratory distress. If able to breathe spontaneously, elevate HOB 45 degrees and stay with resident. notify emergency services immediately. Record review of Resident #105's April 2025 physician orders dated 4/14/25 reflected the following: Change all disposable respiratory tubing and equipment every week and as needed every night shift every Sunday. Review of the April 2025 Medication administration record had no documentation on when the disposable respiratory tubes were last changed. Observation on 04/15/25 at 10:18 AM revealed Resident #105 was receiving oxygen 3 liters per minute by oxygen mask in her room. She was using oxygen continually, and the tubing between the humidifier bottle and an oxygen concentrator, and to the compressor was not labelled. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 04/15/25 at 12:08 PM revealed the Respiratory Therapist and the ADON performing tracheostomy care to Resident #105.The Respiratory Therapist stated staff were supposed to label all the tubing since Resident #105 was admitted on [DATE]. She stated when Resident #105 was admitted , the admitting nurse called her, and they connected Resident #105's tracheostomy tubes and she thought she forgot to tell them to label it. She stated the oxygen tubing was supposed to be labeled so nurses were aware of when they were last changed and when to replace with new ones. She stated the failure to change the tubing put Resident #105 at risk for infection. She stated she did train all nurses before Resident #105 was admitted to the facility and no training records were provided. Interview and observation on 04/15/25 at 12:09 PM with LVN D stated Resident #105's disposable respiratory tubing and equipment were supposed to be labeled by the nurse that admitted Resident #105 on 04/11/25. She stated she was supposed to check the tubing for labelling every shift, but she did not check. Further interview, LVN-D said nurses should have changed all oxygen tubing and the humidifier bottle once a week every Sunday per the physician's order. She did not know what reason the nurses did not follow the order or document on the nurses' treatment administration record. She stated she had done training with the Respiratory Therapist before Resident#105 was admitted and she had been coming to monitor staff perform care. Certification of completion of respiratory /tracheostomy training dated 12/30/24 was provided. Interview on 04/17/25 at 10:38 AM with the ADON revealed, her expectation was nurses should change Resident #105's disposable respiratory tubing once a week every Sunday as per the physician's order to prevent possible respiratory infection and they should label them with the date when last changed. She stated she had seen Resident #105 on 4/14/25 and 4/15/25 and she did not notice the tubing was not dated. She stated before Resident #105 was admitted , the facility did classes and check offs with nurses and no record was provided. She stated the importance of putting the date on tubing was staff would be able to tell when it was last changed and when it needed to be changed again. She stated the failure to put dates when tubing was changed predisposes Resident#105 to infection because the moisture in the tubes harbored bacteria. Interview on 04/17/25 at 01:00 PM with the Interim DON revealed her expectation was nurses to follow orders and put dates when tubing was changed. She stated she had done training to all staff a year ago and she was not sure of current trainings on tracheostomy care. Interview on 04/17/25 at 02:51 PM with LVN E revealed Resident #105 admitted on [DATE] during her shift. She stated she connected her with the disposable respiratory tubing with the Respiratory Therapist on a video call. She stated she knew she was supposed to date the oxygen humidifier bottle and the disposable respiratory tubing on 04/11/25 but she forgot. She stated she did not see the need of putting the dates and the tubing was supposed to be changed again on Sunday as per the physician orders. She stated the failure to put the dates exposed the resident to infection because the nurse would not be able to tell when the tubing was last changed. She stated she had done training on tracheostomy care. Record review of the facility policy, titled Tracheostomy Care Procedure, revised 10/19/09, revealed did not address the disposable respiratory tubing.