STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675966	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Texarkana	4920 Elizabeth St Texarkana, TX 75503

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 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** 44596 Based on observations, record reviews, and interviews, the facility failed to protect and promote the rights of the resident in an environment that promoted maintenance or enhancement of his or her quality of life for 2 of 18 residents (Resident #63, Resident #53) reviewed for resident rights. The facility failed to protect and value Resident # 63's rights when the facility failed to allow Resident #63 call the police to report a potential crime. The facility failed to protect and promote the rights of Resident #53 by not knocking on the door prior to entering the resident's room. This failure could place residents at risk for decreased quality of life, increased anxiety, decreased privacy, and increased stress. Findings included: Record review of Resident #63's face sheet dated 10/24/22 indicated he was [AGE] years old and admitted to the facility on [DATE] with diagnoses including Muscle Wasting and Atrophy (the loss of muscle mass and strength, often caused by disuse, injury, malnutrition, or neurological conditions, resulting in a decrease in muscle size and function), Delusional Disorders (a mental illness that involves having fixed false beliefs, or delusions, that are not based in reality), Hypertensive Heart Disease (a group of heart problems that develop due to long-term high blood pressure). Record review of Resident #63's quarterly MDS dated [DATE] indicated he was understood and understood others. The MDS indicated a BIMS score of 13 which indicated Resident #63 was cognitively intact. The MDS indicated Resident #63 did not reject care. Record review of Resident #63's care plan dated 5/10/24 shows that Resident #63 has a history of being verbally aggressive at times. Shows that Resident #63 has a potential for side effects regarding his psychotropic medications. (continued on next page)

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	During an interview on 12/10/24 at 11:00 a.m. Ombudsman A said she remembered the incident with Resident #63 and Resident #13 . She said that she does not know what to believe with the incident because both residents changed their story so much. She said that Resident #63 did complain to her after describing his side of the story that he wanted to call the police. She said the day she spoke to Resident #63 she also spoke to RN G who she educated that he needed to assist Resident #63 in calling the police. She said she educated the RN on duty as it was the weekend, and he was in charge. She said that she also educated him as Resident #63 said he was not able to call the police the day the incident occurred because he was told that only the Administrator was able to call the police. During an interview on 12/10/24 at 12:40 p.m., Resident #63 said he was not afraid of Resident #13. He said he still leaves his room and goes to all his activities and eats in the dining room, but he will ignore Resident #13. He said he does not remember exactly what happened the day of the incident. He said he wants to call the police and has not been given the opportunity to do so. During an interview on 12/10/24 at 2:55 p.m., RN G said he was working as the charge nurse on the day the incident occurred between Resident #13 and Resident #63. He said that he did hear something going on, but he did not see it. He said that he was told Resident #13 and Resident #63 got into an altercation after Resident #63 ran over the foot of Resident #13 on accident. He said he was told that Resident #13 either tripped and fell on to Resident #63 or Resident #13 slapped Resident #63 . He said he wasn't sure what was true. He said he wasn't sure if he spoke to Ombudsman A and B about the incident and calling the police. During an interview on 12/10/24 at 3:12 p.m., Resident #13 said that she remembers the incident with Resident #63. She said she was shocked when Resident #63 ran over her foot. She said that she slapped Resident #63 in response. She said she felt really bad about it and wished she did not do that. She said she did not slap him hard and that she barely touched him. She said that she was happy Resident #63 was ok and she would never slap anyone again. She said this was the first time she every slapped anyone. She said now she has a sitter with her day and night watching her. She said that she regrets what happened and wants to stay clear of Resident #63 in the future. She said she feels safe at the facility and is not afraid of Resident #63. During an interview on 12/11/24 at 9:13 a.m., with Ombudsman B she said she spoke with RN G with Ombudsman A and they called him into a room and interviewed him alone. She said he was the RN on duty at the time and he said he did not witness the incident. She said he assessed Resident #13's foot and she was unharmed, and it was determined that Resident #63 did not run over Resident #13's foot. She said they asked RN G if he called the police and he said he did not. They said they educated RN G that he was required to call the police if a resident asked to, and Resident #63 had requested to call the police. She said that they educated RN G that they must allow a resident to use the phone if they requested to. During an interview on 12/11/24 at 12:44 p.m. the Director of Nurses said residents have the right to call outside the building to police or anyone else if they request to. She said that residents should be allowed to call the police to make a report whether their story is true or not as it is their right. During an interview on 12/11/24 at 12:55 p.m., the Administrator said residents have the right to call the police if they so desire to do so. She said that if a resident comes to a staff and asks to use the phone to call the police the staff should direct the resident to a phone. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of an undated face sheet revealed Resident #53 was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of anxiety, Diabetes Mellitus Type II (prolonged high levels of glucose in the blood), and dementia (a group of symptoms affecting the memory). Record review of an annual MDS assessment dated [DATE] revealed Resident #53 had a BIMS of 05 which indicated a severe cognitive impairment. Resident #53 was dependent for ADLs such as toileting, transfer, and bathing. During a record review on 12/10/2024 at 10:10 a.m. of the facility Inservice binder, no Inservice was noted on knocking before entering a resident's room. During an observation on 12/10/2024 at 8:20 a.m. CMA H entered Resident #53's room without knocking and Resident #53 was exposed during incontinent care. Resident #53 was facing the wall and the door was closed within 15 seconds. Resident #53 was not aware she was exposed to the hallway, medication aide, and surveyor. During an interview on 12/11/2024 at 9:45 a.m., Resident #53's family member stated he had been a witness to the CNA and Medication Aides not knocking on the door several times. She stated luckily, she had never witnessed any unclothed residents as she walked by rooms. She stated Resident #53 was a private person and would not like knowing she was exposed to the hallway and staff members. During an interview on 12/11/2024 at 10:00 a.m., CMA H stated she was aware she was supposed to knock on the resident's door prior to entering. She stated she accidentally forgot to knock before entering but quickly corrected herself once she saw Resident #53 was exposed. She stated it was not her intention to cause any embarrassment to Resident #53. During an interview on 12/11/2024 at 11:00 a.m., the DON stated it was the resident's right to live in home that was as close to the home they lived in prior to coming to the facility. She stated that was why knocking before entering was important. She stated no one that worked there would enter someone's home without knocking first and it was the same concept at the nursing facility. During an interview on 12/11/2024 at 2:00 p.m., the ADM stated she expected all staff to knock and provide care with dignity and respect for the elders of the community. She stated no one enters the staff's home without knocking and she wanted the staff to understand the correlation. She stated not knocking can make the resident feel less important and as if their privacy was unimportant to the facility. Review of the facility 's policy titled Resident Rights with a revised date of December 2016 indicated, Employees shall treat all residents with kindness, respect, and dignity Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to be free from abuse, neglect, misappropriation of property, and exploitation exercise his or her rights as a resident of the facility and as a resident or citizen of the United States communicate with outside agencies (e.g., local, state, or federal officials, state and federal surveyors, state long-term care ombudsman, protection or advocacy organizations, etc.) regarding any matter. 45643

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44128 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 2 of 23 residents reviewed for environment. (Resident #57 and Resident #72) 1. The facility failed to repair an electrical outlet in the room of Resident #57 a timely manner. 2. The facility failed to provide a functioning bed light pull string for Resident #72. These failures placed residents at risk of injury of, living in an uncomfortable environment and a decrease in quality of life and self-worth. Findings included: 1. Record review of the face sheet 12/10/24 indicated Resident #57 was [AGE] years old and was admitted on [DATE] with diagnoses including heart failure, dementia, and weakness. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #57 was sometimes understood and sometimes understood others. The MDS indicated a BIMS score of 07 indicating Resident #57 was severely cognitively impaired. The MDS indicated Resident #72 was dependent on staff for ADLs. During an observation and interview on 12/09/24 at 10:04 a.m., near the head of the bed of Resident #57's bed was a red electrical outlet hanging out of the wall. The outlet was secured to the wall by metal brackets. The screw in the top bracket was completely out of the wall. The top part of the outlet was approximately 1 inch away from the wall exposing the entire length of the screw, the electrical conduit (a tube that protects and routes electrical wiring in a building or structure), and three holes in the wall. There were three electrical cords plugged into the outlet. Family Member A (family member of Resident #57) said the outlet had been hanging off the wall forever. During an observation and interview on 12/10/24 at 8:12 a.m., Resident #57 was in bed. Approximately 3 feet away from Resident #57 was a red electrical outlet hanging out of the wall. The outlet was secured to the wall by metal brackets. The screw in the top bracket was completely out of the wall. The top part of the outlet was approximately 1 inch away from the wall exposing the entire length of the screw, the electrical conduit (a tube that protects and routes electrical wiring in a building or structure), and three holes in the wall. There were two electrical cords plugged into the outlet. Resident #57 said she did not know how long the outlet had been pulled away from the wall. During an interview on 12/10/24 at 8:24 a.m., Family Member B (family member of Resident #57) said the outlet had been that way for several months. Family Member B said it had concerned them. Family Member B said there had been attempts made in the past to reattach the outlet to the wall, but it never stayed attached very long. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/24 at 9:47 a.m., RN B said he had not noticed the outlet in Resident 57's room. He said all maintenance issues were entered into the maintenance log that was kept at the nurses' station. He said the log was then checked by Maintenance Director so the appropriate repairs could be made. During an interview on 12/11/24 at 7:57 a.m., the Maintenance Director said maintenance issues were supposed to be put in service order books at each nurses' station. He said he had a huge problem with staff not doing this. He said staff just stop maintenance staff in the hall and verbally tell them. He said the outlet had been repaired several times. He said staff raising the head of the bed kept pulling the outlet out of the wall. He said he just found out on 12/10/24 that it was pulled out from the wall again. He said the wall itself and the outlet needed to be repaired and the power would have to be shut off in that room. He said this has been an ongoing issue for approximately 3 weeks. He said the box was originally` anchored to the wall but not anchored to a stud. He said now it was temporarily secured to the wall until the dry wall could be replaced. During an interview on 12/11/24 at 8:11 a.m., CNA C said the outlet beside Resident #57's bed had been hanging out of the wall for months. She said she had verbally reported the outlet being out of the wall to maintenance when it was first pulled from the wall. She said, It's been a good minute. During an interview on 12/11/24 at 8:15 a.m., CNA D said the outlet in Resident 57's room had been pulled out from the wall for months. She said when the bed was raised up it would hand on the outlet. She said she had reported to maintenance herself. She said she reported it to them verbally. She said she did not know if there had been previous attempts by maintenance to repair the outlet. During an interview on 12/11/24 at 9:07 a.m., the DON said she would have expected for the outlet to have been repaired in a timely and appropriate manner. She said the outlet hanging out of the wall could be a fire hazard. During an interview on 12/11/24 at 1:50 p.m., the Administrator said staff should put maintenance request on the log at each nurse's station. She said anything concerning electrical should be repaired immediately. She said would have expected the outlet to have been appropriately prepared and in a timely manner. She said an outlet not being repaired could potentially be a fire hazard or could fall and hit the resident. Record review of an In-service Training Report dated 09/03/24 for All Staff and was titled Maintenance Logs indicated, All staff are required to complete a maintenance request when they observe repairs that are needed. Use the log books that are located at the nurse station. Do no assume the dept is aware. I would rather the request be made over and over other than not at all. The In-Service was conducted by the Administrator. Record review of a Maintenance Repair Log that was in a binder at the nurses' station for Resident #57's hall did not indicate a repair request for the outlet in Resident #57's room . (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of the face sheet 01/31/24 indicated Resident #72 was [AGE] years old and was admitted on [DATE] with diagnoses including Muscle Weakness (occurs when your muscles are unable to contract properly, resulting in reduced strength), Abnormalities of Gait and Mobility (deviations from a normal walking pattern, including issues like limping, shuffling feet, dragging toes, difficulty with coordination, short steps, or an unsteady gait), Schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #72 was understood and understood others. The MDS indicated a BIMS score of 15 indicating Resident #72 was cognitively intact. The MDS indicated Resident #72 required use a walker to ambulate and supervision for some ADLs. During an interview and observation on 12/09/24 at 09:56 a.m., Resident # 72 said is that his only complaint was he wanted his light pull cord fixed. He said he tied his call light button cord to his light switch cord so he could turn his light on. He said he doesn't know if he has asked for it to be fixed. He said that he would prefer for the light above his bed to have a pull cord that was not torn off. It was observed that Resident #72's light above his bed had a frayed and torn pull cord. The cord turns the light on above his bed. It was approximately 75% torn off. Resident #72 said had tied his call light cord to the torn light pull string so he could reach it from his bed, so he didn't have to stand up. During an interview on 12/11/24 at 09:42 a.m., the Maintenance Director said he did not know that resident #72 had a broken pull cord for his light. He said if he had known he would fix it as that was a simple problem. He said that he had issues with staff reporting in their maintenance log broken items that need fixed. He said that residents lived in the facility as their home and should have a comfortable and homelike environment. Record review of facility Maintenance Log revealed that there was no report for Resident #72's light pull cord being frayed and torn. During an interview on 12/11/24 at 12:52 p.m., the Administrator said the Maintenance Director was responsible for maintaining the building including bed light pull cords. She said that the Maintenance Director is required to do rounds in the facility and identify issues such as this. She said that this issue when found by staff should be reported in the maintenance log. She said that rigging up a self-fix so that Resident #72 could turn his light on was a quality-of-life issue that should be addressed immediately. Record review of a facility policy revision date of May 2017 and titled, Quality of Life - Homelike Environment Indicated that, Residents are provided with a safe clean comfortable and homelike environment and encouraged to use their personal belongings to the extent possible Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences Comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable and homelike environment. The lighting design emphasizes sufficient general lighting in resident-use areas task lighting as needed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy revision date of December 2009 and titled, Maintenance Service Indicated that, Maintenance service shall be provided to all areas of the building, grounds, and equipment The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines Maintaining lighting levels that are comfortable, and assuring that exit lights are in good working order Maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned 45643

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interview and record review the facility failed to ensure that resident assessments accurately reflected the resident's status for 1 (Resident #20) of 12 residents reviewed for accuracy of resident assessments. The facility failed to ensure that Resident #20's MDS quarterly assessment accurately reflected the resident had 5 injections of insulin and had no UTI (urinary tract infection). This failure put residents at risk for not receiving care and services needed. Findings included: Record review of Resident #20's face sheet dated 12/09/2024 revealed she was a 77-years-old female, admitted to the facility on [DATE]. She had diagnoses of depression, obesity, glaucoma (a group of eye diseases that can lead to damage of the optic nerve) Record review of the quarterly MDS assessment dated [DATE] indicated Resident #20 had a BIMS of 15, which indicated no cognitive impairment. The MDS also revealed Resident #20 received injections of insulin for 5 days in the prior 7 days. The MDS was not coded for UTI. Record review of the consolidated orders dated 11/2024 indicated Resident #20 was started on Rocephin 1 gram intramuscularly daily on 11/15/2024. There were no orders for insulin. Record review of Resident #20's MAR dated 11/2024 indicated Resident #20 received injections 11/15/2024 daily through 11/24/2024 of antibiotic medication. The MAR had no orders for insulin. Record review of a urinalysis for Resident #20 indicated she had a UTI with 3 separate organisms cultured on 11/15/2024. During an interview on 12/11/2024 at 10:20 a.m., the MDS Coordinator stated she made a mistake by claiming 5 days of injections of insulin for Resident #20. She stated most people that got injections received insulin and it was just an oversight. She stated she had not claimed UTI because she felt it did not meet criteria for a UTI. She stated Resident #20 only had one day of symptoms. She stated this failure would not affect the resident in a negative. During an interview on 12/11/2024 at 2:00 p.m., the DON stated the MDS was important to be coded accurately because it was what was care planned about the resident and that was how the staff knew the individual needs of each resident. She stated Resident #20 was positive for a UTI in November 2024 because she complained of burning and itching with urination and tested positive for multiple bacteria. She stated that UTI should have been claimed as a diagnosis on the MDS. She stated not coding that or the antibiotics was not an accurate reflection of the resident because she was someone with frequent UTI's. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/2024 at 2:15 p.m., the ADM stated she expected the MDS to be coded accurately so the staff new the correct way to care for each resident individually. She stated it was an oversight on the part of the MDS nurse and it was corrected before the interview. She stated the facility followed the RAI manual for their policy on accuracy of the MDS. Review of an undated facility Minimum Data Set (MDS) Policy for MDS assessment Data Accuracy indicated, The purpose of the MDS policy is to ensure each resident receives an accurate assessment by qualified staff to address the needs of the resident .According to CMS's RAI Version 3.0 manual; the MDS is a core set of screening, clinical, and functional status elements .which forms the foundation of a comprehensive assessment for all residents of nursing homes .the items of the MDS standardize communication about resident problems and conditions with nursing homes, between nursing homes, and outside agencies .Federal regulations .require that .the assessment accurately reflects the resident's status .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45643 Based on observation, interview, and record review the facility failed to ensure each resident received adequate supervision to prevent accidents for 2 of 14 residents (Resident #66, Resident #72) reviewed for adequate supervision. The facility failed to ensure that Resident #66 and Resident #72 did not have cigarette lighters in their room and in their personal possession. This failure could place residents at risk for injury, harm, and impairment or death. Findings included: 1. Record review of the face sheet 06/26/24 indicated Resident #66 was [AGE] years old and was admitted on [DATE] with diagnoses including Addisonian Crisis (Adrenal crisis, is a life-threatening medical emergency that requires immediate treatment), Hypoglycemia (occurs when your blood sugar level drops too low), Type 2 Diabetes (a condition that occurs when the body doesn't use insulin properly, leading to high blood sugar levels). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #66 was understood and understood others. The MDS indicated a BIMS score of 13 indicating Resident #66 was cognitively intact. The MDS indicated Resident #66 required use a walker to ambulate and supervision for some ADLs. Record review of Resident #66's Care Plan dated 7/23/24, revealed a problem initiation on 7/23/2024 that Resident #66 was a smoker. Indicated that Resident #66 would keep his smoking materials at the nurse's station. During interview and observation on 12/09/24 at 10:17 a.m., Resident #66 had a lighter on his bedside table. Surveyor asked if Resident #66's lighter worked as it was a type of metal collectable lighters. Resident #66 opened the top of the metal light struck the [NAME] which produced a fire. He said that he keeps his lighter on his bedside table so he can go out and smoke whenever he wants. No cigarettes were observed in the room. 2. Record review of the face sheet 01/31/24 indicated Resident #72 was [AGE] years old and was admitted on [DATE] with diagnoses including Muscle Weakness (occurs when your muscles are unable to contract properly, resulting in reduced strength), Abnormalities of Gait and Mobility (deviations from a normal walking pattern, including issues like limping, shuffling feet, dragging toes, difficulty with coordination, short steps, or an unsteady gait), Schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #72 was understood and understood others. The MDS indicated a BIMS score of 15 indicating Resident #72 was cognitively intact. The MDS indicated Resident #72 required use a walker to ambulate and supervision for some ADLs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #72's Care Plan dated 1/09/23, revealed a problem initiation on 2/20/2024 that Resident #72 was non-compliant with facility smoking policies. Indicated that staff were to Instruct resident about the facility policy on smoking: locations, times, safety concerns. During an interview and observation on 12/09/24 at 9:56 a.m., Resident #72 was observed to have two plastic lighters in his room on his walker in plain sight. He said that he always kept his lighters with him. Resident #72 began getting agitated that the surveyor was asking about his lighters and walked out of the room. During an interview on 12/09/24 at 10:24 a.m., RN B said that Residents are not allows to keep their smoking materials on them or in their room. He said that they residents could start a fire if they are able to keep them. He said he would go confiscate the lighters. He said that it is the responsibility of any staff to confiscate lighters. During an interview on 12/11/24 at 12:44 p.m., the Director of Nurses said it was the policy of the facility that residents cannot keep their lighters with them. She said that their policy says to take the lighters from residents. She said that residents could cause a fire if they have use of their lighters unsupervised . During an interview on 12/11/24 at 12:47 p.m., the Administrator said their policy does not allow a resident to keep their lighters in their room. She said that residents cannot have smoking materials with them. She said that residents could start a fire in the facility if they have their lighters and are unsupervised. Record review of an undated facility policy and titled, Smoking and Vaping Policy Indicated that, Policy: Smoking and/ or vaping is not allowed anywhere WITHIN this facility (by residents and/or staff). It is the policy of this facility to establish and maintain resident smoking and vaping policies. Smoking is not allowed in resident's rooms or inside the facility Materials are not to be carried by residents or allowed in resident rooms. They must be kept in the smoking box or stored in the Administrators office until use is needed.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46929 Based on observation, interview, and record review, the facility failed to attempt to use alternatives prior to installing a side or bed rail, obtain informed consent prior to installation, ensure correct installation, use and maintenance of bedrails for 1 of 23 residents (Resident #30) reviewed for bedrails . 1. The facility failed to ensure informed consent for the use of Resident #30's bed rails were obtained prior to installation. 2. The facility failed to obtain a bed rail assessment to assess the risk of entrapment for Resident #30's bed rails. These failures could place residents at risk of entrapment or injury. Findings included: Record review of Resident #30's face sheet, dated 12/11/24, indicated he was an [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included anxiety disorder (mental health conditions that cause uncontrollable and excessive feelings of fear or anxiety that can interfere with daily life), and myopathy (disease that affects the muscles and causes them to malfunction). Record review of Resident #30's quarterly MDS assessment, dated 09/16/24, indicated he has a BIMS score of 13, which indicated intact cognition. He was able to make himself understood and he was able to understand others. He required substantial assistance with rolling left and right and sit to stand. He was completely dependent on staff for assistance for lying to sitting on side of bed, and chair/bed to chair transfers. Record review of Resident #30's physician's orders, dated 12/11/24, did not indicate an order for bed rails. Record review of Resident #30's care plan, last revised on 10/24/24, indicated a focus of resident is at risk for falls. This focus included a statement of: Assist rail to resident left side of bed. another focus indicated on the care plan was resident is at risk for pressure ulcers/skin breakdown. This focus included a statement of: 2 half rails for positioning. During an observation and interview on 12/09/24 at 09:50 AM, Resident #30 was in his room lying in his bed. His bed had rails that were greater than one-quarter the length of his mattress. He said he used them to help move around in the bed. He said he had not had any issues with them. During an interview on 12/10/24 at 12:52 PM, LVN E said she was responsible for care plans in the facility. She said that the bed rails were added to Resident #30's bed because he had a fall. She said they were for the resident to use to turn and assist for bed mobility. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/10/24 at 1:00PM, Resident #30 was lying in his bed in his room. Corporate Nurse F was present and had a tape measure to measure the bed rails and mattress of Resident #30's bed. His mattress measured approximately 79 inches long and the bed rails were approximately 30.5 inches long. During an interview on 12/10/24 at 01:05PM, the Administrator said they considered the rails on Resident #30's bed to be for mobility and for turn assist. She said they are not intended to keep him from falling or keep him in the bed. she said they did not do any informed consent or bed rail assessments. She said they did not do the assessments and informed consent because they did not consider the rails to be restraints. During an interview on 12/11/24 at 12:47 PM, the DON said Resident #30 should have had the informed consent, assessments, and all the requirements completed for bed rails. She said they will change the rails to the proper turn assist rails. She said the risk to Resident #30 was there could be potential skin breakdown by the rails being too long. Record review of the facility's policy, Proper Use of Side Rails, last revised December 2016, stated: .The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids . .General Guidelines . .2. Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. 3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: a. Bed mobility; b. Ability to change positions, transfer to and from bed or chair, and to stand and toilet; c. Risk of entrapment from the use of side rails; and d. That the bed's dimensions are appropriate for the resident's size and weight. 4. The use of side rails as an assistive device will be addressed in the resident care plan . . 9, Consent for side rail use will be obtained from the resident or legal representative, after presenting (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	potential benefits and risks .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46929 Based on interview and record review, the facility failed to ensure residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs for 2 of 5 residents (Resident #8 and Resident #18) reviewed for unnecessary medications. 1. The facility failed to ensure Resident #8 had an appropriate rationale for declining a GDR for her Zyprexa medication (an antipsychotic medication used to treat bipolar disorder). 2. The facility failed to ensure Resident #18 had an appropriate diagnosis for her prescribed Trileptal (it can treat epileptic seizures). This failure could put residents at risk of possible psychotropic medication side effects, adverse consequences, decreased quality of life, and dependence on unnecessary medications. Findings included: 1. Record review of Resident #8's face sheet, dated [DATE], indicated she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included dementia (a decline in mental ability that affects thinking, memory, and behavior, and interferes with daily life), cerebral infarction (a serious condition that occurs when blood flow to the brain is blocked), bipolar disorder (a serious mental illness that causes extreme shifts in mood, energy, thinking, behavior, and sleep), and anxiety disorder (mental health conditions that cause uncontrollable and excessive feelings of fear or anxiety that can interfere with daily life). Record review of Resident #8's annual MDS assessment, dated [DATE], indicated she had a BIMS score of 6, which indicated severe cognitive impairment. The MDS indicated that she received antipsychotic medication during her assessment window. Record review of Resident #8's physician's orders, dated [DATE], indicated this order: *Zyprexa Tablet 2.5 mg Give 1 tablet by mouth at bedtime related to bipolar disorder. The start date was [DATE]. Record review of Resident #8's consultant pharmacist / physician communication dated [DATE], indicated the consultant pharmacist communicated to the physician that the olanzapine (Zyprexa) medication was due for a GDR and recommended a change in the order to every other night for 14 days and then trial discontinue. The note further indicated If resident failed previous dose reduction attempt or is clinically contraindicated, please document clinical rationale below. The physician / prescriber response stated: hospice care. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:47 PM, the DON said she expected the provider to provide an appropriate rationale for their decision regarding GDR's. She said the risk to the resident was that she could be potentially receiving unnecessary psychotropic medications. During an interview on [DATE] at 01:10 PM, the Administrator said she expected the GDR to be justified. She said the risk to the resident was that it was possible that the resident could be on an unnecessary medication for longer than necessary. 2. Record review of Resident #18's face sheet dated [DATE] indicated an 83-years-old female admitted to the facility on [DATE]. Resident #18 had diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) major depression disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Record review of Resident #18's MDS assessment dated [DATE] indicated Resident #18 was usually understood and usually understood others. Resident #18's BIMS score was a 6. Resident #18 required moderate assistance with toileting and personal hygiene. Resident #18 MDS indicated she had major depression and anxiety disorder, unspecified. Record review of Resident #18's care plan dated [DATE] indicated has impaired cognition diagnosis of Alzheimer's disease, anxiety. Resident #18 has inattention and disorganized thinking at times. Resident has delusional thoughts at times, such as she believes she is babysitting kids and waiting for her family member (who is deceased) to pick her up. Record review of Resident #18's Medication Summary Report dated [DATE] ordered and [DATE] started indicated Trileptal Oral Tablet 150 MG (Oxcarbazepine) Give 1 tablet by mouth three times a day related to anxiety disorder, unspecified. During an interview on [DATE] at 9:44 A.M., RN B said ADON J was responsible for putting the medications in the system and making sure the medications match the diagnosis. He said a negative effect on the medication could not be ineffective if monitoring for the wrong diagnosis. During an interview on [DATE] at 9:51 A.M., ADON J said the nurses were responsible to make sure the medications match the proper diagnosis. She said the doctor was responsible to ensure the medication match the diagnosis when he signed the orders. She said when the nurse gets the orders, they should make sure the orders match the diagnosis. She said the ADON's put the orders in and make sure the orders match the diagnosis. She said a negative effect of a medication with the wrong diagnosis could cause a different effect in the resident and staff would monitor for whatever the medication was used for. During an interview on [DATE] at 10:09 A.M., LVN O said she wrote the orders on admission, but the ADON usually put in the orders in the system with the diagnosis. She said but if the ADON was busy or had not put the orders in the charge nurse would do it. She said a negative effect of a medication not having the correct diagnosis was a medication could not a positive outcome for a resident if staff monitored the resident for the incorrect diagnosis. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:48 P.M., the DON said on admission ADON J normally did the admissions, but if she was not here one of the other ADON's put the orders and diagnosis in the system. She said expected the nurses to make sure the medications were with the correct diagnosis. She said negative effect of not having the correct diagnosis with the medication would be not checking the correct parameters for that medication. During an interview on [DATE] at 2:07 P.M., the ADM said she expected the nurses to put the correct diagnosis with the appropriate medications. She said a negative effect of not having the correct diagnosis with the appropriate medication could cause medication errors and effect quality of care. She said the facility had corrected the issue with the medication. Record review of the facility policy Medication Therapy revised ,d+[DATE] indicated Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks. Medication use shall be consistent with an individual's condition, prognosis, values, wishes and responses to such treatment. Record review of the facility's undated policy, Behavior and Psychoactive Management Program, stated: .Tapering and Gradual Dose Reduction (GDR) . .3. After the first year, GDR or tapering should be attempted once a year. 4. GDR or tapering may be considered clinically contraindicated if the resident's targeted symptoms worsened or returned during the reduction. If this occurs the physician must document the clinical rationale why further GDR attempts should not be done (further attempts may cause impairment of resident function, increase distressed behavior(s), cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder 48958

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643 Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 1 of 12 resident personal refrigerators reviewed for food safety (Resident #75). The facility failed to ensure the refrigerator for Resident #75 did not contain expired bologna and milk. This failure could place resident at risk for food borne illnesses. Findings include: 1. Record review of Resident #75's face sheet dated [DATE] indicated Resident #75 was [AGE] years old male and was admitted on [DATE] with diagnoses including Edema (a condition where fluid builds up in the body's tissues, causing swelling), Muscle Weakness (occurs when your muscles are unable to contract properly, resulting in reduced strength), and Cerebral Infarction (a serious condition that occurs when blood flow to the brain is blocked, resulting in brain tissue death). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #75 was understood and understood others. The MDS indicated a BIMS score of 12 indicating Resident #75 had mildly impaired cognition. The MDS indicated Resident #75 required supervision for some ADLs. Record review of Resident #75's care plan dated [DATE] revealed that Resident #75 required assistance with his activities of daily living. During an observation and interview on [DATE] at 10:24 a.m ., Resident #75's personal refrigerator had expired bologna (13th [DATE]) and milk ([DATE]th 2024) He said that he will eat whatever is in his refrigerator. He said he does not look for expiration dates before eating food. He said he doesn't throw any of the food away. He said staff come every few months and cleans his refrigerator out. During an interview on [DATE] at 08:36 a.m., CNA A said that housekeeping and any staff that enters a resident room and saw that there was expired food in their refrigerator should throw that food away. She said that residents could be placed at risk of illness if they ate expired meat or expired milk. During an interview on [DATE] at 12:44 p.m. the Director of Nursing said housekeeping was responsible for ensuring that residents personal refrigerators were cleaned out and expired foods thrown away . She said non-clinical staff should also double check that housekeeping was removing expired items and cleaning. She said that residents could be placed at risk of foodborne illness eating expired meat and milk. During an interview on [DATE] at 12:55 p.m. the Administrator said resident's personal refrigerators should be cleaned out by any staff that recognizes there was spoiled food in their refrigerators. She said that it was primarily the responsibility of housekeeping. She said that residents would be put at risk for foodborne illness. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy revised July of 2014 titled, Food Receiving and Storage. Policy indicated, Foods shall be received and stored in a manner that complies with safe food handling practices Food items and snacks kept on the nursing units must be maintained as indicated. All food items to be kept below 41 F must be placed in the refrigerator located at the nurses' station and labeled with a use by date. All foods belonging to residents must be labeled with the resident's name, the item and the use by date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observations, interviews, and record reviews the facility failed to ensure the hand hygiene procedures were followed by staff involved in direct resident contact for 1 of 5 residents (Resident #59) reviewed for infection control. The facility failed to ensure Staffing Coordinator M performed appropriate hand washing after incontinent care was performed for Resident #59. This failure could result an increase the infections, cross contamination and decrease quality of life. Record review of face sheet date 12/10/2024 indicated Resident #59 was a [AGE] year old male initially admitted to the facility on [DATE] with a diagnoses which included unspecified dementia (a general term for dementia that doesn't have a specific diagnosis), anoxic brain damage (cerebral hypoxia occurs when the brain doesn't receive enough oxygen) and a personal history of urinary tract infections. Record review of a quarterly MDS dated [DATE] revealed Resident #59 had a BIMS score of 12 and the resident was usually understood and usually understood others. The MDS indicated Resident #59 was dependent with toileting hygiene and required moderate assistance with personal hygiene. Record review of Resident #59 care plan dated 02/21/2024 indicated Resident #59 was incontinent of bowel and bladder, due to diagnosis of neuromuscular dysfunction of bladder (a condition where the nerves controlling bladder function are damaged, leading to impaired bladder muscle activity and resulting in difficulty emptying the bladder or incontinence) and anoxic brain damage. Record review of Staffing Coordinator M Proficiency checkoffs dated 09/16/2024 revealed Handwashing, and Perineal care was satisfactory. During an observation of incontinent care performed on 12/10/24 at 1:50 PM by Staffing Coordinator M on Resident #59. Staffing Coordinator M did not wash her hands after she performed incontinent care on Resident #59 before she applied a clean brief and placed covers over the resident. During an interview on 12/11/24 at 9:33 A.M., CNA I said after incontinent care was performed the CNA should wash their hands or sanitize, then applied clean gloves before a clean brief was placed on a resident and prior to covering the resident. She said improper hygiene could made the resident at risk for infections such as urinary tract infections. During an interview on 12/11/24 at 9:38 A.M., CNA A said after she performed incontinent care she would wash or sanitize her hands then apply clean gloves, then apply a clean brief and apply the covers over the resident. She said she always washed her hands before and after incontinent care. She said the negative effects of improper hand hygiene was it could spread germs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/24 at 9:44 A.M., RN B said after peri care staff should wash their hands before applying a clean brief and applying covers over the resident. He said improper hand hygiene could cause infections. During an interview on 12/11/24 at 9:51 A.M., ADON J said after peri care the aide should wash their hands and applied clean gloves before a clean brief and the covers were applied to the resident. She said negative effect of improper hygiene could cause infections and potentially cause other resident to get infections as well. During an interview on 12/11/24 at 10:09 A.M., LVN O said after peri care was performed peri care the aide should have washed their hands or sanitize their hands then apply clean gloves. She said after the clean gloves were applied the aide could have applied a clean brief and the resident's covers. She said a negative effect of improper hand hygiene was cross contamination. During an interview on 12/11/24 at 10:25 A.M., CNA L said she took her dirty gloves off and wash my hands before she touched anything after incontinent care. She said then she would have applied clean gloves then apply a clean brief and covered the resident. She said a negative effect of improper hygiene was infection. During an interview on 12/11/24 at 10:30 A.M., Staffing Coordinator M said she should had washed her hands and changed her gloves before she grabbed the clean brief and pulled his covers over Resident #59. She said improper hand hygiene could cause cross contamination. During an interview on 12/11/24 at 10:38 A.M., Restorative Aide K said after incontinent, or peri care the aide should most definitely wash their hands apply clean gloves before a clean brief and resident covers were placed on a resident. She said staff could transfer bacteria on the sheets and to the resident. During an interview on 12/11/24 at 1:48 P.M., the DON said she expected the staff to wash their hands and change gloves after incontinent care or peri care was performed. She said after staff had washed their hands and apply clean gloves, then a clean brief and replaced resident covers for the resident should have been done. She said improper hand hygiene can cause cross contamination. During an interview on 12/12/24 at 2:07 P.M., the ADM said she expected staff to perform proper hand hygiene during incontinent or peri care with residents. She said some of the risks with improper hand hygiene are infections and it could affect the resident's quality of life. Record review of the facility Infection Control Policy, undated indicated all employees are required to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Record review of the facility policy Perineal Care revised 10/2010 indicated remove gloves and discard into designed container. Wash and dry your hands thoroughly. Reposition the bed covers. Make resident comfortable. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy Handwashing/ Hand Hygiene revised 08/2015 indicated all personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread on infections to other personnel, residents, and visitors.