STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675970	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memphis Convalescent Center	1415 N 18th St Memphis, TX 79245

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 48491 Based on interview and record review the facility failed to ensure the assessment accurately reflected the resident's status for 3 (Resident #4, Resident #11, and Resident #22) of 12 residents reviewed for accuracy of assessments. 1. On Resident #4's MDS the facility inaccurately coded Resident #4 as receiving anticoagulant medication. 2. On Resident #11's MDS the facility inaccurately coded Resident #11 as receiving anticoagulant medication. 3. On Resident #22's MDS the facility inaccurately coded Resident #22 as receiving anticoagulant medication. These failures could place residents at risk of being inaccurately assessed and therefore not receiving necessary care. Findings Included: 1. Record review of Resident #4's admission record dated 08/05/24 revealed a [AGE] year-old female originally admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning), chronic atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and high blood pressure. Record review of Resident #4's quarterly MDS revealed a completion date of 06/13/24. Section C revealed a BIMS of 8 which indicated moderately impaired cognition. Section N question N0415E revealed Resident #4 was receiving anticoagulant medication. Record review of Resident #4's care plan completed on 06/13/24 revealed Resident #4 was on anticoagulant therapy. Record review of Resident #4's active order summary report dated 08/05/24 revealed no order for anticoagulant medication. The report did reveal the following order: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Aspirin Tablet Chewable 81 MG Give 1 tablet by mouth at bedtime related to CHRONIC ATRIAL FIBRILLATION . Record review of Resident #4's completed, struck out, discontinued orders since her admitted revealed no order for anticoagulant medication. 2. Record review of Resident #11's admission record dated 08/05/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it, stroke), high blood pressure, and dementia (a group of thinking and social symptoms that interferes with daily functioning). Record review of Resident #11's quarterly MDS revealed a completion date of 05/21/24. Section C revealed a BIMS of 14 which indicated intact cognition. Section N question N0415E revealed Resident #11 was receiving anticoagulant medication. Record review of Resident #11's care plan completed on 05/22/24 revealed Resident #11 was on anticoagulant therapy. Record review of Resident #11's active order summary report dated 08/05/24 revealed no order for anticoagulant medication. The report did reveal the following order: Aspirin Tablet 81 MG Give 1 tablet by mouth one time a day related to OTHER SEQUELAE OF OTHER CEREBROVASCULAR DISEASE . Record review of Resident #11's completed, struck out, discontinued orders since her admitted revealed no order for anticoagulant medication. 3. Record review of Resident #22's admission record dated 08/04/24 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, high blood pressure, peripheral vascular disease (blood circulation disorder), and colon cancer. Record review of Resident #22's Admission MDS revealed a completion date of 05/14/24. Section C revealed a BIMS of 15 which indicated intact cognition. Section N question N0415E revealed Resident #22 was receiving anticoagulant medication. Record review of Resident #22's care plan completed on 05/21/24 revealed Resident #22 was on anticoagulant therapy. Record review of Resident #22's active order summary report dated 08/04/24 revealed no order for anticoagulant medication. The report did reveal the following order: Aspirin 81 Oral Tablet Delayed Release (Aspirin) Give 81 mg by mouth one time a day related to PERIPHERAL VASCULAR DISEASE . Record review of Resident #22's completed, struck out, discontinued orders since her admitted revealed no order for anticoagulant medication. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/06/24 at 09:13 AM ADM stated MDS LVN was responsible for completing MDS assessments on residents of the facility. She said MDS assessments affected facility funding as well as direct resident care plans. ADM stated having an inaccurate MDS could therefore negatively impact the care a resident received. During an interview on 08/06/24 at 09:15 AM MDS LVN stated she was responsible for completing MDS assessments. She stated she used the RAI as her policy when completing MDS assessments. When asked if aspirin should be coded as an anticoagulant in section N of the MDS she said it should. She stated, I was not coding aspirin as anticoagulant, and someone told me I needed to be doing that. MDS LVN could not remember who told her to code aspirin as anticoagulant. When she was shown a passage in the RAI which indicated aspirin was not to be coded as anticoagulant, she said, Hmmm. Okay, I guess they were wrong. Good to know! MDS LVN could not think of a negative outcome for residents if aspirin was inaccurately coded as an anticoagulant. During an interview on 08/06/24 at 09:24 AM DON stated having an inaccurate MDS could negatively impact resident care because the care plan was based on the MDS. Record review of the Long-Term Care Facility RAI 3.0 User's Manual Version 1.18.11 dated October 2023 revealed the following: . N041 5: High-Risk Drug Classes: Use and Indication . N041 5E1. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Coding Tips and Special Populations . Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as NO41 5E, Anticoagulant.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 48491 Based on observation, interview, and record review, the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of for 4 of 5 anonymous residents observed for 3 (August 4, 5, and 6 of 2024) of 3 days and reviewed for quality of life. The facility failed to ensure activities provided, met residents' needs or desires. The facility failed to ensure activities were being provided on the weekends. These failures could place residents at risk of boredom and a decline in their quality of life. Findings included: Record review of facility's activities calendar for August 2024 revealed chronicle/devotions scheduled at 10 AM every morning of the month. In addition to this activity, each Saturday and Sunday of the month had table game of choice scheduled for 10:15 AM. Saturdays had bingo scheduled for 2 PM and Sunday's had dominoes scheduled for 2 PM. Observation on 08/04/24 at 10:00 AM, while walking into the dining room, observed scheduled activity of chronicle/devotions not going on. During an observation and interview on 08/04/24 at 10:43 AM, an anonymous resident's room did not have an activity calendar in it. She stated residents did not get activity calendars for their rooms each month, but that there was an activity calendar for the whole facility outside the dining room on the wall. Observation on 08/04/24 at 12:45 PM of activity calendar for the month of August 2024 on wall outside of the dining room revealed the same activities repeated each week. Observation on 08/04/24 at 2:30 PM, revealed a scheduled activity of domino's was not happening in the dining room. During an interview on 08/05/24 at 10:39 AM, 4 of 5 anonymous residents stated they do not get activity calendars for their rooms, and if they want to know what was happening for the day, they must go and view the big calendar outside the dining room. Residents stated that they did not have any activities yesterday, which was Sunday August 04, 2024 and that there was no one in the facility to run activities on the weekends. Residents stated that the AD does not spend enough time with residents and that they have suggested to her that they want new games, but nothing had happened. One resident stated that on Friday, August 2nd, she came to the dining room to do creative crafting which was the 2:00 pm activity on the calendar that day, and she sat in the dining room until 2:30 pm, and when no one came, resident went back to her room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 08/04/24 at 2:57 PM of Facility Grievance Log for 2024 revealed that there were several complaints in the month of June regarding activities. Residents indicated that activities were boring, repetitive, AD was sometimes not present, and scheduled activities did not happen or were cancelled at the last minute. Record review on 08/04/24 at 3:00 PM of resident council minutes for month of July revealed under activities section: no activities offered on the weekends. During an interview on 08/05/24 at 1:08 PM, AD stated that she had worked in the facility since February 2024 and just received her certification for AD. She stated that she tried to do all the activities that are on the calendar each month and that she was aware of residents who had complained about wanting different games and more outings and she was just in the process of looking on the internet for new games to try. AD stated that there was only one time that an activity was cancelled, and it was a birthday party due to a death of a resident's family member. AD was unable to recall any other times when an activity was cancelled or not done. She stated a possible negative outcome for not having new games that were stimulating for residents could be depression and memory loss. AD stated a possible negative outcome for not conducting activities that were scheduled could be boredom and depression. During an interview on 08/05/24 at 1:29 PM, MDS LVN stated she worked weekends and that sometimes she would read the chronicle to the residents. She stated that was their daily newsletter and it was an activity that was on the calendar at 10:00 AM daily. She stated that if she did not have time to read to them, she would pass them out to residents. MDS LVN stated that there was no AD on the weekends, and it was up to nursing staff to set up games or give out activity pages to residents when they had time. During an interview on 08/05/24 at 1:50 PM, AD stated that she did not work on the weekends, and she did not know who ran the activities for her on the weekends, whoever was there she guessed. AD confirmed that dominoes were on the activity calendar every Sunday at 2:00 PM but stated she was not sure who ran that game. During an interview on 08/05/24 at 2:07 PM, ADM stated that as far as she was aware, all activities were happening on the weekends. She stated that the AD was in charge of weekend activities or the nurses. During an interview on 08/05/24 at 2:22 PM, ADM stated that the AD had been put on PIP because she left early on Friday, August 2, 2024 and did not tell anyone about it and did not do the activity that was scheduled at 2:00 PM that day. During an interview on 08/06/24 at 11:09 AM, AD stated that last Friday she had to leave early for a doctor's appointment, and she told the ADM. She stated that she did not know a resident complained about not having the 2:00 PM activity because everyone knew about her leaving. Record review of facility policy titled Resident Rights dated 11/28/16 revealed the following in part: Self-determination-The resident has the right to, and the facility must promote ad facilitate resident self-determination through support of resident choice. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers or health care services consistent with his or her interests, assessments plan of care and other applicable provision of this part. 2. The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. Grievances - The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. The resident has the right to, and the facility must make prompt efforts by the facility to resolve grievances the resident may have. Record review of facility policy titled Activity Programming dated 2011 revealed the following in part: The Activity Director and staff will provide for ongoing Activity programs. .2. Resident's or family's expressed needs and interests are included in the development of programs . .3. Activity programs are to be designed based on resident's leisure interests and implemented to meet the needs (physical, cognitive, creative, social, spiritual, independent, and sensory) of the residents . .7. Programs may take place in mornings, afternoons and/or evenings that span throughout the entire week.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48491 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with the professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure freezer items were properly stored, labeled, and dated. 2. The facility failed to ensure dented cans were not in circulation. 3. The facility failed to ensure pantry foods were properly stored, labeled, and dated. 4. The facility failed to ensure refrigerated foods were properly stored, labeled, and dated. 5. The facility failed to ensure expired foods were disposed of timely. These failures could place residents who ate food served by the kitchen at risk of food-borne illness. Findings include: Observation of the freezer on [DATE] @ 9:32 AM revealed the following: 1. (1) bag of what appeared to be chicken breasts, no label or received/use by date. 2. (1) frozen ham, no date or label. Observation of the refrigerator on [DATE] at 9:40 AM revealed the following: 1. (1) box of what appeared to be whole cucumbers, no label or date. 2. (1) whole cantaloupe, no label or date. 3. (1) ,d+[DATE] cantaloupe, covered in plastic wrap, no label or date. 4. (3) 5-pound tubs of sour cream, no received by or open date. 5. (1) box of what appeared to be bread loaves, open to air, no label or date. 6. (1) box of cream cheese, no received on/use by date. 7. (1) bell pepper in a sack, no label or date. 8. (1) sack full of limes, no label or date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. (1) pitcher of red liquid, half full, no label or date. Observation of walk-in pantry on [DATE] at 9:50 AM revealed the following: 1. (8) bottles of lemon juice, all unopened with expiration dates of [DATE]. 2. (1) box of crunchy taco shells, unopened with expiration date of [DATE]. 3. (11) packages of mini marshmallows, unopened with expiration dates of [DATE]. 4. (1) opened package of mini marshmallows, opened and in a zip top bag with no date or label, with expiration date of [DATE]. 5. (6) packages of brown gravy mix with expiration dates of [DATE]. 6. (1) can of tropical fruit salad, dented, with cans that were in circulation. In an interview on [DATE] at 12:05 PM, [NAME] B stated that whoever unpacked boxes was responsible for labeling and dating the food with the date it was received into the kitchen. She stated that everyone was responsible for putting labels/dates on food and throwing away expired food. In an interview on [DATE] at 3:30 PM, [NAME] A stated a possible negative outcome for giving bad or expired food to residents was they would not know that the food was spoiled. She stated that it was not good to give expired canned food to anyone, because residents could get sick. In an interview on [DATE] at 3:31 PM, [NAME] C stated that it was everyone's responsibility to check that food was labeled and dated properly. He stated that a possible negative outcome of food not being labeled and dated was not knowing when food was cooked or when it expired. In an interview on [DATE] at 7:38 AM, DM stated that everyone was responsible for making sure that food was labeled and dated, and that expired food was to be thrown out. She stated a possible negative outcome for not labeling, dating, and throwing away expired food would be that they could serve contaminated food to residents which could make them sick. She stated that dating and labeling was important so they would know when food was expired. Record Review of facility policy dated 2012 titled Storage Refrigerators revealed in part: .5. Food must be covered when stored, with a date label identifying what is in the container . Record Review of facility policy dated 2012 titled Food Safety, revealed in part: .2. Food is to be wrapped or sealed and covered in clean containers. Opened food shall be labeled, dated, and stored properly . .7. Dented or otherwise damaged cans will not be used. Dented cans will be stored in a separate location and returned to the food vendor for credit. Record review of U.S. Food and Drug Administration's Food Code version [DATE] revealed in part: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	. Food . shall be labeled as specified . Label information shall include: (1) The common name of the FOOD .