STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676002	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Plaza at Edgemere	8502 Edgemere Dallas, TX 75225

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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** 47743 Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for one (Resident #29) of 5 residents reviewed for dignity. The facility failed to treat Resident #29 with dignity and promote enhancement of his quality of life when the resident's catheter bag was not placed away from the door as care planned. This failure placed residents at risk of not having their right to a dignified existence maintained. Findings included: Review of Resident #29's Face Sheet, dated 10/03/2024, reflected resident was a [AGE] year-old male admitted on [DATE]. Resident #29 was diagnosed with complete at T2 - T6 (second to sixth thoracic vertebrae) level of thoracic spinal cord (bundle of nerve fibers), paraplegia (paralysis of the lower part of the body), and neurogenic dysfunction of bladder (the normal bladder function is disrupted due to nerve damage). Review of Resident #29's Quarterly MDS Assessment, dated 09/02/2024, reflected Resident #29 was cognitively intact with a BIMS score of 13. The Quarterly MDS Assessment indicated that the resident had an indwelling catheter. Review of Resident #29's Comprehensive Care Plan, dated 08/29/2024, reflected Resident #29 had a suprapubic catheter and one of the interventions was to put the catheter away from the door. Review of Resident #29's Physician Order, dated 08/30/2024, reflected CATHETER: Suprapubic Size: 12 fr (French: unit used to indicate the size of the catheter) Balloon Size: 10 ml Diagnosis: neurogenic bladder. (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	Observation and interview with Resident #29 on 10/01/2024 at 11:16 AM revealed the resident was in his bed, awake. Resident #29 had a catheter bag hanging at the railings below the bed. The catheter bag and its contents were visible upon entrance to the room. The catheter bag did not have a privacy bag. Resident #29 stated he had the catheter for the longest time because he had a severed spinal cord. He said he was paralyzed and unable to move from his waist down. In an interview with LVN D on 10/01/2024 at 11:41 AM, LVN D stated there should be a privacy bag for the urine drainage bag so that it will not be visible to other residents or visitors. She said without the privacy bag, the resident might be embarrassed. She said she did not notice the urine drainage bag was exposed during her rounds. She said the facility had a lot of privacy bags and she would get one to put Resident #29's catheter bag inside. In an interview with the ADON on 10/02/2024 at 2:45 PM, the ADON stated for a resident with a catheter, there should be a privacy bag to maintain dignity. He added without the privacy bag, other residents or the resident's visitors could see the catheter bag and its contents. He said the expectation was for the staff to put a catheter bag inside a privacy bag. He said they would do an in-service about putting a catheter bag inside a privacy bag. In an interview with the DON on 10/02/2024 at 3:08 PM, the DON stated the catheter bag should have been placed inside a privacy bag to avoid embarrassment and humiliation. The DON said the expectation was for the catheter bag to have a privacy bag when the resident was on the bed or in the wheelchair. She said she would do an in-service about putting the catheter bag inside the privacy bag. In an interview with the Administrator on 10/03/2024 at 8:06 AM, the Administrator stated his expectation was the catheter bag was covered. He said he would coordinate with the DON on how to go forward about the issue. Observation on 10/03/2024 at 11:12 AM revealed Resident #29 was in his bed, awake. The resident's catheter bag was hanged away from the door and was placed inside a privacy bag. Review of facility policy, Resident Rights revealed Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality . Compliance Guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity . 2. During interactions with residents, staff must report, document and act upon information regarding resident preferences.

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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 - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure that assessments accurately reflected the resident's status for one (Resident #32) of eight residents reviewed for Accuracy of Assessments. The facility failed to ensure Resident #32's Comprehensive MDS Assessment accurately reflected that Resident #32 was using a CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open). This failure could place residents at risk for not receiving care and services to meet their needs, for diminished function of health, and for regressions in their overall health. Findings included: Review of Resident #32's Face Sheet, dated 10/03/2024, reflected the resident was an [AGE] year-old male admitted on [DATE]. Resident #32 was diagnosed with acute and chronic respiratory failure with hypoxia (insufficient amount of oxygen in the body). Review of Resident #32's Comprehensive MDS Assessment, dated 08/30/2024, reflected Resident #32 had severe impairment in cognition with a BIMS score of 07. Resident #32's Quarterly MDS Assessment did not indicate that the resident was using a CPAP. Review of Resident #32's Comprehensive Care Plan on 08/08/2024 reflected the resident had COPD and used a CPAP at night and one of the interventions was to use CPAP as ordered. Review of Resident #32's Physician Order, dated 08/07/2024, reflected BIPAP (bilevel positive airway pressure - normalizes breathing by delivering pressurized air into the upper airway leading into the lungs)/CPAP 16CM02 (centimeters of water pressure setting) at bedtime AND in the morning. Observation and interview with Resident #32 on 10/01/2024 at 9:11 AM revealed Resident #32 was in his bed, awake. It was observed that a CPAP machine was on top of the resident's right side table and a CPAP mask was attached to the CPAP machine. Resident #32 stated he would sometimes use his CPAP. Observation and interview with LVN D on 10/01/2024 at 11:08 AM revealed LVN D went inside Resident #32's room to attend to the resident. LVN D stated Resident #32 had an order for CPAP and could use it at night or in daytime. Observation and interview with the MDS Nurse on 10/02/2024 at 11:47 AM, the MDS Nurse stated she was responsible for doing the MDS Assessment. She said if a resident was using a CPAP, it should be reflected on the resident's MDS. The MDS Nurse logged on to her computer, checked the resident's profile, and confirmed that Resident #32 was had a physician's order for CPAP and it was not triggered on his MDS assessment. She said the medical diagnosis, physician order, the MDS, and the care plan should be all in sync to provide a clear overview of the resident's current condition. She said it was an oversight on her part and she would make an audit to make sure the MDS would reflect the current condition of the residents. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the ADON on 10/02/2024 at 2:45 PM, the ADON stated if a resident was using a CPAP, it should be reflected on the system to make sure the effectiveness of the resident's use of the CPAP. He added there should be an accurate assessment to know how to care for the residents. The ADON said if there was no accurate assessment, there could be a misunderstanding about the care needed by the resident and the resident might not be able to get the treatment needed. In an interview with the DON on 10/02/2024 at 3:08 PM, the DON stated an accurate assessment was important so that the staff would know how to take care of the residents. She said the care plan of the residents would be based on the assessment of the resident. She said if a resident was using a CPAP, it should be reflected on the medical diagnosis, physician orders, the MDS, and the care plan. She said if the residents were not properly assessed, the proper care and needs would not be met. The DON said the expectation was that the residents were properly assessed not only during admission but every day to see if there were changes in condition or a resident acting different than usual. She said she would collaborate with the MDS Nurse to audit the MDS Assessments and make the appropriate changes. In an interview with the Administrator on 10/03/2024 at 8:06 AM, the Administrator stated the current condition of the resident should be reflected in the system to address the current needs of the resident. He said she would coordinate with the DON to evaluate the situation. Record review of facility policy, Conducting an Accurate Resident Assessment revealed Policy: The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment . qualified health professionals correctly document the resident's medical . problems.

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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** 47743 Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth 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 a resident for one (Resident #19) of seven residents reviewed for Care Plans. The facility failed to ensure Resident #19 was care planned for Hospice Care. This failure could place the residents at risk of not receiving the necessary care and services. Findings included: Review of Resident #19's Face Sheet, dated 10/03/2024, reflected the resident was an [AGE] year-old female admitted on [DATE]. Resident #19 was diagnosed with dementia. Review of Resident #19's Quarterly MDS Assessment, dated 07/18/2024, reflected Resident #19 had severe impairment in cognition with a BIMS score of 00. Resident #19's Quarterly MDS Assessment indicated the resident was receiving hospice care while a resident of the facility. Review of Resident #19's Comprehensive Care Plan on 09/04/2024 reflected no care plan for hospice. Review of Resident #19's Physician Order, dated 01/08/2024, reflected Hospice to Evaluate and treat and admit as appropriate. Review of Resident #19's Progress Note, dated 01/12/2024, reflected Resident #19 was admitted to Hospice on 1/12/24. Review of Resident #19's Progress Note, dated 08/09/2024, reflected the resident was refusing to be weighed and hospice was made aware. Observation and interview with HN on 10/01/2024 at 9:46 AM revealed HN just finished assessing Resident #19. She said the resident was on hospice since early this year for failure to thrive. Said the resident was refusing care and medications. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with the MDS Nurse on 10/02/2024 at 11:47 AM, the MDS Nurse stated she was responsible for doing the care plan. The MDS Nurse said care plans were important to ensure the residents were getting the care needed. She said care plans served as guides on how the staff would take care of the residents. The MDS Nurse added that without the care plans, the staff might overlook the interventions needed by the residents. She said if a resident was receiving hospice care, there should be a care plan for it. The MDS Nurse said she knew Resident #19 was on hospice. The MDS Nurse logged on to her computer, checked the resident's profile, and confirmed that Resident #19 did not have a care plan for hospice. After confirming the resident did not have a care plan, the MDS Nurse started making a care plan for hospice care. She said it was an oversight on her part and she would make an audit of the residents' care plans. In an interview with the ADON on 10/02/2024 at 2:45 PM, the ADON stated if a resident was in hospice, there should be a care plan for hospice care. the ADON said Resident #19 was admitted to hospice. The ADON said it was important that residents have a care plan to fully provide the care and services the residents needed. He said without the care plan, the staff would not be in sync on the care of the residents and their needs would not be addressed. He said the expectation was all the issue of the residents were care planned. In an interview with the DON on 10/02/2024 at 3:08 PM, the DON stated every resident needed a comprehensive care plan to make sure the residents received the appropriate care needed. The DON said the care plan should be in place so that the staff providing care would be on the same page. The DON stated the care plan was important because it reflected the resident's problem lists, goals, and intervention. She said the care plan should be resident-centered and should show what specific care the resident needed. She said she knew Resident #19 was receiving hospice care but was not sure why she did not have a care plan for hospice care. She said the expectation was for all residents to have a complete and detailed care plan. She said she would coordinate with the MDS Nurse to audit the care plans of the resident. In an interview with the Administrator on 10/03/2024 at 8:06 AM, the Administrator stated all the residents should have a care plan appropriate to their needs. He said without the care plan, the staff would not know the goals and the interventions needed by the residents. The Administrator concluded that the expectation was for the staff to ensure that the residents were care planned accordingly. He said he would coordinate with the DON to make sure all the residents were care planned. Record review of facility's policy, Care Plans - Comprehensive Nursing Services Policy and Procedure Manual for Long-Term Care, 2001 MED-PASS, Inc. (Revised September 2010) revealed Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for three (Resident #6, Resident #15, and Resident #32) of eight residents reviewed for Respiratory Care. 1. The facility failed to ensure that Resident #6's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) was properly stored. 2. The facility failed to ensure that Resident #15's CPAP mask (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open) was stored properly. 3. The facility failed to ensure that Resident #32's CPAP mask was stored properly. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Review of Resident #6's Face Sheet, dated 10/03/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #6 was diagnosed with hypoxemia (low blood oxygen) and anemia (a problem of not having enough healthy red blood cells to carry oxygen to the body's tissue). Review of Resident #6's Quarterly MDS Assessment, dated 07/29/2024, reflected that Resident #6 had moderate impairment in cognition with a BIMS score of 9. Resident #6's Quarterly MDS Assessment indicated the resident was on oxygen therapy while a resident of the facility. Review of Resident #6's Comprehensive Care Plan, dated 07/22/2024, reflected that the resident has oxygen therapy r/t Ineffective gas exchange and one of the interventions was OXYGEN SETTINGS: O2 @ 2-4 L/min via NC. Review of Resident #6's Physician Order, dated 08/19/2024, reflected 02 @ 2-4L/min via NC. every shift for SOB. Observation on 10/01/2024 at 9:38 AM revealed Resident #6 was in her bed, sleeping. It was observed that the resident was on oxygen therapy via nasal cannula at 3 liters per minute. It was observed that she had a portable oxygen tank beside her dresser with a nasal cannula attached to it. The nasal cannula was hanging on top of the oxygen tank and was not bagged. 2. Review of Resident #15's Face Sheet, dated 10/03/2024, reflected the resident was an [AGE] year-old female admitted on [DATE]. Resident #15 was diagnosed with acute and chronic respiratory failure with hypercapnia (too much carbon dioxide in the blood). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #15's Comprehensive MDS Assessment, dated 08/30/2024, reflected Resident #15 was cognitively intact with a BIMS score of 14. Resident #15's Comprehensive MDS Assessment indicated the resident was using a CPAP. Review of Resident #15's Comprehensive Care Plan, dated 8/15/2024, reflected the resident has oxygen therapy and CPAP AT QHS r/t COPD (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and one of the interventions was CPAP as ordered. Observation and interview on 10/01/2024 at 9:09 AM revealed Resident #15 was in her wheelchair, awake. It was observed that a CPAP mask was inside the drawer on the resident's right-side table. The CPAP mask was not bagged. Resident #15 said she went for a surgery and was not able to use her CPAP. She said she was not sure who put the CPAP in her drawer. Observation and interview with LVN C on 10/01/2024 at 12:09 PM. LVN C stated the nasal cannula and the CPAP mask should be bagged when not in use. He said he was not sure how long Resident #6's nasal cannula was hanging on the portable oxygen tank. He said he would disconnect the nasal cannula and discard it. He said he would also put Resident #15's CPAP mask in a bag. He said the nasal cannula and the CPAP mask should be bagged to prevent cross contamination and possible respiratory infections. 3. Review of Resident #32's Face Sheet, dated 10/03/2024, reflected the resident was an [AGE] year-old male admitted on [DATE]. Resident #32 was diagnosed with acute and chronic respiratory failure with hypoxia (insufficient amount of oxygen in the body. Review of Resident #32's Comprehensive MDS Assessment, dated 08/30/2024, reflected Resident #32 had severe impairment in cognition with a BIMS score of 07. Resident #32's Quarterly MDS Assessment did not indicate that the resident was using a CPAP. Review of Resident #32's Comprehensive Care Plan on 08/08/2024 reflected the resident had COPD (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and used a CPAP at night and one of the interventions was to use CPAP as ordered. Review of Resident #32's Physician Order, dated 08/07/2024, reflected BIPAP (bilevel positive airway pressure - normalizes breathing by delivering pressurized air into the upper airway leading into the lungs)/CPAP 16CM02 (centimeters of water pressure setting) at bedtime AND in the morning. Observation and interview with Resident #32 on 10/01/2024 at 10:51 AM revealed Resident #32 was in his bed, awake. Resident #32 had a CPAP machine sitting on top of the resident's left-side table. There was a CPAP mask connected to the machine. The CPAP mask was not bagged. According to Resident #32, he could put it on and take it off but sometimes a staff would put it on and take it off early morning. He said he was not aware if the staff were putting it inside a plastic bag. He said nobody told him to put it in a plastic bag if he was taking it off. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with LVN D on 10/01/2024 at 11:08 AM revealed LVN D went inside Resident #32's room to check on him. After checking on him, she went out of the room and did not notice the resident's CPAP mask was on the table and was not bagged. When asked if the CPAP mask was bagged, LVN D went inside the room and said the CPAP was not bagged. LVN D looked for a plastic bag and found one in the drawer. She put the CPAP mask inside the plastic bag. She said she did not notice the CPAP mask was not bagged. She said Resident #32 used a CPAP and she would sometimes take it off in the morning. She said the CPAP mask should not be exposed nor touching anything because it could cause cross contamination and infection. In an interview with the ADON on 10/02/2024 at 2:45 PM, the ADON stated the nasal cannula and the CPAP masks should be bagged when not in use. He said if the nasal cannula and the CPAP mask were exposed and touching surfaces that were dirty, cross contamination and possible respiratory infections could occur. He said the expectation was for the staff to bag the nasal cannula and the CPAP masks when not in use. She said she would coordinate with the DON pertaining to respiratory care. In an interview with the DON on 10/02/2024 at 3:08 PM, the DON stated the nasal cannula and the CPAP masks should be bagged when not in use to keep them clean. She said if those breathing apparatus were not bagged, were exposed, or touching surfaces that were not clean, there could be cross contamination, respiratory infection, and oxygen administration could be compromised. She said the expectation was for the staff to be mindful in making sure that the nasal cannula and the CPAP mask of the residents were bagged when not in use. The DON said she would conduct an in-service and check-off about the respiratory care. She said she would personally monitor if the staff were bagging the nasal cannula and CPAP mask. In an interview with the Administrator on 10/03/2024 at 8:06 AM, the Administrator stated everything that the residents were using should be kept clean to prevent infection and all the orders would be in the system. He said he was not a clinician but would coordinate with the DON on how to go forward about the issue of respiratory care. Record review of facility's policy, Oxygen Administration 2001 MED-PASS, Inc. (Revised October 2010) revealed Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Policy for respiratory care specific for bagging the nasal cannula and the CPAP mask was requested on 10/03/2024 at 8:51 AM but was not provided during exit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure that one (Resident #148) of five residents were provided medications and/or biologicals and pharmaceutical services to meet their needs. The facility failed to ensure LVN C did not leave Resident #148's medications inside the resident's room. This failure could place the residents at risk of not receiving medications as ordered by the physician. Findings included: Review of Resident #148's Face Sheet, dated 10/03/2024, reflected the resident was an [AGE] year-old male admitted on [DATE]. Relevant diagnoses included encephalopathy (a disease that affects the brain), depression, and cognitive communication deficit. Review of Resident #148's Quarterly MDS Assessment, dated 07/08/2024, reflected resident had moderate impairment in cognition with a BIMS score of 11. The Quarterly MDS Assessment also indicated Resident #148 had debility (weakness) and cardiorespiratory (relating to the heart and the lungs) conditions. Review of Resident #148's Comprehensive Care Plan, dated 09/09/2024, reflected the resident had impaired cognitive function or impaired thought process. Resident #148's Comprehensive Care Plan did not indicate that the resident could self-administer his medications. Review of Resident #148's Assessment for self-medication on 10/03/2024 reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment that the resident was competent to manage their own medications. Review of Resident #148's Physician Order for folic acid, dated 01/06/2024, reflected Folic Acid Tablet 1 MG. Give 1 tablet by mouth one time a day for supplement. Review of Resident #148's Physician Order for gabapentin, dated 01/06/2024, reflected Gabapentin Capsule 100 MG. Give 1 capsule by mouth three times a day for Neuropathy (dysfunction of the nerve). Review of Resident #148's Physician Order for loperamide, dated 03/22/2024, reflected Loperamide HCl Capsule 2 MG. Give 2 capsule by mouth three times a day for Loose stool Hold for no stool in 24 hours. Review of Resident #148's Physician Order for multivitamins, dated 01/08/2024, reflected Multiple Vitamin Tablet. Give 1 tablet by mouth one time a day for supplementation. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #148's Physician Order for multivitamins, dated 01/06/2024, reflected Potassium Chloride ER Tablet Extended Release 10 MEQ. Give 1 tablet by mouth one time a day for Hypokalemia (low level of potassium in the blood). Review of Resident #148's Physician Order for sertraline, dated 01/06/2024, reflected Sertraline HCl Tablet 100 MG. Give 1 tablet by mouth one time a day for depression. Review of Resident #148's Physician Order for thiamine, dated 01/06/2024, reflected Thiamine HCl Oral Tablet 100 MG (Thiamine HCl). Give 1 tablet by mouth one time a day for Supplement. Review of Resident #148's Physician Order for thiamine, dated 09/13/2024, reflected Vitamin D (Ergocalciferol) Capsule 50000 UNIT. Give 1 capsule by mouth one time a day every Tue, Fri for low vit d. Observation and interview with Resident #148 on 10/01/2024 at 9:11 AM revealed the resident was in his bed, awake. It was observed that the resident was eating breakfast using his overbed table. A small plastic cup with nine pills inside was noted on top of the overbed table. According to Resident #148, his nurse left it with him and he would take them after he was finished with his breakfast. The resident said it was not the first time that his medications were left with him. He said all he could remember was his morning pills included his vitamins and his pain pill. In an interview with Resident #148 on 10/01/2024 at 9:55 AM, resident #148 stated he already took his medications. In an interview with LVN C on 10/01/2024 at 10:12 AM, LVN C stated he left Resident #148's morning pills with him because somebody called him. He said he should have returned to the room and checked on the resident. He said he should have stayed with the resident until the resident had taken the medications. He said the pills should not be left with the resident because the resident might not take them, throw them, or choke while taking them and no one would know. He said he would check if the resident took the medications. In an interview with the ADON on 10/02/2024 at 2:45 PM, the ADON stated medications were not left with the residents. He said the staff administering the medications should stay with the resident until the resident was done taking the medications. He said the resident might not take them or someone else might, like another resident or a visitor. He said the resident might aspirate while taking the medications and nobody was with him. He said he would coordinate with the DON to do an in-service about not leaving the medications with the residents. In an interview with the DON on 10/02/2024 at 3:08 PM, the DON stated staff should never leave the medications at the bedside for the resident to take later. She said the staff must ensure the resident took his medications before leaving the room. She said so much could go wrong. She said the resident could hoard or hide the pills to avoid taking them. She said the residents could overdose on hoarded pills. The DON said she would do an in-service pertaining to not leaving the medications with a resident. (continued on next page)

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	676002	A. Building B. Wing	10/03/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 10/03/2024 at 8:06 AM, the Administrator stated staff should not leave medications unattended because of the risk of the resident not taking them or the pills not taken on time. He said he would coordinate with the clinicians on how to go forward to prevent untoward outcomes of leaving the medications with a resident. Record review of facility policy, Administering Medications Nursing Services Policy and Procedure Manual for Long-Term Care (C) 2001 MED-PASS, Inc. (Revised December 2012) revealed Policy Interpretation and Implementation . 16. During administration of medications . the medication cart . be kept in the doorway of the resident's room . 17. For residents . unavailable to receive medication on the pass, the MAR may be flagged. After completing the medication pass, the nurse will return to the missed resident to administer the medication . 24. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.

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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** 49459 Based on observation, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for 2 kitchens reviewed for food storage, labeling, dating, and kitchen sanitation. 1. The facility failed to ensure foods in the refrigerator and freezer, were properly sealed from air-borne contaminations. 2. The facility failed to clean the food storage bins in the dry food storage area in the main kitchen. The facility failed to clean the Ice Machine on both the 3rd floor (Main Kitchen) and 2nd floor (Secondary Kitchen). These failures could place residents at risk for cross contamination and air-borne illnesses. Findings included: Observations on [DATE] from 8:39 AM to 9:00 AM in the facility's main kitchen reflected: The food storage bins in the dry food storage area, were noted to have stains to the top of the container lid. Observations on [DATE] from 12:27 PM to 12:33 PM in the facility's secondary kitchen area located on the second floor reflected: Ice machine upper inside surface contained brownish sticky substance on approximately ,d+[DATE] of the surface. On [DATE], at 8:39 AM observations in the main kitchen refrigerator include the following: One large tray containing assorted sandwich and hamburger buns not properly sealed exposed to air contaminants. One large bin containing assorted breads was not properly sealed and exposed to air contaminants, not dated and no visible expiration date was observed. The findings in the main kitchen freezer included the following: One large bin containing celery not properly sealed and exposed to air contaminants. One partial roll of hamburger meat undated not properly sealed and exposed to air contaminants. One medium size bin containing tomato sauce not properly sealed and exposed to air contaminants. One medium size bin containing sauce not properly sealed and exposed to air contaminants. One large piece of cake on a tray not properly sealed and exposed to air contaminants. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	One large bag of grapes not properly sealed and exposed to air contaminants. Observation on [DATE] at approximately 8:45 AM the main Ice Machine on 3rd floor was noted to have, the lid and interior portion had 10 brownish and blackish thick sticky stains on the top portion of the ice bins. Observation on [DATE] at 9:00 AM of the secondary ice Machine located on the 2nd floor, the ice scooper holder had a brownish substance at the bottom of the container. Record review of the Ice Machine Cleaning Log on ,d+[DATE] showed the log to have been maintained and reflected it being serviced for January - [DATE]. September had (Out of Order) marked through it on [DATE], but did not reflect any further cleaning being done for [DATE]. In an interview with Dietary Manager on [DATE] at 11:55 AM, she advised has been the DM at this facility for 2 years and a total of [AGE] years in the food service industry. The DM advised of the concerns observed in the kitchen area. She was shown images of all the concerns observed in the kitchen. She stated she was the person overall responsible for ensuring the kitchen was meeting guidelines for food storage and kitchen sanitization. She stated the Ice Machines are supposed to be cleaned monthly. The chef is responsible to check it once a month. It also is the supervisor of the day of that shift. The supervisor checks the cleaning log. The DM advised labeling and dating are done by the person who gets it in from the delivery it is their responsibility to label it and place it properly She said a full in-service was done regarding proper labeling and cleaning logs, of kitchen items. In an interview on [DATE] at 12:30 PM, the Administrator was advised there were concerns observed in the kitchen. He was made aware of these concerns and has spoken with the DM. He advised that the issues could cause food contamination and this matter would be resolved. If items are expired you don't want to serve, it to residents. The ADMIN said the risk of all these concerns observed in the kitchen could result in residents getting. exposed to contaminated foods resulting in food borne illnesses. Review of All food handling and safety must comply with the Texas Food Establishment Rules (TFER) and the CMS and Texas Health and Human Services Commission (HHSC)of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S ,d+[DATE].18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts ,d+[DATE] - , d+[DATE].

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 49459 Based on interview and record review, the facility failed to electronically submit to CMS complete and accurate direct care staffing information, including information, for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specification established by CMS for 1 of 4 FY quarters (FY Quarter 3 for 2024 (April 1-June 30) reviewed for administration. The facility failed to submit staffing data to CMS for (April 1- June 30). The facility's failure could place residents at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feelings of well-being within their living environment. Findings included: Record review of the CMS PBJ Staffing Data Report, CASPER Report 1705D FY Quarter 3 2024 (April 1 - June 30), dated 09/24/2024, revealed the following entry: Failed to Submit Data for the Quarter .Triggered . Triggered=No Data Submitted for the Quarter. In an interview on 10/03/24 at 12:55 PM, ADMIN said that he was responsible for uploading the PBJ he said he was responsible for submitting the PBJ data. When he was advised the CMS reported the information was not submitted timely. He said the PBJ submission was usually reported after it was completed. He said he was aware of the reporting regulation. When asked about his understanding of the importance of reporting PBJ data, he said the purpose was to ensure the facility was accurately staffed to care for the residents. He said the facility has been fully staffed at this time, and during the time it states it not being submitted. When asked what the potential negative outcome was for not submitting the PBJ data, he said failure to report would be that it would not reflect the accuracy of staffing in connection to the census. He stated staffing was important because the staff ensures residents' needs were met. In a follow up interview with ADMIN, 10/14/2024, he advised I did all the legwork for our reporting and failed to hit send on the document to CMS. He said I would not have known had you not mentioned this, we did not receive any notices or warnings and was totally convinced I had submitted it early. He said that he thought it was done. He said after he discovered it was not completed, he submitted the PBJ data to CMS. Record review of the CMS, Electronic Staffing Data Submission Payroll-Based Journal, Long-Term Care Facility Policy Manual, Version 2.6, June 2022, section 1.2 Submission Timeliness and Accuracy, reflected Direct care staffing and census data will be collected quarterly, and is required to be timely and accurate. Further review revealed Report Quarter 3 date range as April 1- June 30 Policy manual reflected, Deadline: Submissions must be received by the end of the 45th calendar day (11:59 PM Eastern Time) after the last day in each fiscal quarter in order to be considered timely.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Resident #18 and Resident #198) of eight residents observed for Infection Control. 1. The facility failed to ensure that CNA A changed her gloves and performed hand hygiene while providing incontinent care to Resident #18. 2. The facility failed to ensure that CNA B and the MDS Nurse changed their gloves and performed hand hygiene while providing incontinent care to Resident #198. These failures could place the residents at risk of cross-contamination and development of infections. Findings included: 1. Review of Resident #18's Face Sheet, dated 10/03/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #18 was diagnosed with abnormalities of gait and mobility. Review of Resident #18's Quarterly MDS Assessment, dated 06/11/2024, reflected that Resident #18 was cognitively intact with a BIMS score of 15. Resident #18's Quarterly MDS Assessment indicated the resident was frequently incontinent for bowel and bladder. Review of Resident #18's Comprehensive Care Plan, dated 09/09/2024, reflected the resident had bowel incontinence and one of the interventions was provide pericare. Observation and interview with CNA A on 10/01/2024 at 1:29 PM revealed CNA A was about to do Resident #18's incontinent care. The resident was already inside the bathroom with a sit-to-stand lift in front of her. CNA A said she was waiting for the resident to finish relieving herself. When the resident said she was finished, CNA A sanitized her hands and put on a pair of gloves. CNA A took a brief, opened it, and hanged it on the railing beside the toilet seat. CNA A took a plastic bag, opened it, and put it on the trash can. CNA A did not change her gloves after touching the trash can. CNA A raised the sit-to-stand, pulled some wipes, and cleaned the front part of the resident using a front to back technique. After cleaning the front part of the resident, CNA A pulled some wipes and cleaned the bottom of the resident. After cleaning the bottom of the resident, CNA A took the brief hanging on the railing, slid it between the resident's legs, and fixed it. She did not change her gloves after cleaning the resident's bottom and before touching the new brief. After fixing the brief, CNA A rolled the sit-to-stand and transferred the resident to her wheelchair. CNA A stated hands should be washed or sanitized before and after doing incontinent care. CNA A said gloves should be changed after touching the waste can and after cleaning the bottom of the resident, and before touching the new brief. She said germs from the waste can and soiled brief could transfer to the new brief. She said they had in-services about infection control and hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #198's Face Sheet, dated 10/03/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #198 was diagnosed with chronic kidney disease and muscle weakness. Review of Resident #198's Comprehensive MDS Assessment, dated 09/03/2024, reflected Resident #198 was cognitively intact with a BIMS score of 14. The Quarterly MDS Assessment indicated that the resident was frequently incontinent of bowel. Review of Resident #198's Comprehensive Care Plan, dated 09/13/2024, reflected the resident was incontinent for bladder and one of the interventions was clean peri-area with each incontinent care. Observation on 10/02/2024 at 9:12 AM revealed CNA B and the MDS Nurse were about to do Resident #198's incontinent care. CNA B and the MDS Nurse both washed their hands and put on a pair of gloves. CNA B took a brief and a plastic bag and placed them on the side of the resident's right leg. While CNA B was preparing the brief and the plastic bag, the MDS Nurse unfastened the resident's brief and tucked it between the resident's legs. The MDS Nurse did not change her gloves after touching the soiled brief. CNA B cleaned the front part using the front to back technique. After cleaning the front part of the resident, CNA B and the MDS Nurse assisted the resident to roll to her left side. CNA B pulled the soiled brief, threw it on the plastic bag, and cleaned the resident's bottom. After cleaning the resident's bottom, CNA B took a container of cream, got a handful of cream, and spread it on the resident's bottom. She did not change her gloves before getting some cream and before spreading it on the resident's bottom. After spreading the cream, she removed her gloves, and put on a new pair of gloves. She did not sanitize her hands before putting on a new pair of gloves. CNA B put the new brief under the resident's bottom, assisted the resident to roll back, and both CNA B and the MDS Nurse fixed the brief. When incontinent was done, CNA B and the MDS Nurse transferred the resident to her wheelchair using the stand-pivot transfer. After the transfer, The MDS Nurse washed her hands and went out of the room. CNA B fixed the trash, washed her hands, and went out of the room. In an interview with the MDS Nurse on 10/02/2024 at 9:27 AM, the MDS Nurse stated hand hygiene was the basic component in the prevention of cross contamination and development of infection. The MDS Nurse said the gloves should be changed after tucking the soiled brief in between the resident's legs and/or before helping in fixing the new brief. The MDS Nurse said touching soiled items and then touching clean items could cause the transfer of germs. In an interview with CNA B on 10/02/2024 at 9:31 AM, CNA B stated she did hand hygiene before doing any care for a resident. She said, during incontinent care, the gloves should have been changed after cleaning the resident's bottom and before applying the skin protector cream. She said the cream was a form of a treatment and should be applied using clean gloves. She said hand hygiene should also be done in between changing of gloves. She said if hand hygiene and changing of gloves were not done, cross contamination and infection could happen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the ADON on 10/02/2024 at 2:45 PM, the ADON stated hand hygiene was included in all the procedures of any care. He said the staff should do hand hygiene before and after any care. He said gloves should be changed after cleaning the residents' bottoms, after touching the trash can, before getting the new brief, and before applying any form of treatment. He said not changing the gloves after touching soiled items, or after touching soiled body parts could result in cross contamination and probable infections. He said the expectation was for the staff to do hand hygiene before and after every care, after changing their gloves, and when transitioning from a dirty site to a clean site. The ADON said they would do in-service about infection control. In an interview with the DON on 10/02/2024 at 3:08 PM, the DON stated hand hygiene was the most effective way to prevent cross contamination and infection. She said gloves should be changed after touching the soiled brief and the trash to prevent transfer of microorganism to any clean items. She said the staff should do hand hygiene before putting on a new pair of gloves. She said the expectation was for the staff to change their gloves when going from dirty to clean and to do hand hygiene when changing the gloves. She said she will do an in-service and skills check-off about infection control and would observe the staff personally. In an interview with the Administrator on 10/03/2024 at 8:06 AM, the Administrator stated staff should make sure to change their gloves after touching anything soiled and sanitize their hands before putting on new gloves. He said not changing the gloves after touching soiled items and not sanitizing the hands could contribute to cross contamination and infection. He said the expectation was for the staff to follow the policy and procedures pertaining to infection control. He said he would collaborate with the DON to in-service the staff about infection control. Review of facility policy, Hand Hygiene undated, revealed Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility . Hand Hygiene Table . After handling contaminated objects . Before and after handling clean or soiled dressings . Before and after providing care to residents . After handling items potentially contaminated with blood, body fluids, secretions, or excretions . When, during resident care, moving from a contaminated body site to a clean body site . After assistance with personal body functions . e.g., Elimination. Review of facility policy, Perineal Care undated, revealed Policy: It is the practice of this facility to provide perineal care to all incontinent residents . to promote cleanliness and comfort, prevent infection . 10 . Change gloves if soiled and continue with perineal care.16. Remove gloves and discard. Perform hand hygiene.