STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676033	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town Hall Estates	300 Happy LN Hillsboro, TX 76645

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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 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** 47795 Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the residents' rights, which included measurable objectives and timeframe's to meet a resident's medical, nursing, and mental, and psychosocial needs that were identified in the comprehensive assessment for 1 of 8 residents (Resident #16) reviewed for care plans. The facility failed to ensure Resident #16's comprehensive care plan, dated 05/02/2024, reflected the resident received routine and as needed pain medication for a diagnosis of low back pain . This deficient practice could place residents at risk of not receiving proper care for pain management and other services due to inaccurate care plans. The findings were: A record review of Resident #16's face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with a readmission on 6/30/2023. Resident #16 had diagnoses which included Coronary Artery Disease (Damage or disease in the hearts major blood vessels, the usual cause in the buildup of plague), Heart Failure (A chronic condition in which the heart disease does not pump blood as well as it should), Alzheimer's disease (A progressive disease that destroys memory and other important mental functions) and Low Back Pain (a common, painful condition affecting the lower portion of the back). A record review of Resident #16's Quarterly MDS assessment, dated 6/3/2024, reflected a BIMS score of 14, which indicated cognitively intact cognition. The resident received a scheduled pain medication regiment and non-medication interventions for pain. A record review of Resident #16's Care Plan, revised 1/10/2024 , reflected no focus, goal or interventions for pain management. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #16's Physician Orders, dated 6/27/2024, reflected an order for Acetaminophen (Tylenol) 2 tablets by mouth two times a day for chronic low back pain written 12/2/2022, Acetaminophen Tablet (Tylenol) 2 tablets by mouth every 6 hours as needed for pain, do not exceed 3000 mg in 24 hours written 12/2/2024, Bio freeze external gel 4% apply to affected areas topically every 12 hours as needed for pain, Naproxen Oral Tablet 500 mg 1 tablet by mouth every 12 hours as needed for low back pain, written 4/6/2023, Lidoderm patch 5% (lidocaine) apply to lower back topically one time a day for lower back pain, apply to lower back in the morning and remove 12 hours later written 8/10/2022 Tramadol Hydrochloride (a muscle relaxer) Tablet 50 mg give 1 tablet by mouth every 6 hours as needed for moderate or severe pain written 8/11/2022, and Tizanidine Hydrochloride (a pain reliever) tablet 2 mg give 1 tablet by mouth at bedtime for pain written 5/3/2022. Observation of Resident #16 on 06/26 /2024 at 11:05 AM revealed the resident lying in bed with slight grimacing and c/o pain. The resident stated she had just received something for pain and was waiting for it to take effect. Observation on 6/26/2024 at 1:30 PM revealed Resident #16 appeared slightly uncomfortable but no grimacing present. Observation on 6/27/2024 09:00 am revealed the resident was awake and alert with a calm demeanor, the resident denied pain at this time. Interview with Resident #16 on 6/26/2024 at 1:30 PM revealed this morning her pain was an 8 . The nurses were good about giving her medication to control the pain, when she asked for it, some days were better than others. In an interview with the MDS Nurse on 6/27/2024 at 2:00 PM, she stated the IDT were responsible for the care plan and any member could updated the care plan. There was a morning meeting where updates were given. She stated something that triggered on the MDS should be reflected on the care plan. She stated she was not aware Resident # 16's care plan did not address her pain and it should be on the care plan as it was triggered on the MDS. She stated an inaccurate care plan could affect quality of life and care of the resident. In an interview with the DON on 6/27/2024 at 3:30 PM revealed it was her expectation the care plans reflected the care the residents received. Inaccurate care plans put the resident at risk of not receiving what they needed as far as care and support. The IDT was responsible for the care plans and the MDS nurse should verify them and if it needed to be update for accuracy. She stated that a resident on a pain management program with both scheduled and as needed medication should have those and non-pharmaceutical interventions care planned. In an interview with the ADM on 6/27/2024 at 4:00 PM revealed it was her expectations the care plans were updated with the needs of the resident in real time as they occurred. They had daily meetings to discuss the changes and those should be reflected by the IDT and the MDS Nurse. A care plan that did not reflect the actual needs of the resident could be harmful as the resident may not get the care and resources, they needed to function at their best . Record review of the facility's Care Plan, policy:, revised July 2021, reflected Each resident will have a resident-centered care plan developed specifically based on their individual needs and preferences, revised, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and reviewed by an interdisciplinary team [IDT] made up of qualified persons. Each resident/resident representative will be afforded the opportunity to participate in the care planning process. *Each resident's care plan will be developed/reviewed by the IDT with a date and each team member will physically sign the care plan review sheet starting with the comprehensive care plan. This sheet will then be placed in the resident's clinical chart. *A registered nurse will be responsible for the formulation and implementation of nursing care plans and other disciplines will be responsible for the formulation and implementation of non-nursing care plans according to their scope. Implementation is upon signing the review sheet. *An LVN [licensed vocational nurse] and other appropriate disciplines may revise an existing care plan under the direction of a registered nurse. The revision is upon revising the care plan date and/or signing the review sheet.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49048 Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 3 of 3 residents (Resident #8, Resident #12 and Resident #13) reviewed for activities of daily living . The facility failed to document Resident #8, Resident #12 and Resident #13 received showers as scheduled. The facility failed to assist Resident #8 with hygiene and Resident #12 with grooming. The facility failed to provide Resident #13 with showers as scheduled. This failure could place residents at risk of embarrassment, injury, skin breakdown and infection. Findings include: 1. Record review of Resident #8's, undated, Care Plan reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Chronic Viral Hepatitis C (an infection caused by a virus that attacks the liver and leads to inflammation), Iron Deficiency Anemia (decrease in red blood cells due to low iron), Type 2 Diabetes Mellitus (the pancreas cannot make enough insulin) with Diabetic Neuropathy (type of nerve damage), Hyperlipidemia (high cholesterol), Acquired Absence of Right and Left Fingers, Acquired Absence of Right and Left Legs Below Knee, Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris (accumulation of plaque on the inner walls of blood vessels), Muscle Weakness, Unsteadiness on Feet and Muscle Wasting and Atrophy (shrinking) . Record review of Resident #8's admission MDS Assessment, dated 3/22/2024, reflected a BIMS score of 10, which indicated moderate cognitive impairment. It reflected that she was dependent for oral hygiene, toileting, bathing, dressing and personal hygiene. Record review of Resident #8's, undated, care plan reflected the following: Resident has an ADL self-care performance deficit due to amputation of all fingers and legs below the knees. The resident requires total dependence by one staff with showering three times weekly and as necessary. Shower days are Tuesday, Thursday, and Saturday. Record review of Resident #8's shower log in PCC for Resident #8 reflected between 06/01/2024 and 6/25/2024 the resident received a bath/shower on 6/6, 6/11, 6/20 and 6/25/2024. The shower documentation in PCC did not match the shower documentation on the shower sheets . Record review of Resident #8's shower sheets, dated 5/29/2024 to 6/26/2024, reflected refused showers on 6/1 and 6/13/2024 (bruising on shoulder noted) and she received showers on 6/4, 6/18 and 6/22/2024. The documentation on the shower sheets did not match the shower documentation in PCC . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 6/25/2024 at 10:20 AM, revealed Resident #8 sitting in the living room wearing a navy blue and white striped shirt. The front of the shirt had dried food particles and liquid stains. The resident was unable to answer questions . Observation on 6/26/2024 at 8:30 AM, revealed Resident #8 sitting in living room wearing that same shirt as the previous day, with dried food and liquid stains. The resident had food around her mouth, on the top of her hand, and on her shoulder immobilizer. The resident was unable to answer questions . 2. Record review of Resident #12's, undated Care Plan reflected a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnoses included Cerebral Infarction (stroke), Asthma (lung disease), Hypothyroidism (low thyroid hormone production), Hemiplegia (paralysis on one side) and Hemiparesis (weakness on one side) following Cerebral Infarction (stroke) affecting right dominant side, Diabetes Mellitus due to Underlying Condition (the pancreas cannot make enough insulin), Hypertension (high blood pressure), Depression, Chronic Obstructive Pulmonary Disease (obstructed airflow from lungs), Hyperlipidemia (high cholesterol), Unsteadiness on Feet, Muscle Wasting and Atrophy (muscle degeneration) and Heart Disease (diseased heart). Record review of Resident #12's quarterly MDS Assessment, dated 5/15/2024, reflected a BIMS score of 12, which indicated moderately impaired cognitive skills. It reflected that she was dependent for showers and transfers. Record review of Resident #12's, undated, care plan reflected the following: The resident requires total dependence by one staff with (Specify bathing/showering) Monday, Wednesday, Friday and as necessary. Record review of Resident #12's shower log in PCC reflected between 5/29/2024 and 6/26/2024 the resident received a bath/shower on 5/29, 5/30, 5/31, 6/1, 6/2, 6/3, 6/5, 6/6, 6/10, 6/11, 6/14, 6/19 (two showers), 6/20, 6/24 and 6/24/2024 . The shower documentation in PCC did not match the shower documentation on the shower sheets. Record review of Resident #12's shower sheets, dated 5/29/2024 to 6/26/2024, reflected refused showers on 5/30, 6/4, 6/8, 6/13, 6/22/2024 and she received showers on 6/1 and 6/18 . The documentation on the shower sheets did not match the shower documentation in PCC. Observation on 06/25/2024 at 10:15 AM revealed Resident #12 was in bed. Her hair was disheveled, and she was wearing a shirt and an adult brief. Her shirt had ridden up to just below her breasts. When interviewed, the resident said she received great care at the facility, and they assisted her with bathing and dressing. Observation and interview on 06/26/2024 at 8:15 AM, revealed Resident #12 was in bed eating breakfast. She was wearing the same shirt as the day before. The resident stated she had not received a shower the evening prior. Observation and interview on 06/27/2024 at 9:43 AM, revealed Resident #12 was in bed. She said the staff helped her with bathing and showers when she wanted one and she sometimes refused . She could not recall when she last received a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #13's, undated, care plan for Resident #3 reflected a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnoses included Chronic Pain Syndrome (persistent pain), Pruritis (itching), Major Depressive Disorder (depression), anxiety disorder (feeling anxious), Cystoid Macular Degeneration (swelling of the retina), Hypertension (high blood pressure), Myocardial Infarction (heart attack), Hypertension (low blood pressure), Hyperlipidemia (high cholesterol), Polyneuropathy (damage of the peripheral nerve), Muscle Wasting and Atrophy (muscle degeneration), and Lack of Coordination. Record review of Resident #13's quarterly MDS Assessment, dated 3/28/2024, reflected a BIMS score of 15, which indicated intact cognition. It reflected the resident was dependent for bathing/showering, dressing, and personal hygiene. Record review of Resident #13's, undated, care plan reflected, Bathing/Showering: The resident requires total dependence by two staff with showering three times weekly and as necessary. Personal Hygiene: The resident requires total dependence by one staff with personal hygiene and oral care. Record review of Resident #13's shower log in PCC reflected between 6/14/2024 through 6/25/2024, the resident received showers on Friday 6/14, Tuesday 6/18, and Sunday 6/23/2024. The shower documentation in PCC did not match the shower documentation on the shower sheets. Review of the shower sheets provided by the ADON reflect the resident received showers on 6/18 and 6/23/2024. The documentation on the shower sheets does not match the shower documentation in PCC. Observation and interview on 6/25/2024 at 9:34 AM with Resident #13 revealed she was lying in bed with a sheet over her face and head. She removed the sheet to speak but did not open her eyes. She said she was not getting her bath/showers as scheduled on Tuesday, Thursday, and Sunday evenings. She said she got her bath/showers on Tuesdays consistently. She said staff told her they did not have enough staff to bath/shower her on Tuesdays and Sundays . She said she had not received a bath/shower since last Tuesday (6/18/2024). She said, It's posted all over my room what days I'm supposed to get my showers. Observed multiple 81/2 by 11-inch pieces of paper hanging on the walls in multiple places around the resident's room. The papers read, Showers on Tuesday, Thursdays and Sunday . Observation and interview on 6/25/2024 at 1:48 PM with Resident #13, she was lying in bed with a sheet over her face. She said her face was cold. When asked if she got her shower on Tuesday (the day prior), she said, Yes. I only have a problem getting showers on Thursdays and Sundays. Observation on 6/27/2024 at 8:56 AM revealed there were no staff observed at the main nurse's station. Review of the binder labeled Shower Logs. There were no more than 75% of shower sheets within the daily dividers for the month of June. There were multiple shower sheets (two types of shower sheet forms) in the front pocket and additional forms in the back pocket of the binder. Interview on 6/27/2024 at 9:09 AM with CNA A, she stated the CNAs were responsible to complete the shower sheets and documented showers in PCC. She said if the resident refused a bath/shower, they were to report to the nurse and then follow-up with the resident later to see if they changed their mind. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/27/2024 at 9:13 AM with the DON, she stated the CNAs were responsible to complete the shower sheets, then they went to the charge nurse to sign off on the form and the nurse was responsible for filing the shower sheets in the appropriate divider in the binder. The ADON left the DONs office and went to the nurse's station to ask staff where the shower sheets were located. She did not return to speak with the State Surveyors. Interview on 6/27/2024 at 2:50 PM with CNA B, she stated the CNAs were responsible to complete the shower sheets and document in PCC. She said the CNAs reported refusals to the nurse and the CNAs followed-up with the resident three times to offer a shower. Interview on 6/27/2024 at 3:45 PM with the ADON, she stated the CNAs were responsible to document on the shower sheets, in PCC, file the shower sheets in the shower log after the nurses sign off on them. She said her expectation was all documentation should match. Interview on 6/27/2024 at 4:10 PM with the DON, she stated the CNAs were responsible to document on the shower sheets and in PCC. She said her expectation was all documentation should match 100%. She said the CNA ADM was responsible for ensuring the shower documentation in PCC done by the CNAs was accurate. Interview on 6/27/2024 at 4:30 PM with the ADM, she stated her expectation was for all documentation to match. She said it was the responsibility of the charge nurse to review the CNA documentation in PCC; however, it was ADON and DON who were ultimately responsible. Record review of the facility's policy titled Personal Care, section Shower/Tub Bath/Bed Bath, revision date October 2009, by MED-PASS, Inc. reflected: Purpose: The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation: The following information should be recorded on the resident's ADL record and/or in the resident's medical record. 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath. 3. All assessment data (e.g., any reddened areas, sores, etc. on the resident's skin) obtained during the shower/tub bath. 4. How the resident tolerates the shower/tub bath. 5. If the resident refused the shower/tub bath, the reason(s) why the intervention taken. 6. The signature and title of the person recording the data. Reporting: 1. Notify the supervisor if the resident refuses the shower/tub bath. (continued on next page)

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 44317 Based on observation, interview and record review the facility failed to ensure the nurse staffing information was posted on a daily basis and included the total number and the actual hours worked by licensed and unlicensed nursing staff for 2 of 3 days (6/25/24 and 6/26/24) reviewed for nurse staffing and the facility failed to maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater, for the last 18 months. 1. The facility failed to ensure the Daily Staffing log contained the total number and actual hours worked of licensed and unlicensed nursing staff directly responsible for resident care per shift for registered nurses, licensed practical or vocational nurses, and certified nurse aides on 6/25/24 and 6/26/24. 2. The facility failed to maintain the nurse staffing data from December 2022 through June 26, 2024. These deficient practices could place residents and visitors at risk of not knowing the current staffing and not being able to request the daily nurse staffing data record for the last 18 months. Findings included: An observation on 06/25/24 at 09:35 AM revealed no staffing information was posted in a prominent place readily accessible to residents and visitors. An observation on 6/25/24 at 10:23 AM revealed no staffing information was posted. An observation on 6/25/24 at 12:33 PM revealed a Daily Staffing Sheet was posted. The sheet did not contain the total number and the actual hours worked by RNs, LPNs, LVNs, or CNAs. An observation on 06/26/24 at 10:15 AM revealed no staffing information was posted. During an interview on 06/25/24 at 9:35 AM, the DON stated she would text the person responsible for posting the numbers to get the information. The DON offered the daily staffing schedule. During an interview on 06/26/24 at 1:05 PM, CNA E stated she was responsible for posting the staffing daily. She stated she made the sheets in advance for the days she would not be at the facility and the charge nurse posted them. She stated she was not aware of any specific requirements for what needed to be on the form. CNA E stated she was not aware of any policy about the form. When asked for the previous 30 days of postings for review, she stated she was not aware of any retention requirements for the forms. She stated she had not saved any of the old forms. During an interview on 06/26/24 at 1:30 PM, with both the ADON and the DON, they both stated they were not aware of information required to be on the posting. Neither was aware of the retention policy for the documents. The DON stated CNA E was responsible for posting the documents daily. The ADON stated it did not meet her expectations that the correct information was not posted to allow residents and visitors to see the census and staffing. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 06/26/24 at 1:39 PM, the ADM stated CNA E had the information and she was responsible for posting the information daily. She stated she was not aware the current posted form did not contain the required information and stated the form had recently changed. She stated not posting or retaining the information could cause residents, visitors, or the public to not know the direct care staffing numbers. Record review of the facility's, undated, Posting Direct Care Daily Staffing Numbers policy, reflected in part, 1. Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) an in a clear and readable format. 3. Shift staffing information shall be recorded . the information recorded on the form shall include: a. The name of the facility. b. The date for which the information is posted. C. The resident census at the beginning of the shift . d. Twenty-four (24)-hour shift schedule operated by the facility. f. Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift. g. the actual time worked during that shift for each category and type of nursing staff. h. Total number of licensed and non-licensed nursing staff working for the posted shift . 8. Records of staffing information for each shift will be kept for a minimum of twenty-four (24) months or as required by state law (whichever is greater). 9. Staffing information during the recorded time period shall be made available to resident, family members and the public within 24 hours of a written or verbal request

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on observation, interview and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, included the appropriate accessory and cautionary instructions, and the expiration date when applicable and failed to store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 1) of 2 medication carts (East Hall medication cart) and 1 of 1 medication refrigerator (Middle Hall medication refrigerator) reviewed for medication storage. 1. The facility failed to ensure the middle hall medication refrigerator was within an acceptable temperature range by not checking the temperature on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. [DATE] and [DATE]. 2. The facility failed to ensure there were no loose medications in the East Hall medication cart when 3 loose pills were found on [DATE]. These failures could place residents at risk of not receiving an accurate dose of medication, missing doses of medications, or receiving potentially ineffective medications and thus not receiving the desired therapeutic effect of the ordered medication. Findings include: 1. An observation on [DATE] at 1:00 PM revealed a Daily Temperature Log for Refrigerator in a plastic sleeve on the medication refrigerator. There were no temperatures recorded for [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. [DATE] and [DATE] . There were multiple insulin syringes stored inside the refrigerator. During an interview on [DATE] at 1:02 PM with LVN C, she stated the night shift nurse was responsible for monitoring the refrigerator temperature. She stated by not recording the temperature, you would not know if the medications were maintained at the proper temperature. She stated medications not stored at the proper temperature may not work properly. During an interview on [DATE] at 3:08 PM, the DON stated housekeeping was responsible for monitoring the refrigerator temperature but then clarified housekeeping monitored refrigerators in the resident rooms and the night shift nurses were responsible for monitoring the medication refrigerators. She stated it did not meet her expectations that the temperatures had not been monitored daily. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation and interview on [DATE] at 3:10 PM, the East Hall medication cart revealed 3 loose pills in the bottom of a drawer. LVN D, who was responsible for the med cart, stated the nurses were responsible for checking the cart for expired or loose medications and the nurses were responsible for keeping the carts clean. She stated the carts should have been checked at least weekly then added, If you drop a pill, you should pick it up immediately. LVN D stated loose pills in the carts could result in the resident not getting the intended medication or missing a dose of medication. During an interview on [DATE] at 3:09 PM, the ADON stated everything in the medication cart had its place. Expired and loose pill should have been removed. She stated all the nurses, including the ADON and DON, were responsible to ensure the medications were stored properly. The ADON stated loose pills could cause a missed dose or a wrong medication being administered. She stated not monitoring refrigerator temperatures could have resulted in medications being stored at the wrong temperature. She stated storing medications at the wrong temperature could cause the medications to go bad. During an interview on [DATE] at 3:37 PM, the DON stated the medication carts should always be kept clean and organized. She stated it did not meet her expectations that there was loose medication in the medication cart. The DON stated loose medications could fall out of the cart and anyone could ingest it. She stated a resident may miss a dose of medication if the pill was dropped into the cart. During an interview on [DATE] at 3:48 PM, the ADM stated it was best practice to clean out the carts routinely. She stated the nurses were responsible for the cleanliness of the carts and it should be monitored by the ADON or DON. She stated the pharmacist looked at the carts during visits. The ADM stated the medication room refrigerator temperature should be monitored daily. She stated by not monitoring the temperature, they would not know if the medications were stored at the correct temperature. She stated if medications were stored at the wrong temperature, the medications could have gone bad. Record review of the facility's Storage of Medications policy, revised [DATE], reflected in part, 1. Drugs and biologicals shall be stored in the packaging, containers or other dispensing system in which they are received. 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49048 Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safely for the only facility kitchen reviewed for food storage and sanitation. The facility failed to ensure food and beverages were labeled and dated in the refrigerator and freezer. This deficient practice could place residents at risk of foodborne illness. The findings include: Observation on 6/25/2024 at 8:59 AM revealed a clear storage bag, knotted at the top which contained square hash brown patties. There was no open-on date. Observation on 6/25/2024 at 8:59 AM revealed a clear storage bag, knotted at the top which contained irregularly shaped meat products (chicken or fish). There was no open-on date. Observation on 6/25/2024 at 9:00 AM revealed an opened gallon container of Whole Milk. There was no open-on and use-by date. Observation on 06/25/2024 at 9:01 AM revealed an opened gallon container of Lactaid Whole Milk. There was no open-on and use-by date. Observation on 6/25/2024 at 9:01 AM revealed a large metal pan with loosely fitting clear wrap across the top, contained an orange substance which resembled a gelatin dessert. There was no label to identify the contents and no use-by date. Interview on 6/27/2024 at 1:30 PM with DC, she stated she had not read the facility's policy for labeling and storage. She said food in the refrigerator and freezer should have been labeled with a received-on and use-by date. She stated the importance of proper labeling and storage was to rotate stock and ensure proper temperature of the storeroom. She stated the adverse outcomes for residents were risk of illness for residents and serving food that was not fresh. Interview on 6/27/2024 at 1:45 PM with the DM , she stated she read the facility's policy for labeling and storage. She stated, foods should be labeled with an opened-on date and an expiration date for three days later. She stated the adverse outcomes for residents were risk of foodborne illness. She stated it was her responsibility to ensure kitchen staff were properly labeling and storing food items . Record review of the facility's, undated, policy, titled Food Date/Label Policy reflected: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PURPOSE: It is the purpose of this facility to ensure time/temperature sensitive food and beverage products are dated and labeled according to the manufacture's requirements and state/federal regulations . USDA Definitions: 1. A Best if Used By/Before indicates when a product will be of best flavor or quality. It is not a purchase or safety date. 2. A Sell By date tells the store how long to display the product for sale for inventory management. It is not a safety date. 3. A Use By date is the last date recommended for the use of the product while at peak quality. It is not a safety date except for when used on infant formula as described below. PROCEDURES: 1. Time and temperature sensitive foods and beverages that are opened, removed from the original container, or prepared from scratch will be labeled, dated, and refrigerated at 41 degrees F or less. These foods will be discarded after 4-5 days if not consumed. 2. The manufacture's storage instructions and dates for commercially prepared foods will be followed. Record review of the 2022 FDA Food Code. The facilities policy follows regulation.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49048 Based on interview and record review, the facility failed to ensure the medical record contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatments and/or services, and changes in his/her condition for 1 (Resident #1) of 4 residents reviewed for resident assessments. This failure could place residents at risk of embarrassment, injury, skin breakdown and infection. Findings include: 1. Record review of Resident #8's, undated, Care Plan reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Chronic Viral Hepatitis C (an infection caused by a virus that attacks the liver and leads to inflammation), Iron Deficiency Anemia (decrease in red blood cells due to low iron), Type 2 Diabetes Mellitus (the pancreas cannot make enough insulin) with Diabetic Neuropathy (type of nerve damage), Hyperlipidemia (high cholesterol), Acquired Absence of Right and Left Fingers, Acquired Absence of Right and Left Legs Below Knee, Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris (accumulation of plaque on the inner walls of blood vessels), Muscle Weakness, Unsteadiness on Feet and Muscle Wasting and Atrophy (shrinking). Record review of Resident #8's admission MDS Assessment, dated 3/22/2024, reflected a BIMS score of 10, which indicated moderate cognitive impairment. It reflected that she was dependent for oral hygiene, toileting, bathing, dressing and personal hygiene. Record review of Resident #8's, undated, care plan reflected the following: Resident has an ADL self-care performance deficit due to amputation of all fingers and legs below the knees. The resident requires total dependence by one staff with showering three times weekly and as necessary. Shower days are Tuesday, Thursday, and Saturday. Record review of Resident #8's shower log in PCC for Resident #8 reflected between 06/01/2024 and 6/25/2024 the resident received a bath/shower on 6/6, 6/11, 6/20 and 6/25/2024. The shower documentation in PCC did not match the shower documentation on the shower sheets. Record review of Resident #8's shower sheets, dated 5/29/2024 to 6/26/2024, reflected refused showers on 6/1 and 6/13/2024 (bruising on shoulder noted) and she received showers on 6/4, 6/18 and 6/22/2024. The documentation on the shower sheets did not match the shower documentation in PCC. Observation on 6/25/2024 at 10:20 AM, revealed Resident #8 sitting in the living room wearing a navy blue and white striped shirt. The front of the shirt had dried food particles and liquid stains. The resident was unable to answer questions. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 6/26/2024 at 8:30 AM, revealed Resident #8 sitting in living room wearing that same shirt as the previous day, with dried food and liquid stains. The resident had food around her mouth, on the top of her hand, and on her shoulder immobilizer. The resident was unable to answer questions. 2. Record review of Resident #12's, undated Care Plan reflected a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnoses included Cerebral Infarction (stroke), Asthma (lung disease), Hypothyroidism (low thyroid hormone production), Hemiplegia (paralysis on one side) and Hemiparesis (weakness on one side) following Cerebral Infarction (stroke) affecting right dominant side, Diabetes Mellitus due to Underlying Condition (the pancreas cannot make enough insulin), Hypertension (high blood pressure), Depression, Chronic Obstructive Pulmonary Disease (obstructed airflow from lungs), Hyperlipidemia (high cholesterol), Unsteadiness on Feet, Muscle Wasting and Atrophy (muscle degeneration) and Heart Disease (diseased heart). Record review of Resident #12's quarterly MDS Assessment, dated 5/15/2024, reflected a BIMS score of 12, which indicated moderately impaired cognitive skills. It reflected that she was dependent for showers and transfers. Record review of Resident #12's, undated, care plan reflected the following: The resident requires total dependence by one staff with (Specify bathing/showering) Monday, Wednesday, Friday and as necessary. Record review of Resident #12's shower log in PCC reflected between 5/29/2024 and 6/26/2024 the resident received a bath/shower on 5/29, 5/30, 5/31, 6/1, 6/2, 6/3, 6/5, 6/6, 6/10, 6/11, 6/14, 6/19 (two showers), 6/20, 6/24 and 6/24/2024 . The shower documentation in PCC did not match the shower documentation on the shower sheets. Record review of Resident #12's shower sheets, dated 5/29/2024 to 6/26/2024, reflected refused showers on 5/30, 6/4, 6/8, 6/13, 6/22/2024 and she received showers on 6/1 and 6/18 . The documentation on the shower sheets did not match the shower documentation in PCC. Observation on 06/25/2024 at 10:15 AM revealed Resident #12 was in bed. Her hair was disheveled, and she was wearing a shirt and an adult brief. Her shirt had ridden up to just below her breasts. When interviewed, the resident said she received great care at the facility, and they assisted her with bathing and dressing. Observation and interview on 06/26/2024 at 8:15 AM, revealed Resident #12 was in bed eating breakfast. She was wearing the same shirt as the day before. The resident stated she had not received a shower the evening prior. Observation and interview on 06/27/2024 at 9:43 AM, revealed Resident #12 was in bed. She said the staff helped her with bathing and showers when she wanted one and she sometimes refused . She could not recall when she last received a shower. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #13's, undated, care plan for Resident #3 reflected a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnoses included Chronic Pain Syndrome (persistent pain), Pruritis (itching), Major Depressive Disorder (depression), anxiety disorder (feeling anxious), Cystoid Macular Degeneration (swelling of the retina), Hypertension (high blood pressure), Myocardial Infarction (heart attack), Hypertension (low blood pressure), Hyperlipidemia (high cholesterol), Polyneuropathy (damage of the peripheral nerve), Muscle Wasting and Atrophy (muscle degeneration), and Lack of Coordination. Record review of Resident #13's quarterly MDS Assessment, dated 3/28/2024, reflected a BIMS score of 15, which indicated intact cognition. It reflected the resident was dependent for bathing/showering, dressing, and personal hygiene. Record review of Resident #13's, undated, care plan reflected, Bathing/Showering: The resident requires total dependence by two staff with showering three times weekly and as necessary. Personal Hygiene: The resident requires total dependence by one staff with personal hygiene and oral care. Record review of Resident #13's shower log in PCC reflected between 6/14/2024 through 6/25/2024, the resident received showers on Friday 6/14, Tuesday 6/18, and Sunday 6/23/2024. The shower documentation in PCC did not match the shower documentation on the shower sheets. Review of the shower sheets provided by the ADON reflect the resident received showers on 6/18 and 6/23/2024. The documentation on the shower sheets does not match the shower documentation in PCC. Observation and interview on 6/25/2024 at 9:34 AM with Resident #13 revealed she was lying in bed with a sheet over her face and head. She removed the sheet to speak but did not open her eyes. She said she was not getting her bath/showers as scheduled on Tuesday, Thursday, and Sunday evenings. She said she got her bath/showers on Tuesdays consistently. She said staff told her they did not have enough staff to bath/shower her on Tuesdays and Sundays . She said she had not received a bath/shower since last Tuesday (6/18/2024). She said, It's posted all over my room what days I'm supposed to get my showers. Observed multiple 81/2 by 11-inch pieces of paper hanging on the walls in multiple places around the resident's room. The papers read, Showers on Tuesday, Thursdays and Sunday . Observation and interview on 6/25/2024 at 1:48 PM with Resident #13, she was lying in bed with a sheet over her face. She said her face was cold. When asked if she got her shower on Tuesday (the day prior), she said, Yes. I only have a problem getting showers on Thursdays and Sundays. Observation on 6/27/2024 at 8:56 AM revealed there were no staff observed at the main nurse's station. Review of the binder labeled Shower Logs. There were no more than 75% of shower sheets within the daily dividers for the month of June. There were multiple shower sheets (two types of shower sheet forms) in the front pocket and additional forms in the back pocket of the binder. Interview on 6/27/2024 at 9:09 AM with CNA A, she stated the CNAs were responsible to complete the shower sheets and documented showers in PCC. She said if the resident refused a bath/shower, they were to report to the nurse and then follow-up with the resident later to see if they changed their mind. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/27/2024 at 9:13 AM with the DON, she stated the CNAs were responsible to complete the shower sheets, then they went to the charge nurse to sign off on the form and the nurse was responsible for filing the shower sheets in the appropriate divider in the binder. The ADON left the DONs office and went to the nurse's station to ask staff where the shower sheets were located. She did not return to speak with the State Surveyors. Interview on 6/27/2024 at 2:50 PM with CNA B, she stated the CNAs were responsible to complete the shower sheets and document in PCC. She said the CNAs reported refusals to the nurse and the CNAs followed-up with the resident three times to offer a shower. Interview on 6/27/2024 at 3:45 PM with the ADON, she stated the CNAs were responsible to document on the shower sheets, in PCC, file the shower sheets in the shower log after the nurses sign off on them. She said her expectation was all documentation should match. Interview on 6/27/2024 at 4:10 PM with the DON, she stated the CNAs were responsible to document on the shower sheets and in PCC. She said her expectation was all documentation should match 100%. She said the CNA ADM was responsible for ensuring the shower documentation in PCC done by the CNAs was accurate. Interview on 6/27/2024 at 4:30 PM with the ADM, she stated her expectation was for all documentation to match. She said it was the responsibility of the charge nurse to review the CNA documentation in PCC; however, it was ADON and DON who were ultimately responsible. Record review of the facility's policy titled Personal Care, section Shower/Tub Bath/Bed Bath, revision date October 2009, by MED-PASS, Inc. reflected: Purpose: The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation: The following information should be recorded on the resident's ADL record and/or in the resident's medical record. 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath. 3. All assessment data (e.g., any reddened areas, sores, etc. on the resident's skin) obtained during the shower/tub bath. 4. How the resident tolerates the shower/tub bath. 5. If the resident refused the shower/tub bath, the reason(s) why the intervention taken. 6. The signature and title of the person recording the data. Reporting: 1. Notify the supervisor if the resident refuses the shower/tub bath. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Notify the physician of any skin areas that may need to be treated. 3. Report other information in accordance with facility policy and professional standards of practice.