

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/02/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Terrace Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 Stillhouse Road Paris, TX 75460	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review, the facility failed to notify the resident's representative immediately when there was a significant change in the resident's physical, mental, or psychosocial status that is, a deterioration of health, mental, or psychosocial status in either life-threatening conditions or clinical complications for 1 of 24 residents (Resident #57) reviewed for notification of changes. The facility failed to notify Resident #57's representative when the new areas of shearing, hematoma, bruising, and redness were found on Resident #57. This failure placed residents' caregivers at risk of not being aware of any changes in their conditions and could result in a delay in treatment and decline in residents' health and well-being. Findings included: Record review of Resident #57's face sheet dated 02/29/24, indicated an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included heart failure (progressive heart disease that affects pumping action of the heart muscles), atrial fibrillation (abnormal heart rhythm), weakness, protein-calorie malnutrition (not consuming enough protein or calories), and anxiety. Record review of Resident #57's comprehensive care plan dated 12/28/2023 and revised on 02/22/2024, indicated Resident #57 had a bruise with interventions to attempt to determine the cause of bruising, if known attempt to alleviate that factor. The care plan indicated Resident #57 had a skin tear, laceration, or abrasion with interventions to assess reason for skin injury occurrence, notify staff of cause and determine measures to prevent further skin injuries. The care plan indicated Resident #57 had a pressure ulcer or potential for pressure ulcer development due to limited mobility and occasional bowel and bladder incontinence. The care plan interventions included to inform Resident #57's family of any new areas of skin breakdown. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #57's weekly skin assessment dated [DATE] at 09:40 PM , indicated Resident #57 had no bruising. The skin assessment indicated Resident #57 had a skin tear to left arm measuring 11.4 cm x 8.0 cm. The skin assessment did not indicate the new shearing with hematoma measuring 22 cm x 19 cm, 1 cm x 6 cm skin tear to right upper arm, reddened areas to inner thighs, or discolorations to upper back and center chest found on Resident #57 at 09:58 PM that night. The skin assessment indicated there were no new areas that have not been communicated to the physician/nurse practitioner or family. Record review of Resident #57's progress note dated 02/05/24 at 9:58 PM and signed by ADON E indicated MD (medical director) visit to resident room and assessment of resident, with MD requesting myself and DON to resident's room for skin assessment findings. Resident noted to have area to right upper arm appearing to be shearing with hematoma (blood filled swelling) pooling at posterior upper arm measuring 22 cm x 19 cm and a 1 cm x 6 cm skin tear to right, anterior upper arm. Telfa (clear wound dressing) nonadherent dressing with wrap in place noted. Multiple areas of discoloration to the upper back and one noted to the upper, center chest. Blanchable reddened areas to inner thighs bilateral from the brief. New orders for zinc oxide to bilateral arms, upper back, peri area, and any reddened areas for skin integrity. Ace bandage wraps to bilateral legs beginning above toes and extending above knees for compression to lessen edema. CNA documentation notes skin discoloration areas. A new order from MD was received for a left arm x-ray and change ABT to begin in a.m. The progress note did not indicate Resident #57's family member had been notified of the new areas or orders. Record review of Resident #57's quarterly MDS assessment dated [DATE], indicated Resident #57 was usually understood and usually understood others. The MDS assessment indicated Resident #57 had a BIMS score of 12, which indicated her cognition was moderately impaired. The MDS indicated Resident #57 required partial/moderate assistance with toileting, bathing, dressing, and personal hygiene. Resident #57 required substantial/maximal assistance with chair/bed to chair transfer. The MDS assessment indicated Resident #57 had one venous or arterial ulcers present and skin tears. Record review of Resident #57's order summary report dated 02/29/24, indicated Resident #57 had the following orders: * Wrap bilateral legs with ACE bandage from just above the toes to above knees for compression in the morning for compression to reduce edema. May remove for daily skin observation with an order date of 02/05/2024. During an interview on 02/29/2024 at 11:32 AM, Resident 57's family members said they were not notified by facility staff of the new skin concerns on Resident #57 on 02/05/2024. Resident 57's family members said they noticed the areas themselves, when they were assisting Resident #57 to bed (unsure of date). (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/29/2024 at 01:08 PM, ADON E said Resident #57's skin was so fragile. ADON E said on February 5, 2024, the MD came and got her because he wanted the DON and herself to look at Resident #57's skin since Resident #57 had different scattered bruising. She said Resident #57's legs were swollen and as a group he wanted them to see what they could do to care for Resident #57. ADON E said she saw the MD step outside the room and call Resident's #57's family member that day but she must have not charted that he had called them . ADON E said if it was not documented then it was not done. ADON E said it was important for Resident #57's family to be notified of the new skin concerns and orders because they should be involved in her care. ADON E said failure to notify resident's representative indicated they were not notified of any changes in care for the resident. During an interview on 03/01/2024 at 01:53 PM, the DON said Resident #57 constantly had bruising and said she was unable to recall if the injuries found on 02/05/2024 were a new discovery. The DON said she was unsure of how Resident #57 had sustained them but believed Resident #57 had constant multiple discolored areas due to her condition. The DON said the progress note did not indicate Resident #57's family was notified of the new skin areas or orders. The DON said Resident #57's family should have been notified of the news areas and orders because it was a change in condition, and they should have been made aware of new areas and orders. The DON said it was the responsibility of the nurse to notify the family of any changes. During an interview on 03/01/2024 at 10:45 AM, Resident #57's family member said they were not notified by the MD regarding any new skin concerns found on Resident #57 on 02/05/2024. During an interview on 03/02/2024 at 02:22 PM, the Interim Administrator said he expected the resident's representatives to be notified of any changes in the resident's care. The Interim Administrator said he expected the staff to document of the notification to the family. The Interim Administrator said Resident #57's family should have been notified of the new areas and orders because Resident #57's family could come in, see, and suspect Resident #57 was being abused. The Interim Administrator said the nurse was responsible for notifying the resident's representative. The Interim Administrator said he was unsure if there was a system in place to monitor if resident's representatives where being notified of any changes in condition or new orders. Record review of the facility's policy Notifying the Physician of Change in Status revised March 11, 2013 indicated . 5. The resident's family member or legal guardian should be notified of significant change in resident's status unless the resident has specified otherwise . 7. The nurse will document all attempts to contact the physician, all attempts to notify the family and/or legal representative.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview and record review the facility failed to ensure each resident was informed before, or at the time of admission, and periodically during the residents stay, of services available in the facility and of changes for those services, which included changes for services not covered under Medicare/Medicaid or by the facility's per diem rate for 1 of 2 residents (Resident #57) reviewed for Medicare/Medicaid coverage. The facility failed to ensure Resident #57 was given a SNFABN (SNFABN document that informs a Medicare beneficiary that Medicare will no longer pay for skilled services) when discharged from skilled services at the facility prior to covered days being exhausted. This failure could place residents at risk for not being aware of changes to provided services. Findings include: Record review of Resident #57's face sheet dated 02/29/24, indicated an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included heart failure (progressive heart disease that affects pumping action of the heart muscles), and weakness. Record review of Resident #57's quarterly MDS assessment dated [DATE], indicated Resident #57 was usually understood and usually understood others. The MDS assessment indicated Resident #57 had a BIMS score of 12, which indicated her cognition was moderately impaired. Record review of the SNF Beneficiary Protection Notification Review indicated Resident #57 was receiving Medicare Part A services starting on 12/27/2023 and the last covered day of Part A services was 02/15/2024, however it was revealed that a SNF ABN was not completed which would have informed Resident #57 of the option to continue services at the risk of out-of-pocket cost. During an interview on 03/02/2024 at 1:57 PM, MDS Coordinator R said Resident #57 should have been given a SNF ABN form. MDS Coordinator R said she had forgotten about it because she does not usually provide the SNF ABN forms. MDS Coordinator R said MDS Coordinator N was typically responsible for completing the SNF ABN forms, but he had been out of the facility, and she had to fill in for him. MDS Coordinator R said it was important for the SNF ABN form to be completed so the residents knew their options and they could decide if they wanted to stay, and for them to know how much it would cost without Medicare paying and decide if they wanted to continue with therapy services. During an interview on 03/02/2024 at 4:30 PM, the Administrator said MDS Coordinator N and the BOM were responsible for completing the Skilled Nursing Facility Advance Beneficiary Notice. The Administrator said he expected for them to complete the form per the requirements. The Administrator said it was important to complete this form to let the resident know or the family know that they were being discharged from skilled services and they do have the ability to appeal. (continued on next page)		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an undated document titled, Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 (2018), indicated, Medicare requires SNFs to issue the SNFABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: not medically reasonable and necessary; or considered custodial . The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility .		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview and record review, the facility failed to ensure prompt efforts were made to resolve grievances for 1 of 6 residents (Resident #57) reviewed for grievances . The facility failed to appropriately resolve Resident #57's grievance when issues with receiving baths continued. This failure could place residents at risk for grievances not being addressed or resolved promptly. Findings included: Record review of Resident #57's face sheet dated 02/29/24, indicated an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included heart failure (progressive heart disease that affects pumping action of the heart muscles), atrial fibrillation (abnormal heart rhythm), weakness, protein-calorie malnutrition (not consuming enough protein or calories), and anxiety. Record review of Resident #57's comprehensive care plan dated 12/28/2023 and revised on 02/22/2024 indicated Resident #57 had an ADL self-care performance deficit with interventions she required one staff member for assistance with bathing. Record of review of Resident #57's grievance dated 01/05/2024 indicated Resident #57's family member had a grievance regarding, room condition, showering/bathing/hygiene, medications, therapy, food and other. The grievance report indicated Resident #57 had been having issues with receiving baths. The grievance report indicated under pertinent findings and conclusion that Resident #57 was given a bed bath immediately. The grievance report under corrective action to be taken to prevent further recurrence did not address Resident #57's baths from being missed. The grievance report indicated the grievance was confirmed and was resolved on 01/05/2024 . Record review of Resident #57's quarterly MDS assessment dated [DATE], indicated Resident #57 was usually understood and usually understood others. The MDS assessment indicated Resident #57 had a BIMS score of 12 which indicated her cognition was moderately impaired. The MDS indicated Resident #57 required partial/moderate assistance with toileting, bathing, dressing, and personal hygiene. Resident #57 required substantial/maximal assistance with chair/bed to chair transfer. The MDS assessment indicated Resident #57 had one venous or arterial ulcers present and skin tears. The MDS assessment did not indicate Resident #57 had any behaviors or refused care. During an interview on 02/28/2024 at 09:00 AM, Resident #57's family member said Resident #57 was not on a bath schedule. Resident #57's family member said Resident #57 has had to ask for a bath in the past. Resident #57's family member said they would prefer for Resident #57's showers/baths to be somewhat consistent and it was not happening. Resident #57's family member said all they had asked for, from the facility staff, was for Resident #57 to be provided a reasonable level of care and for them to have the confidence that Resident #57 was being provided the care she deserved. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/28/24 at 11:45 AM, Resident #57's family member said they were very involved in Resident #57's care. Resident #57's family member said they had thought of putting a sign in Resident #57's room as a reminder for staff of Resident #57's scheduled bath days. Resident #57's family member said they felt they needed to remind staff of when Resident #57's baths/showers were scheduled so her baths would not be missed. Resident #57's family member said they had voiced their concerns to the corporate staff and never received a follow up phone call. Resident #57's family member said they had also reported their concerns regarding Resident #57's care to the previous administrator and her response was we can help you find another facility. Record review of Resident #57's progress notes dated 01/30/2024-03/01/2024 did not indicate Resident #57 had refused any showers/baths. Record review of Resident #57's follow-up question report dated 02/01/2024-02/28/2024 indicated Resident #57 received a bath/shower on 02/02/24, 02/05/2024, 02/07/2024, 02/12/2024, 02/14/2024, 02/16/2024, 02/19/2024, 02/23/2024, and 02/28/2024. Resident #57's scheduled bath days were on Monday, Wednesday, Friday on the 6:00 AM- 2:00 PM shift. The facility failed to provide a bath/shower to Resident #57 on 02/09/2024, 02/21/2024, and 02/26/2024. During an interview on 03/02/2024 at 02:04 PM, the DON said she expected the baths/showers to be completed according to their bath schedule unless there was an extraneous circumstance the bath/shower could not be provided. The DON said she expected the resident to have a file if they refused their bath/shower. The DON said the charge nurses and aides were responsible for ensuring the baths/showers were being provided as scheduled. The DON said there was a report she could print to indicate if the showers were being completed but she did not review it. The DON said she believed the ADONs were responsible for reviewing the report. The DON said if a resident was not receiving their bath/showers as desired, they could become upset, and it could lead to skin issues. During an interview on 03/02/2024 at 02:22 PM, the Interim Administrator said he expected the residents to receive their showers/baths on their scheduled bath day. The Interim Administrator said if a resident was to refuse their bath/shower, he expected staff to ask again or get a staff member that had a better rapport with the resident to ask. The Interim Administrator said if the resident continued to refuse then he expected the staff to document the refusal. The Interim Administrator said he was unsure, if a resident was to receive their baths as scheduled, helped with skin breakdown, or preventing skin issues since he was not clinical. The Interim Administrator said residents not receiving their baths/showers as scheduled was an infection control issue. During an observation and interview on 03/02/2024 at 05:23 PM, Resident #57's family member was seen coming out of her room and was extremely upset. Resident #57's family member voiced that Resident #57 was not provided a bath the day before, on 03/01/2024. Resident #57's family member said her last bath had been given on 02/28/2024. Resident #57's family member said they had voiced concerns of Resident #57's baths not being provided consistently multiple times to the facility staff. Resident #57's family member was observed voicing his concerns to the Interim Administrator. During an interview on 03/02/2024 at 05:33 PM, the SW said when a grievance was filed, it was placed in the resident's medical record. The SW said the management staff (nursing) was responsible for handling this grievance. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/02/2024 at 05:50 PM. The Interim Administrator said Resident #57's family member had not voiced any concerns to him regarding Resident #57's care. The Interim Administrator said he expected once a grievance was resolved, he did not expect the same issues to continue. The Interim Administrator said Resident #57's grievance had not been resolved as she continued having issues receiving her baths. Record review of the facility's policy titled Grievance revised on 11/02/2016, indicated . The Resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal . The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances s the resident may have All written grievances decisions will include: . Any corrective action taken or to be taken by the facility as a result of the grievance .		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review, the facility to ensure the right of the residents to be free from abuse and neglect 7 of 11 residents reviewed for abuse and neglect. (Resident #'s 44, 55, 41, 47, 52, 179 and 36) The facility failed to ensure Resident #44 was protected from Resident #41 after an alleged resident to resident assault resulting in Resident 44 being sent to a local emergency. Resident #44 was assessed with a head contusion (bruise) and a hematoma (a collection of blood outside of the vessel) when she was left alone with her alleged assailant Resident #41. The facility failed to ensure Resident #55 was not left alone with Resident #41 after he allegedly assaulted Resident #44. The facility failed to ensure Resident #179 was not verbally and physically abused by CNA B. The facility failed to ensure Resident #179 was not suffering on-going neglect by CNA B of not performing incontinent care and not responding to his call light. The facility failed to ensure Resident #36 was not verbally abused when cursed by CNA B. The facility failed to prevent verbal abuse when Resident #47 cursed at Resident #52 and did not allow him to enter his room. The facility failed to prevent abuse and neglect when LVN C reported abuse to the DON and the DON did not report it to HHSC. An IJ was identified on 2/27/2024. The IJ template was provided to the facility on [DATE] at 3:39 p.m. While the IJ was removed on 3/01/2024, the facility remained out of compliance due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: 1)Record review of a face sheet dated 2/27/2024 indicated Resident #44 was an [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia (memory loss), muscle weakness, reduced mobility, anxiety disorder. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a Significant Change MDS dated [DATE] indicated Resident #44 was sometimes understood and usually understands others. The MDS indicated Resident #44 was unable to complete her BIMS exam due to her cognition. The MDS indicated Resident #44 had inattention and disorganized thinking being continuously present. The MDS indicated Resident #44 had no behavioral symptoms but wandered 1-3 days during the assessment period. The MDS indicated Resident #44 required extensive assistance of two staff for transfers, and extensive assistance of one staff member for bed mobility, and locomotion on and off the unit. The MDS indicated Resident #44 had a history of falls with fractures within the last 6 months. Record review of the comprehensive care plan dated 12/13/2023 and updated on 1/07/2024 indicated Resident #44 was at risk to fall related to unsteady gait/balance, generalized weakness, and poor safety awareness. The care plan indicated Resident #44 was at risk to wander related to a history of attempts to leave the facility related to poor safety awareness and resides on the secured unit. Record review of the of an Event Nurses' note dated 2/25/2024 at 6:30 p.m., indicated LVN D documented she was called to Resident #55's room. LVN D documented Resident #44 was lying on the floor beside the closet door on the floor on her back with Resident #41 standing over her. LVN D documented Resident #44 had an abrasion to her right temple area with bruising to her right inner arm. LVN D documented Resident #44 was unable to state what had happened but Resident #55 said Resident #41 pushed Resident #44 against the closet door. The event note indicated LVN D sent Resident #44 to the local hospital. The note indicated interventions in place prior to this fall was none. Record review of a progress note dated 2/25/2024 at 7:30 p.m., LVN D wrote she was called to another resident room where she found Resident #44 was found on the floor bedside the closet door on her back with Resident #41 standing over her, and Resident #55 stated Resident #41 pushed Resident #44 against the closet door. Record review of a Fall-Risk assessment dated [DATE] documented after the Resident #44's incident with Resident #41 by LVN D indicated Resident #44 had intermittent confusion, no falls in the past 3 months, was ambulatory, and was incontinent. LVN D documented Resident #44 had a balance problem while standing, balance problem while walking, decreased muscular coordination, and change in her gait pattern when walking through a doorway. Record review of a hospital Emergency Department History of Present Illness indicated Resident #44 was sent to the local emergency roiaognom on [DATE] with the chief complaint as assault. The note written by the physician indicated Resident #44 assessment revealed a head contusion (bruise) and a hematoma (a collection of blood outside of the vessel). The note indicated in the review of systems Resident #44 had a headache. The physical examination documented indicated Resident #44 was moderately distressed, had ecchymosis (bruising caused by injury), swelling, and tenderness to the right side of her head. Record review of a CT Head without Intravenous Contrast dated 2/25/2024 indicated Resident #44's CT impression indicated she had a right parietal scalp hematoma (A scalp hematoma is a collection of blood (either flowing or clotted from ruptured blood vessels that will then collect in the area of space and tissue between the skull and skin). (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 2/27/2024 at 9:00 a.m., Resident #44 was sitting at the dining table with a large size raised area with bruising noted to her right side of her head in the temporal/parietal region. Resident #44 said she felt well but she denied having her head hurt. 2) Record review of a face sheet dated 3/2/2024 indicated Resident #41 was an [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia with behavioral disturbances, the need for continuous supervision, and high blood pressure. Record review of a Significant Change MDS dated [DATE] indicated Resident #41 was usually understood and sometimes understands. The MDS indicated Resident #41's cognition was severely impaired. The MDS indicated Resident #41 had no physical, or verbal behaviors exhibited. The MDS indicated Resident #41 wandered daily. Record review of the comprehensive care plan dated 8/08/2023 and revised on 9/08/2023 indicated Resident #41 was at risk for mood problems and received medications. The goal of the care plan indicated Resident #41 would have an improved mood state. The care plan interventions included administer medications, behavioral health consults as needed, monitor and record mood to determine if problems seem to be related to external causes. Record review of a progress note dated 2/25/2024 at 6:00 p.m., LVN D documented she was called to a resident room by CNA A. LVN D documented Resident #41 was in Resident #55's room where she found Resident #44 on the floor beside the closet door. LVN D documented Resident #41 was standing over Resident #44. LVN D documented she asked Resident #41 and Resident #44 what had occurred, and neither could explain. LVN D documented Resident #55 said Resident #41 pushed Resident #44 against the closet door and she fell . LVN D documented Resident #41 was very uncooperative and had tried to hit CNA A and Resident #55. Record review of Behavior Nurses Note dated 2/25/2023 at 6:30 p., LVN D documented she was called to the secured unit by the nurse aide. LVN D documented Resident #41 was in Resident #55's room. LVN D documented she found Resident #44 on the floor lying beside the closet door. LVN D documented Resident #41 was standing over Resident #44. LVN D documented Resident #55 said he pushed her up against the closet door and she fell . LVN D said Resident #41 and #44 was unable to indicate what had happened. LVN D said Resident #41 was very uncooperative and had tried to the hit the CNA on duty and Resident #55. Record review of an Event Nurses' note dated 2/25/2024 at 6:30 p.m., indicated LVN D documented Resident #41 was found in another resident room. LVN D documented Resident #41 had displayed physical, and resident to resident behaviors with another resident injured. The Event Nurses' note indicated LVN D moved Resident #41's room and initiated every 15-minute checks. Record review of a Every 15 Minute Check sheet indicated Resident #41 was placed on every 15-minute checks starting on 02/25/2024 at 6:30 p.m. The Every 15- minute checks at 0015 indicated LVN D documented at 12:15 a.m., Resident #44 was asleep. LVN D had only her initials beside the other every 15-minute checks starting at 12:30 a.m. - 5:45 a.m. on 02/26/2024 there was no remarks indicating anything in regarding Resident #41. During an observation on 2/25/2024 at 9:31 a.m., Resident #41 was lying in his bed asleep. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Brentwood Terrace Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 Stillhouse Road Paris, TX 75460	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 2/26/2024 at 10:54 a.m., LVN F said Resident #44 was discharged to the hospital and Resident #41 was on every 15-minute checks for aggressive behaviors. LVN F said after she reviewed Resident #44's electronic medical record and said there was not a progress note, a SBAR (situation, background, assessment, recommendation) note, a transfer note, or an incident report. LVN F said the electronic medical record should have had those assessments completed . LVN F said the nurse was responsible for documenting all the events occurring with the incident with Resident #'s 41,44, and 55. During an interview on 2/26/2024 at 11:46 a.m., the DON said on 2/25/2024 CNA A heard a noise and responded to the noise. The DON said LVN D called and said Resident #41 was upset and wandering in other rooms. The DON said CNA A had said Resident #44 was on the floor. The DON said she was unsure of Resident #44 hitting her head although she had an abrasion to her head. The DON said Resident #44 was sent to the emergency room closer to midnight due to complaining her head was hurting. During an interview on 2/26/2024 at 11:51 a.m., LVN D said she was called to the unit by CNA A. LVN D said Resident #44 was lying in the floor of Resident #55's room, with Resident #41 standing over Resident #44 around 6:30 p.m. on 2/25/2024. LVN D said Resident #55 said Resident #41 pushed Resident #44 against the closet and Resident #41 fell . LVN D said at the time of the incident Resident #44 had an abrasion to her right temple area and a bruise to her inner right arm. LVN D said Resident #41 was very uncooperative and attempted to hit others. LVN D said she was advised to place Resident #41 on every 15-minute checks by the DON. LVN D said although her documentation was not completed yet Resident #41 remained asleep. LVN D said CNA A had to leave Resident #44 to come for help. LVN D said she was not on the secured unit but was on hall 400 when the incident occurred. During an interview on 2/26/2024 at 12:22 p.m., CNA H said CNA A had always worked the secured unit alone. CNA H said when CNA A was in the room with other residents who would be watching the other residents, or who would go for help. CNA H said there was no one on the unit to get help when CNA A needed help. During an interview on 2/26/2024 at 4:17 p.m., the SW said she was notified by the DON regarding the incident with Resident #44 and Resident #41. The SW said upon her arrival Resident #44 was already at the local emergency room , and Resident #41 was wandering on the unit. The SW said Resident #41 and Resident #55 both were unable to recollect the recent incident. During an interview on 2/26/2024 at 9:32 p.m., CNA A said she was alone on the secured unit gathering her supplies in the spa/communal shower room when she heard a loud scream. CNA A said she ran out of the spa room and ran toward the end of the hall where she believed the sound was heard from. CNA A said upon entering the room, Resident #44 was lying in the floor, Resident #55 said Resident #41 had thrown Resident #44 into the door. CNA A said Resident #41 was aggressive with her at the time and tried to swing at her. CNA A said she left Resident #55's room and ran the length of the secured unit, opened the door, and yelled for help. CNA A said she was alone on the secured unit and had no other recourse than to go for help. CNA A said LVN D was passing medications and another nurse responded to her call for help. 3) Record review of a face sheet dated 3/02/2024 indicated Resident #55 was a [AGE] year-old male who admitted on [DATE] with the diagnoses of stroke, high blood pressure, and dementia (memory loss). (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the Annual MDS dated [DATE] indicated Resident #55 was usually understood, and usually understands. The MDS indicated Resident #55 had severe cognitive impairment. The MDS indicated Resident #55 had not displayed any verbal or physical behaviors. During an observation and interview on 2/26/2024 at 12:42 p.m., Resident #55 was sitting at the dining table and was unable to recall the incident in his room last night. This was determined to be an Immediate Jeopardy (IJ) on 2/27/2024 at 3:39 p.m. The facility Administrator and assistant Administrator were notified. The Administrator was provided with the IJ templates on 2/27/2024 at 3:39 p.m and a Plan of Removal was requested. 4)Record review of the face sheet, dated 02/29/2024, revealed Resident #47 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of sepsis (an infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever), metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), and altered mental status (broad term used to indicate an abnormal state of alertness or awareness). Record review of the significant change MDS assessment, dated 12/20/2023, revealed Resident #47 had clear speech and was usually understood by others. The MDS revealed Resident #47 was sometimes able to understand others. The MDS revealed Resident #47 had short-term and long-term memory problems. The MDS revealed Resident #47 was not able to recall the current season, the location of his room, staff names or faces, and that he was in a nursing facility. The MDS revealed Resident #47 had severely impaired decision-making skills. The MDS revealed Resident #47 had continuous inattention and disorganized thinking. The MDS revealed Resident #47 had no behaviors or refusal of care. Record review of the comprehensive care plan, revised on 02/21/2024, revealed Resident #47 had potential to demonstrate verbally abuse behaviors. The interventions included: analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document .assess resident's coping skills and support system .evaluate for side effects of medications .notify the charge nurse of any abusive behaviors . provide positive feedback for good behavior, emphasize the positive aspects of compliance . psychiatric/psychogeriatric consult as indicated. Record review of the nursing progress note on 02/19/2024 at 12:20 AM, revealed Resident #47 was repeatedly yelling at his roommate [Resident #52] You son-of-a-bitch get out of my room! The nursing progress note further revealed the DON was notified immediately and told LVN C to notify the Medical Director because there was no abuse coordinator at the facility. The progress note revealed the Medical Director was notified and Resident #47 was placed in a different room. 5) Record review of a face sheet dated 03/02/2024 indicated Resident #52 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia, unspecified severity, with other behavioral disturbance (deterioration of memory, language, and other thinking abilities with behaviors) , anxiety disorder, and depression. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #52 was usually able to understand others and was usually understood by others. The MDS assessment indicated Resident #52 had a BIMS score of 5, which indicated his cognition was severely impaired. The MDS assessment indicated Resident #52 had no physical, verbal, or other behaviors directed toward others. The MDS assessment indicated Resident #52 required setup or cleanup assistance with eating, supervision for oral, toileting, and personal hygiene, and partial to moderate assistance with showering and dressing. Record review of Resident #52's care plan last revised 02/02/2024 indicated Resident #52 had impaired cognitive function/dementia or impaired thought processes. Record review of Resident #52's progress notes indicated: o 02/19/2024 12:20 AM Resident #52 was very forgetful and usually confused. He was pacing, wandering, and coming in and out of his room. This resident was redirected numerous times back to his room and to bed. The last time resident was redirected back to his room, his roommate was cursing, repeatedly telling this resident, You son-of-a-bitch get out of my room! Which explained why Resident #52 would not stay in his room. CNA remained in the room with both residents until the DON and doctor were notified. DON notified immediately and stated to call the Medical Director. 12:35 AM both residents were separated with the roommate moved to another room. o Strike out note dated 2/23/2024, effective date for the note prior to strike out 02/19/2024 created by LVN C indicated, 12:20 AM the DON stated they did not have an abuse coordinator at the time, that their new administrator was supposed to start work that day (02/19/24). The DON stated to call the Medical Director and report it to him. During an observation and attempted interview on 02/23/2024 at 3:48 PM Resident #52 was observed walking down the hall with his rollator (walker with wheels). Resident #52 did not want to be interviewed at the time. During an interview on 02/26/2024 at 9:07 PM, LVN C said Resident #52 kept getting up and coming out of his room, and she kept telling him to go back to his room because it was in the middle of the night. LVN C said she finally decided to take him back to his room, and that was when she realized Resident #52's roommate, Resident #47, was yelling and cursing at Resident #52 to get out of the room and calling him a son of a bitch'. LVN C said this was really confusing Resident #52. LVN C said she called the DON, who was the abuse coordinator at the time, and she told her to keep them separated. LVN C said she called the Medical Director, and he told her to separate them and place them in 2 different rooms. Regarding the struck out note about the incident, LVN C said when she called the DON, she did not know the DON was the abuse coordinator. LVN C said the DON told her they currently did not have an abuse coordinator, but the new administrator was starting that day to notify the Medical Director. LVN C said she learned the DON was the abuse coordinator after talking to the DON on the phone. LVN C said one of her co-workers informed her if there was no administrator it automatically fell on the DON to be the abuse coordinator. LVN C said ADON E instructed her to correct her note to show that she did call the DON immediately. LVN C said after notifying the DON of the incident the night it occurred, the DON never talk to her about the incident again. LVN C said there had been a lot of changes in administrators and administration and they were not providing education on who was the abuse coordinator. LVN C said in the past she had called to report other incidents of abuse to who she thought was the abuse coordinator for them to tell her they were no longer employed at the facility. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 02/27/2024 at 8:46 AM, the DON said she was not able to recall any incident with Resident #47 and Resident #52. The DON said she did not remember an incident where Resident #47 cursed out Resident #52. The DON said the staff were supposed to report abuse to the Administrator and herself. The DON said the staff were notified when there were changes in administration one-on-one. The DON denied LVN C calling her to report when Resident #47 cursed at Resident #52. The DON said if the Administrator was not in the facility, she was the abuse coordinator. During an interview on 02/28/2024 at 3:33 PM, the Area Director of Operations said she was a consultant for the facility. The Area Director of Operations said she was there as a resource for the facility administration to reach out to her with assistance regarding the policies and procedures. The Area Director of Operations said the administrators were responsible for the facility and that is why when one administrator left an interim was put in place. The Area Director of Operations said she did not provide oversight for the facility that was the administrators responsibility because she had 10 other facilities, she was over. The Area Director of Operations said she made sure the facilities were in the green and monitored their spending to help them reach their financial goals. During an interview on 02/28/2024 at 9:24 PM, the Medical Director said there had been at least 5 administrators and half a dozen DONs and several ADONs in the past year. The Medical Director said there was no consistency, and the staff were unfamiliar with the residents and left often, which resulted in difficulty maintaining staff stability. The Medical Director said resident to resident altercations were a regular situation on the secured unit and was directly related to lack of supervision. The Medical Director said the residents should never have been left unsupervised. The Medical Director said the issue with the resident-to-resident altercations was staffing, and the facility being understaffed. The Medical Director said he had expressed his concerns regarding staffing to upper management. The Medical Director said amongst all the changes in administrators and DONs he did not know who was supposed to be keeping the facility together to prevent system failures, but he knew the Area Director of Operations was one of the major decision makers. The Medical Director said one evening he had been in to assess Resident #57, and he had noticed Resident #57 had 2 spots on her skin as if somebody had grabbed her strong and a very large skin tear on her body. The Medical Director said he told the staff those were traction marks as if somebody had been holding her too tight. The Medical Director said he had told the staff they might have to use the Hoyer lift to transfer her. The Medical Director said the incident happened earlier in February 2024 . During an interview on 03/01/2024 at 1:22 PM, the Administrator said he expected bruises to be automatically reported to him, and if not to him directly to the DON or nursing supervisor and they would report it to him. The Administrator said when he was notified of an injury of unknown injury, he would investigate it and report it within the 2 hours. The Administrator said he had not had a chance to look for Resident #44's soft file in his office (the soft file was never provided exit date 03/02/2024). The Administrator said they reviewed incidents and accidents every morning in the morning meetings and care plan the issues. The Administrator said if there was an injury of unknown origin, they should look at the last skin assessment to try to piece together a timeline, staff would be interviewed, the resident would be interviewed, if able to be interviewed. The Administrator said he expected the staff to call him and report to him any abuse concerns no matter the time of day. The Administrator said in his absence the staff should report to the DON, and the DON should report it per the requirements to HHSC and to him . (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/01/2024 at 1:50 PM, the DON said she had started at the facility on January 13, 2024. The DON said if the nurses found a new bruise, she expected them to notify the Administrator or herself, so it could be reported to HHSC within 2 hours and investigated. The DON said the staff should report abuse to the abuse coordinator, the Administrator, and in his absence to her. During an interview on 03/02/2024 at 10:04 AM, Resident #52 said he did not remember his roommate (Resident #47) yelling and cursing at him. During an interview on 03/02/2024 at 5:36 PM, ADON E said she had been employed at the facility for 3 years, but she had been out for several months for medical reasons. ADON E said she had told LVN C to edit her note regarding notifying the DON about Resident #47 cursing at Resident #52 because the DON had denied LVN C notifying her about the incident. ADON E proceeded to say they called her and told her to tell LVN C to change her documentation. ADON E said she often gets called and instructed to tell the nurses to edit their documentation. ADON E said she could not remember who called her to instruct her to tell the nurses to edit their documentation. 6) Record review of a face sheet dated 03/02/2024 indicated Resident #179 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis of all four limbs, and the trunk of the body), congenital insufficiency of aortic valve (heart defect that prevents blood from flowing backward through the heart), neuromuscular dysfunction of the bladder (condition where a person lacks bladder control due to brain, spinal cord, or nerve problems), major depressive disorder recurrent (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks), and anxiety disorder. Record review of the Comprehensive MDS assessment dated [DATE], indicated Resident #179's speech was unclear, was sometimes able to make himself understood, and understood others. The MDS assessment indicated Resident #179 had a BIMS score of 12 which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #179 was dependent on staff for all ADLs. Record review of the care plan last revised 02/23/2024 indicated Resident #179 had quadriplegia to assist with ADLs and locomotion as required. During an observation and interview on 02/26/2024 at 10:46 AM, Resident #179 said he did not like it at night. Resident #179 said CNA B was mean to him, and she throws me around with the sheet. He said CNA B ignored his call light and did not provide incontinent care. Resident #179 became very emotional and started crying because he said CNA B said she was not going to take care of him, and he had to wait to be changed until 6 AM the next morning. Resident #179 said he was not able to remember the exact day of the incident, but he had told the DON one night she had worked on the floor. Resident #179 said the DON told him she would handle it, but she never returned to tell him how she handled it. Resident #179 said CNA B was still supposed to provide care for him, but she refused to provide care to him. Resident #179 remained tearful throughout the rest of the interview. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 02/26/2024 at 12:22 PM, the DON said she had worked on the floor on the night shift to help the CNAs provide ADL care (the DON did not specify the date). The DON said no residents had reported to her any abuse allegations. The DON said if a resident reported an abuse allegation to her, she would start and investigation, fill out a grievance, and notify the abuse coordinator, the AIT, immediately, and call the Social Worker. The DON said she had talked to Resident #179, and he was a bit hard to understand, but he had not notified her of any abuse or neglect allegations. The DON said no residents had complained about CNA B to her. The DON said Resident #179 could have reported the abuse to another staff member. During an interview on 02/27/2024 at 10:35 AM, CNA B said she had been employed at the facility since October 2022, and she worked the night shift. CNA B said she provided care to Resident #179. CNA B said she answered Resident #179's call light and denied any abuse towards Resident #179 . CNA B said there were times when she was not able to provide the care required to the residents because the facility was short-handed. CNA B said sometimes from 6 PM-10PM the facility only had 2 CNAs. CNA B said Resident #179 was needy. CNA B said Resident #179 was very needy, and he required 2 staff assist with his ADLs. CNA B said she could do what he asked her to do and ask him if he was satisfied, and when she walked out, he would turn his call light on. CNA B repeated that Resident #179 was very needy, and she would have to tell him that she had other people to take care of and he would say ok. During an observation and interview on 02/27/2024 at 4:40 PM, CNA EE and SNA O were in Resident #179's room. Upon entering room, surveyor noticed Resident #179 was crying uncontrollably and emotionally distraught. CNA EE and SNA O were attempting to reassure and comfort Resident #179. CNA EE said Resident #179 was crying because he did not want them to leave for the day (referring to the 6 AM-6PM shift) because the night shift would not turn him or answer his call light. Resident #179 started crying even more and said CNA OO had called him a rat for telling on CNA B, took his call light away, and told him nobody wanted to answer his call light the previous night (02/26/24). Resident #179 had not reported the incident to any other facility staff . During an interview on 03/02/2024 at 10:43 AM, CNA OO said Resident #179 was a high-risk care because he was a 2-person total assist with mobility and his ADLs. CNA OO said she had never had any issues with him, and she had not taken his call light away. CNA OO said generally when she went into Resident #179's room there was another staff member with her. CNA OO said she had not called Resident #179 a rat . 7)Record review of Resident #36's face sheet dated 02/27/2024, indicate Resident # 36 was a [AGE] year-old female admitted to the facility on [DATE], with a diagnosis which include Metabolic Encephalopathy (a problem in the brain), morbid severe obesity due to excess calories (BMI greater than 40, a BMI of greater than 35 with at least one serious obesity-related condition, or being more than 100 pounds over your recommended weight), abnormal posture (rigid body movements and chronic abnormal positions of the body), muscle weakness (commonly due to lack of exercise, aging, muscle injury) chronic obstructive pulmonary disease (disease that causes airflow blockage and breathing-related problems). Bipolar disorder, current episode depressed, severe, without psychotic features (depressed, as in severe depressive episode without psychotic symptoms, and has had at least one authenticated hypomanic, manic, or mixed affective episode in the past). (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident # 36's Quarterly MDS assessment dated [DATE], indicated Resident #36 was understood and was able to understand others. The MDS assessment indicated Resident #36 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #36 had no delusions or hallucinations. The MDS assessment indicated Resident #36 had no physical, verbal, or other behavioral symptoms directed toward others. Record review of Resident #36's a care plan dated 02/26/2024, indicated Resident #36 has a behavior problem: will request certain services and tasks then refuse or state it was not offered. (Showers, therapy, meal preferences). Record review of Resident #36's progress notes dated 02/27/2024, revealed no documented incidents regarding Resident #36's allegations with CNA B. During an interview on 02/26/2024 at 10:23 AM, Resident # 36 stated CNA came into her room with an attitude. Resident #36 stated she asked the CNA if she was having a bad day and the CNA said do not worry about me. Resident #36 stated she said then do not worry about me either. Resident #36 stated the CNA said well fuck you		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review, the facility failed to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, and misappropriation of resident property and establish policies and procedures to report and investigate such allegations for 8 of 11 residents (Resident #'s 44, 55, 41, 47, 52, 179, 57 and 36) reviewed for abuse and neglect. The facility failed to report and investigate when Resident #44 was found to have a large purple bruise to her inner thigh and a fractured hip. The facility failed to ensure Resident #44 was protected from Resident #41 after a resident to resident assault allegation resulting in Resident # 44 being sent to a local emergency room . Resident #44 was assessed with a head contusion (bruise) and a hematoma (a collection of blood outside of the vessel). when she was left alone with her alleged assailant Resident #41. The facility failed to ensure Resident #55 was protected by not leaving him alone with Resident #41 after Resident #41 allegedly assaulted Resident #44. The facility failed to ensure Resident #179 was not verbally and physically abused by CNA B. The facility failed to ensure Resident #179 was not suffering on-going neglect abuse by CNA B of not performing incontinent care and not responding to his call light. The facility failed to ensure Resident #36 was not verbally abused when cursed by CNA B. The facility failed to ensure the DON reported physical and verbal abuse and neglect to the abuse coordinator after Resident #179 reported it to her in February 2024. The facility failed to ensure the DON reported abuse to HHSC, after LVN C reported abuse to her on 02/19/2024. The facility failed to ensure Resident #52 was not cursed at and not allowed in his room by Resident #47 who had a history of verbal abuse. The facility failed to report to the state agency when Resident #57 had shearing, hematoma, bruising, and a skin tear. An IJ was identified on 3/01/2024. The IJ template was provided to the facility on [DATE] at 11:05 a.m. While the IJ was removed on 3/01/2024, the facility remained out of compliance due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Brentwood Terrace Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 Stillhouse Road Paris, TX 75460	
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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's policy dated 03/29/2018, titled, Abuse/Neglect, indicated, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation . Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members, or legal guardians, friends, or other individuals . Verbal Abuse: Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability . Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again, etc . 5. Physical Abuse: Includes, hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. Abuse as defined in 40 TAC 19.101 (1). 6. Mental Abuse: Includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Abuse as defined in 40 TAC 19.101(1). 7. Neglect: is the failure of the facility. its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . 12. Injury of Unknown Source any injury to a resident where: o The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and o The injury is suspicious because of the extent of the injury or the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time . The facility will take necessary measures to protect residents and employees from harm during and following an abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property investigation . Resident to Resident the above policy will apply to potential resident-to-resident abuse . 1) Record review of a face sheet dated 2/27/2024 indicated Resident #44 was an [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia (memory loss), muscle weakness, reduced mobility, anxiety disorder. Record review of a Significant Change MDS dated [DATE] indicated Resident #44 was sometimes understood and usually understands others. The MDS indicated Resident #44 was unable to complete her BIMS exam due to her cognition. The MDS indicated Resident #44 had inattention and disorganized thinking being continuously present. The MDS indicated Resident #44 had no behavioral symptoms but wandered 1-3 days during the assessment period. The MDS indicated Resident #44 required extensive assistance of two staff for transfers, and extensive assistance of one staff member for bed mobility, and locomotion on and off the unit. The MDS indicated Resident #44 had a history of falls with fractures within the last 6 months. Record review of the comprehensive care plan dated 12/13/2023 and updated on 1/07/2024 indicated Resident #44 was at risk to fall related to unsteady gait/balance, generalized weakness, and poor safety awareness. The care plan indicated Resident #44 was at risk to wander related to a history of attempts to leave the facility related to poor safety awareness and resides on the secured unit. Record review of a Weekly Skin assessment dated [DATE] and documented by LVN CCC, indicated Resident #44's skin was normal with no bruising. The note indicated Resident #44's had a surgical incision to the right hip with staples and Steri-strips (tape like strips) in place with no drainage and no signs of infection. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a Fall Nurses Note dated 6/12/2023 and documented by LVN YY indicated Resident #44 had a fall with a bump on the right side of her head. Record review of a Weekly Skin assessment dated [DATE] documented by LVN DDD, indicated Resident #44's skin was normal with no bruising. Record review of a SBAR note dated 6/18/2024 documented by LVN YY indicated Resident #44 had swelling and pain to the right hip replacement. The note indicated Resident #44 was ordered a mild pain reliever and an x-ray to the right hip. Record review of a right hip x-ray dated 6/19/2023 indicated Resident #44's prosthetic right femoral head (hip joint) was in proper alignment. Resident #44's x-ray revealed there were no fractures or acute dislocation. The x-ray indicated Resident #44's prosthesis was properly situated without any loosening. The x-ray conclusion indicated the right hip arthroplasty (joint restoration) was intact. Record review of a progress note dated 6/21/2023 at 6:15 a.m., LVN YY documented Resident #44 had a bruise to the inner thigh on the right leg measuring 17 centimeters x approximately 11 centimeters with pain but no pain level was documented. LVN YY noted she administered a mild pain reliever to Resident #44 . Record review of an Event Nurses' note dated 6/21/2023 at 6:15 a.m., LVN YY documented a bruise was found to Resident #44's right inner thigh measuring 17 centimeters x approximately 11 centimeters. The note indicated Resident #44's bruise was blue/purple and painful. LVN YY documented Resident #44 could not provide a statement related to her cognitive impairment. LVN YY said previous factors included previous falls. Record review of an incident note dated 6/21/2023 documented by LVN YY indicated Resident #44 had a large purple bruise on her inner right thigh (front) measuring 17 centimeters x approximately 11 centimeters. LVNYY said Resident #44 was unable to state what had happened. LVN YY documented there were no predisposing environmental factors, and the predisposing physiological factor was Resident #44 had memory impairment. Record review of a Weekly Skin assessment dated [DATE] indicated Resident #44 skin color was normal, temperature was normal, with a large purple bruise to the right inner thigh with a firm center with bruising to her knee. Record review of a Consultation note dated 6/21/2023 indicated the orthopedic physician documented he knew Resident #44. The physician said he had treated her femoral neck fracture (connects the hip ball to the femur bone) a month previous. The physician wrote he had seen Resident #44 a week ago and the x-rays showed a well-fitted well-fixed bipolar hip. The physician wrote he had plans to surgically repair Resident #44's right hip by removing the prosthesis, wire her with cables then reimplant the prosthesis and then put a plate and screws with wires and screws around the periprosthetic fracture. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 2/29/2024 at 11:42 a.m., LVN YY said she was notified of Resident #44's by CNA K. LVN YY said she assessed and measured the bruising and notified the physician, family, DON, and Administrator (previous). LVN YY said she was unsure how Resident #44 sustained the bruise and unsure why no one else had seen the bruise. LVN YY said reporting to the DON and Administrator was the policy of the facility. During an interview on 2/29/2024 at 3:22 p.m., CNA K said she had found the bruising to Resident #44's right leg and reported to LVN YY. CNA K said while she was providing incontinent care for Resident #44, she moved the pillow between Resident #44's legs when she found a large purple bruise. During an interview on 2/29/2023 at 3:40 p.m., the DON said she was not the DON during the incident on 6/21/2023 with Resident #44 but she indicated she would have investigated and report the bruising. During an interview on 03/01/2024 at 8:52 AM, previous Administrator ZZ said she always did an investigation when something was reported to her but depending on her investigation if she reported. Administrator ZZ said if she had not reported the incident with Resident #44's bruising/hip fracture it had to be for a reason. Administrator ZZ said she did not remember the specifics off the top of her head, and she kept a soft file in the administrator's office with her investigations. Administrator ZZ said a bruise that was not correlated with an incident was considered an injury of unknown injury and should be reported within 2 hours of finding it or being notified. During an interview on 03/01/2024 at 1:22 PM, the Administrator said he expected bruises to be automatically reported to him, and if not to him directly to the DON or nursing supervisor and they would report it to him. The Administrator said when he was notified of an injury of unknown injury, he would investigate it and report it within the 2 hours. The Administrator said he had not had a chance to look for Resident #44's soft file in his office (the soft file was never provided prior to the exit date of 03/02/2024). The Administrator said they reviewed incidents and accidents every morning in the morning meetings and care plan the issues. The Administrator said if there was an injury of unknown origin, they should look at the last skin assessment to try to piece together a timeline, staff would be interviewed, the resident would be interviewed, if able to be interviewed. The Administrator said he expected the staff to call him and report to him any abuse concerns no matter the time of day. The Administrator said in his absence the staff should report to the DON, and the DON should report it per the requirements to HHSC and to him. 2)Record review of the of an Event Nurses' note dated 2/25/2024 at 6:30 p.m., indicated LVN D documented she was called to Resident #55's room. LVN D documented Resident #44 was lying on the floor beside the closet door on the floor on her back with Resident #41 standing over her. LVN D documented Resident #55 had an abrasion to her right temple area with bruising to her right inner arm. LVN D documented Resident #44 was unable to state what had happened but Resident #55 said Resident #41 pushed Resident #44 against the closet door. The event note indicated LVN D sent Resident #44 to the local hospital. Record review of a progress note dated 2/25/2024 at 7:30 p.m., LVN D wrote she was called to another resident room where she found Resident #44 on the floor bedside the closet door on her back with Resident #41 standing over her, and Resident #55 stated Resident #41 pushed Resident #44 against the closet door. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a Fall-Risk assessment dated [DATE] documented by LVN D indicated Resident #44 had intermittent confusion, no falls in the past 3 months, was ambulatory, and was incontinent. LVN D documented Resident #44 had a balance problem while standing, balance problem while walking, decreased muscular coordination, and change in her gait pattern when walking through a doorway. Record review of a hospital Emergency Department History of Present Illness indicated Resident #44 was sent to the local emergency roignom on [DATE] with the chief complaint as assault. The note written by the physician indicated Resident #44 assessment revealed a head contusion (bruise) and a hematoma (a collection of blood outside of the vessel). The note indicated in the review of systems Resident #44 had a headache. The physical examination documented indicated Resident #44 was moderately distressed, had ecchymosis (bruising caused by injury), swelling, and tenderness to the right side of her head. Record review of a CT Head without Intravenous Contrast dated 2/25/2024 indicated Resident #44's CT impression indicated she had a right parietal scalp hematoma (A scalp hematoma is a collection of blood (either flowing or clotted from ruptured blood vessels that will then collect in the area of space and tissue between the skull and skin). Record review of the of an Event Nurses' note dated 2/25/2024 at 6:30 p.m., indicated LVN D documented she was called to Resident #55's room. LVN D documented Resident #44 was lying on the floor beside the closet door on the floor on her back with Resident #41 standing over her. LVN D documented Resident #55 had an abrasion to her right temple area with bruising to her right inner arm. LVN D documented Resident #44 was unable to state what had happened but Resident #55 said Resident #41 pushed Resident #44 against the closet door. The event note indicated LVN D sent Resident #44 to the local hospital Record review of a progress note dated 2/25/2024 at 7:30 p.m., LVN D wrote she was called to another resident room where she found Resident #44 was found on the floor bedside the closet door on her back with Resident #44 standing over her, and Resident #55 stated Resident #41 pushed Resident #44 against the closet door. Record review of a Fall-Risk assessment dated [DATE] documented by LVN D indicated Resident #44 had intermittent confusion, no falls in the past 3 months, was ambulatory, and was incontinent. LVN D documented Resident #44 had a balance problem while standing, balance problem while walking, decreased muscular coordination, and change in her gait pattern when walking through a doorway. Record review of a hospital Emergency Department History of Present Illness indicated Resident #44 was sent to the local emergency roignom on [DATE] with the chief complaint as assault. The note written by the physician indicated Resident #44 assessment revealed a head contusion (bruise) and a hematoma (a collection of blood outside of the vessel). The note indicated in the review of systems Resident #44 had a headache. The physical examination document indicated Resident #44 was moderately distressed, had ecchymosis (bruising caused by injury), swelling, and tenderness to the right side of her head. Record review of a CT Head without Intravenous Contrast dated 2/25/2024 indicated Resident #44's CT impression indicated she had a right parietal scalp hematoma (A scalp hematoma is a collection of blood (either flowing or clotted from ruptured blood vessels that will then collect in space and tissue between the skull and skin). (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3)Record review of a face sheet dated 3/2/2024 indicated Resident #41 was an [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia with behavioral disturbances, the need for continuous supervision, and high blood pressure. Record review of a Significant Change MDS dated [DATE] indicated Resident #41 was usually understood and sometimes understands. The MDS indicated Resident #41's cognition was severely impaired. The MDS indicated Resident #41 had no physical, or verbal behaviors exhibited. The MDS indicated Resident #41 wandered daily. Record review of the comprehensive care plan dated 8/08/2023 and revised on 9/08/2023 indicated Resident #41 was at risk for mood problems and received medications. The goal of the care plan indicated Resident #41 would have an improved mood state. The care plan interventions included administer medications, behavioral health consults as needed, monitor and record mood to determine if problems seem to be related to external causes. Record review of a progress note dated 2/25/2024 at 6:00 p.m., LVN D documented she was called to a resident room by CNA A. LVN D documented Resident #41 was in Resident #55's room where she found Resident #44 on the floor beside the closet door. LVN D documented Resident #41 was standing over Resident #44. LVN D documented she asked Resident #41 and Resident #44 what had occurred, and neither could explain. LVN D documented Resident #55 said Resident #41 pushed Resident #44 against the closet door and she fell . LVN D documented Resident #41 was very uncooperative and had tried to hit CNA A and Resident #55. Record review of Behavior Nurses Note dated 2/25/2023 at 6:30 p., LVN D documented she was called to the secured unit by the nurse aide. LVN D documented Resident #41 was in Resident #55's room. LVN D documented she found Resident #44 on the floor lying beside the closet door. LVN D documented Resident #41 was standing over Resident #44. LVN D documented Resident #55 said he pushed her up against the closet door and she fell . LVN D said Resident #41 and #44 was unable to indicate what had happened. LVN D said Resident #44 was very uncooperative and had tried to the hit the CNA on duty and Resident #55. Record review of an Event Nurses' note dated 2/25/2024 at 6:30 p.m., indicated LVN D documented Resident #41 was found in another resident room. LVN D documented Resident #41 had displayed physical, and resident to resident behaviors with another resident injured. The Event Nurses' note indicated LVN D moved Resident #41's room and initiated every 15-minute checks. Record review of a Every 15 Minute Check sheet indicated Resident #41 was placed on every 15-minute checks starting on 2/25/2024 at 6:30 p.m. The Every 15- minute checks at 0015 indicated LVN D documented at 12:15 a.m., Resident #44 was asleep. LVN D had only her initials beside the other every 15-minute checks starting at 12:30 a.m. -5:45 a.m. on 2/26/2024 there was no remarks indicating anything in regarding Resident #44. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 2/26/2024 at 9:32 p.m., CNA A said she was alone on the secured unit gathering her supplies in the spa/communal shower room when she heard a loud scream. CNA A said she ran out of the spa room and ran toward the end of the hall where she believed the sound was heard from. CNA A said upon entering the room, Resident #44 was lying in the floor, Resident #55 said Resident #41 had thrown Resident #44 into the door. CNA A said Resident #41 was aggressive with her at the time and tried to swing at her. CNA A said she left Resident #55's room and ran the length of the secured unit, opened the door, and yelled for help. CNA A said she was alone on the secured unit and had no other recourse than to go for help. CNA A said LVN D was passing medications and another nurse responded to her call for help. During an interview on 2/26/2024 at 11:46 a.m., the DON said on 2/25/2024 CNA A heard a noise and responded to the noise. The DON said LVN D called and said Resident #41 was upset and wandering in other rooms. The DON said CNA A had said Resident #44 was on the floor. The DON said she was unsure of Resident #44 hitting her head although she had an abrasion to her head. The DON said Resident #44 was sent to the emergency room closer to midnight due to complaining her head was hurting. During an interview on 2/26/2024 at 11:51 a.m., LVN D said she was called to the unit by CNA A. LVN D said Resident #44 was lying in the floor of Resident #55's room, with Resident #41 standing over Resident #44 around 6:30 p.m. on 2/25/2024. LVN D said Resident #55 said Resident #41 pushed Resident #44 against the closet and Resident #41 fell. LVN D said at the time of the incident Resident #44 had an abrasion to her right temple area and a bruise to her inner right arm. LVN D said Resident #41 was very uncooperative and attempted to hit others. LVN D said she was advised to place Resident #41 on every 15-minute checks by the DON. LVN D said although her documentation was not completed yet Resident #41 remained asleep. LVN D said CNA A had to leave Resident #44 to come for help. LVN D said she was not on the secured unit but was on hall 400 when the incident occurred. During an observation and interview on 2/27/2024 at 9:00 a.m., Resident #44 was sitting at the dining table with a large size raised area with bruising noted to her right side of her head in the temporal/parietal region. Resident #44 said she felt well but she denied having her head hurt. 4) Record review of a face sheet dated 3/02/2024 indicated Resident #55 was a [AGE] year-old male who admitted on [DATE] with the diagnoses of stroke, high blood pressure, and dementia (memory loss). Record review of the Annual MDS dated [DATE] indicated Resident #55 was usually understood, and usually understands. The MDS indicated Resident #55 had severe cognitive impairment. The MDS indicated Resident #55 had not displayed any verbal or physical behaviors. During an observation on 2/25/2024 at 9:31 a.m., Resident #41 was lying in his bed asleep. During an interview on 2/26/2024 at 10:54 a.m., LVN F said Resident #44 was discharged to the hospital and Resident #41 was on every 15-minute checks for aggressive behaviors. LVN F said after she reviewed Resident #44's electronic medical record and said there was not a progress note, a SBAR (situation, background, assessment, recommendation) note, a transfer note, or an incident report. LVN F said the electronic medical record should have had those assessments completed. During an observation and interview on 2/26/2024 at 12:42 p.m., Resident #55 was sitting at the dining table and was unable to recall the incident in his room last night. (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5)Record review of the face sheet, dated 02/29/2024, revealed Resident #47 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of sepsis (an infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever), metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), and altered mental status (broad term used to indicate an abnormal state of alertness or awareness). Record review of the significant change MDS assessment, dated 12/20/2023, revealed Resident #47 had clear speech and was usually understood by others. The MDS revealed Resident #47 was sometimes able to understand others. The MDS revealed Resident #47 had short-term and long-term memory problems. The MDS revealed Resident #47 was not able to recall the current season, the location of his room, staff names or faces, and that he was in a nursing facility. The MDS revealed Resident #47 had severely impaired decision-making skills. The MDS revealed Resident #47 had continuous inattention and disorganized thinking. The MDS revealed Resident #47 had no behaviors or refusal of care. Record review of the comprehensive care plan, revised on 02/21/2024, revealed Resident #47 had potential to demonstrate verbally abuse behaviors. The interventions included: analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document .assess resident's coping skills and support system .evaluate for side effects of medications .notify the charge nurse of any abusive behaviors . provide positive feedback for good behavior, emphasize the positive aspects of compliance . psychiatric/psychogeriatric consult as indicated. Record review of the nursing progress note on 02/19/2024 at 12:20 AM, revealed Resident #47 was repeated yelling at his roommate [Resident #52] You son-of-a-bitch get out of my room! The nursing progress note further revealed the DON was notified immediately and told LVN C to notify the Medical Director because there was no abuse coordinator at the facility. The progress note revealed the Medical Director was notified and Resident #47 was placed in a different room. 6) Record review of a face sheet dated 03/02/2024 indicated Resident #52 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia, unspecified severity, with other behavioral disturbance (deterioration of memory, language, and other thinking abilities with behaviors) , anxiety disorder, and depression. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #52 was usually able to understand others and was usually understood by others. The MDS assessment indicated Resident #52 had a BIMS score of 5, which indicated his cognition was severely impaired. The MDS assessment indicated Resident #52 had no physical, verbal, or other behaviors directed toward others. The MDS assessment indicated Resident #52 required setup or cleanup assistance with eating, supervision for oral, toileting, and personal hygiene, and partial to moderate assistance with showering and dressing. Record review of Resident #52's care plan last revised 02/02/2024 indicated Resident #52 had impaired cognitive function/dementia or impaired thought processes. Record review of Resident #52's progress notes indicated: (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o 02/19/2024 12:20 AM Resident #52 was very forgetful and usually confused. He was pacing, wandering, and coming in and out of his room. This resident was redirected numerous times back to his room and to bed. The last time resident was redirected back to his room, his roommate was cursing, repeatedly telling this resident, You son-of-a-bitch get out of my room! Which explained why Resident #52 would not stay in his room. CNA remained in the room with both residents until the DON and doctor were notified. DON notified immediately and stated to call the Medical Director. 12:35 AM both residents were separated with the roommate moved to another room. o Strike out note dated 2/23/2024, effective date for the note prior to strike out 02/19/2024 created by LVN C indicated, 12:20 AM the DON stated they did not have an abuse coordinator at the time, that their new administrator was supposed to start work that day (02/19/24). The DON stated to call the Medical Director and report it to him. During an observation and attempted interview on 02/23/2024 at 3:48 PM Resident #52 was observed walking down the hall with his rollator (walker with wheels). Resident #52 did not want to be interviewed at the time. During an interview on 02/26/2024 at 9:07 PM, LVN C said Resident #52 kept getting up and coming out of his room, and she kept telling him to go back to his room because it was in the middle of the night. LVN C said she finally decided to take him back to his room, and that was when she realized Resident #52's roommate, Resident #47, was yelling and cursing at Resident #52 to get out of the room and calling him a son of a bitch'. LVN C said this was really confusing Resident #52. LVN C said she called the DON, who was the abuse coordinator at the time, and she told her to keep them separated. LVN C said she called the Medical Director, and he told her to separate them and place them in 2 different rooms. Regarding the struck out note about the incident, LVN C said when she called the DON, she did not know the DON was the abuse coordinator. LVN C said the DON told her they currently did not have an abuse coordinator, but the new administrator was starting that day to notify the Medical Director. LVN C said she learned the DON was the abuse coordinator after talking to the DON on the phone. LVN C said one of her co-workers informed her if there was no administrator it automatically fell on the DON to be the abuse coordinator. LVN C said ADON E instructed her to correct her note to show that she did call the DON immediately. LVN C said after notifying the DON of the incident the night it occurred, the DON never talk to her about the incident again. LVN C said there had been a lot of changes in administrators and administration and they were not providing education on who was the abuse coordinator. LVN C said in the past she had called to report other incidents of abuse to who she thought was the abuse coordinator for them to tell her they were no longer employed at the facility. During an interview on 02/27/2024 at 8:46 AM, the DON said she was not able to recall any incident with Resident #47 and Resident #52. The DON said she did not remember an incident where Resident #47 cursed out Resident #52. The DON said the staff were supposed to report abuse to the Administrator and herself. The DON said the staff were notified when there were changes in administration one-on-one. The DON denied LVN C calling her to report when Resident #47 cursed at Resident #52. The DON said if the Administrator was not in the facility, she was the abuse coordinator. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Brentwood Terrace Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 Stillhouse Road Paris, TX 75460	
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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 02/28/2024 at 3:33 PM, the Area Director of Operations said she was a consultant for the facility. The Area Director of Operations said she was there as a resource for the facility administration to reach out to her with assistance regarding the policies and procedures. The Area Director of Operations said the administrators were responsible for the facility and that is why when one administrator left an interim was put in place. The Area Director of Operations said she did not provide oversight for the facility that was the administrators responsibility because she had 10 other facilities, she was over. The Area Director of Operations said she made sure the facilities were in the green and monitored their spending to help them reach their financial goals. During an interview on 02/28/2024 at 9:24 PM, the Medical Director said there had been at least 5 administrators and half a dozen DONs and several ADONs in the past year. The Medical Director said there was no consistency, and the staff were unfamiliar with the residents and left often, which resulted in difficulty maintaining staff stability. The Medical Director said resident to resident altercations were a regular situation on the secured unit and was directly related to lack of supervision. The Medical Director said the residents should never have been left unsupervised. The Medical Director said the issue with the resident-to-resident altercations was staffing, and the facility being understaffed. The Medical Director said he had expressed his concerns regarding staffing to upper management. The Medical Director said amongst all the changes in administrators and DONs he did not know who was supposed to be keeping the facility together to prevent system failures, [TRUNCATED]		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source were reported immediately, but no later than 2 hours after the allegation was made, for 5 of 11 residents (Resident #'s 44, 47, 52, 57, 179) reviewed for abuse and neglect reporting. The facility failed to report to the state agency when Resident #44's large bruise and fractured hip were found on 6/21/2024. The facility failed to report to the state agency when Resident #52 was cursed at and not allowed in his room by Resident #47 who had a history of verbal abuse. The DON was notified of this incident and failed to report the abuse. The facility failed to ensure the DON reported the abuse to HHSC within 2 hours, after LVN C reported abuse to her on 02/19/2024. The facility failed to report to the state agency when Resident #57 had shearing, hematoma, bruising, and a skin tear. The facility failed to ensure the DON reported physical and verbal abuse and neglect to the abuse coordinator immediately after Resident #179 reported it to her in February 2024. These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: 1. Record review of a face sheet dated 2/27/2024 indicated Resident #44 was an [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia (memory loss), muscle weakness, reduced mobility, anxiety disorder. Record review of a Significant Change MDS dated [DATE] indicated Resident #44 was sometimes understood and usually understands others. The MDS indicated Resident #44 was unable to complete her BIMS exam due to her cognition. The MDS indicated Resident #44 had inattention and disorganized thinking being continuously present. The MDS indicated Resident #44 had no behavioral symptoms but wandered 1-3 days during the assessment period. The MDS indicated Resident #44 required extensive assistance of two staff for transfers, and extensive assistance of one staff member for bed mobility, and locomotion on and off the unit. The MDS indicated Resident #44 had a history of falls with fractures within the last 6 months. Record review of the comprehensive care plan dated 12/13/2023 and updated on 1/07/2024 indicated Resident #44 was at risk to fall related to unsteady gait/balance, generalized weakness, and poor safety awareness. The care plan indicated Resident #44 was at risk to wander related to a history of attempts to leave the facility related to poor safety awareness and resides on the secured unit. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Weekly Skin assessment dated [DATE] and documented by LVN CCC, indicated Resident #44's skin was normal with no bruising. The note indicated Resident #44's had a surgical incision to the right hip with staples and steri-strips in place with no drainage and no signs of infection. Record review of a Fall Nurses Note dated 6/12/2023 and documented by LVN YY indicated Resident #44 had a fall with a bump on the right side of her head. Record review of a Weekly Skin assessment dated [DATE] documented by LVN DDD, indicated Resident #44's skin was normal with no bruising. Record review of a SBAR note dated 6/18/2024 documented by LVN YY indicated Resident #44 had swelling and pain to the right hip replacement. The note indicated Resident #44 was ordered a mild pain reliever and an x-ray to the right hip. Record review of a right hip x-ray dated 6/19/2023 indicated Resident #44's prosthetic right femoral head (hip joint) was in proper alignment. Resident #44's x-ray revealed there were no fractures or acute dislocation. The x-ray indicated Resident #44's prosthesis was properly situated without any loosening. The x-ray conclusion indicated the right hip arthroplasty (restoration repair) was intact. Record review of a progress note dated 6/21/2023 at 6:15 a.m., LVN YY documented Resident #44 had a bruise to the inner thigh on the right leg measuring 17 centimeters x approximately 11 centimeters with pain. LVN YY noted she administered a mild pain reliever to Resident #44. Record review of an Event Nurses' note dated 6/21/2023 at 6:15 a.m., LVN YY documented a bruise was found to Resident #44's right inner thigh measuring 17 centimeters x approximately 11 centimeters. The note indicated Resident #44's bruise was blue/purple and painful. LVN YY documented Resident #44 could not provide a statement related to her cognitive impairment. LVN YY said previous factors included previous falls. Record review of an incident note dated 6/21/2023 documented by LVN YY indicated Resident #44 had a large purple bruise on her inner right thigh (front) measuring 17 centimeters x approximately 11 centimeters. LVN YY said Resident #44 was unable to state what had happened. LVN YY documented there were no predisposing environmental factors, and the predisposing physiological factor was Resident #44 had memory impairment. Record review of a Weekly Skin assessment dated [DATE] indicated Resident #44 skin color was normal, temperature was normal, with a large purple bruise to the right inner thigh with a firm center with bruising to her knee. Record review of a Consultation note dated 6/21/2023 indicated the orthopedic physician documented he knew Resident #44. The physician said he had treated her femoral neck fracture a month previous. The physician wrote he had seen Resident #44 a week ago and the x-rays showed a well-fitted well-fixed bipolar hip. The physician wrote he had plans to surgically repair Resident #44's right hip by removing the prosthesis, wire her with cables then reimplant the prosthesis and then put a plate and screws with wires and screws around the periprosthetic fracture. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/29/2024 at 11:42 a.m., LVN YY said she was notified of Resident #44's by CNA K. LVN YY said she assessed and measured the bruising and notified the physician, family, DON, and Administrator (previous). LVN YY said she was unsure how Resident #44 sustained the bruise and unsure why no one else had seen the bruise. During an interview on 2/29/2024 at 3:22 p.m., CNA K said she had found the bruising to Resident #44's right leg and reported to LVN YY. CNA K said while she was providing incontinent care for Resident #44, she moved the pillow between Resident #44's legs when she found a large purple bruise. During an interview on 2/29/2023 at 3:40 p.m., the DON said she was not the DON during the incident on 6/21/2023 with Resident #44 but she indicated she would have investigated and report the bruising to the state agency within the two-hour window. During an interview on 03/01/2024 at 8:52 AM, previous Administrator ZZ said she always did an investigation when something was reported to her but depending on her investigation if she reported. Administrator ZZ said if she had not reported the incident with Resident #44's bruising/hip fracture it had to be for a reason. Administrator ZZ said she did not remember the specifics off the top of her head, and she kept a soft file in the administrator's office with her investigations . Administrator ZZ said a bruise that was not correlated with an incident was considered an injury of unknown injury and should be reported within 2 hours of finding it or being notified. 2) Record review of the face sheet, dated 02/29/2024, revealed Resident #47 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of sepsis (an infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever), metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), and altered mental status (broad term used to indicate an abnormal state of alertness or awareness). Record review of the significant change MDS assessment, dated 12/20/2023, revealed Resident #47 had clear speech and was usually understood by others. The MDS revealed Resident #47 was sometimes able to understand others. The MDS revealed Resident #47 had short-term and long-term memory problems. The MDS revealed Resident #47 was not able to recall the current season, the location of his room, staff names or faces, and that he was in a nursing facility. The MDS revealed Resident #47 had severely impaired decision-making skills. The MDS revealed Resident #47 had continuous inattention and disorganized thinking. The MDS revealed Resident #47 had no behaviors or refusal of care. Record review of the comprehensive care plan, revised on 02/21/2024, revealed Resident #47 had potential to demonstrate verbally abuse behaviors. The interventions included: analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document .assess resident's coping skills and support system .evaluate for side effects of medications .notify the charge nurse of any abusive behaviors . provide positive feedback for good behavior, emphasize the positive aspects of compliance . psychiatric/psychogeriatric consult as indicated. Record review of the nursing progress note on 02/19/2024 at 12:20 AM, revealed Resident #47 was repeatedly yelling at his roommate [Resident #52] You son-of-a-bitch get out of my room! The nursing progress note further revealed the DON was notified immediately and told LVN C to notify the Medical Director because there was no abuse coordinator at the facility. The progress note revealed the Medical Director was notified and Resident #47 was placed in a different room. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Record review of Resident #57's face sheet dated 02/29/24, indicated an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included heart failure (progressive heart disease that affects pumping action of the heart muscles), atrial fibrillation (abnormal heart rhythm), weakness, protein-calorie malnutrition (not consuming enough protein or calories), and anxiety. Record review of Resident #57's comprehensive care plan dated 12/28/2023 and revised on 02/22/2024, indicated Resident #57 had a bruise with interventions to attempt to determine the cause of bruising, if known attempt to alleviate that factor. The care plan indicated Resident #57 had a skin tear, laceration, or abrasion with interventions to assess reason for skin injury occurrence, notify staff of cause and determine measures to prevent further skin injuries. The care plan indicated Resident #57 was on anticoagulant therapy for atrial fibrillation and to report any bruising to the charge nurse immediately. Record review of Resident #57's progress note dated 02/05/24 at 9:58 PM and signed by ADON E indicated MD (medical director) visit to resident room and assessment of resident, with MD requesting myself and DON to resident's room for skin assessment findings. Resident noted to have area to right upper arm appearing to be shearing with hematoma (blood filled swelling) pooling at posterior upper arm measuring 22 cm x 19 cm and a 1 cm x 6 cm skin tear to right, anterior upper arm. Telfa (clear wound dressing) nonadherent dressing with wrap in place noted. Multiple areas of discoloration to the upper back and one noted to the upper, center chest. Blanchable reddened areas to inner thighs bilateral from the brief. New orders for zinc oxide to bilateral arms, upper back, peri area, and any reddened areas for skin integrity. Ace bandage wraps to bilateral legs beginning above toes and extending above knees for compression to lessen edema. CNA documentation notes skin discoloration areas. A new order from MD was received for a left arm x-ray and change ABT to begin in a.m. Record review of Resident #57's weekly skin assessment dated [DATE] at 09:40 PM, indicated Resident #57 had no bruising. The skin assessment indicated Resident #57 had a skin tear to left arm measuring 11.4 cm x 8.0 cm. The skin assessment did not indicate the new shearing with hematoma measuring 22 cm x 19 cm, 1 cm x 6 cm skin tear to right upper arm, reddened areas to inner thighs, or discolorations to upper back and center chest found on Resident #57 at 09:58 PM that night. Record review of Resident #57's quarterly MDS assessment dated [DATE], indicated Resident #57 was usually understood and usually understood others. The MDS assessment indicated Resident #57 had a BIMS score of 12, which indicated her cognition was moderately impaired. The MDS indicated Resident #57 required partial/moderate assistance with toileting, bathing, dressing, and personal hygiene. Resident #57 required substantial/maximal assistance with chair/bed to chair transfer. The MDS assessment indicated Resident #57 had one venous or arterial ulcers present and skin tears. The MDS assessment indicated Resident #57 received anticoagulant medications within the 7-day look back period. During an interview on 02/28/2024 at 9:24 PM, the Medical Director said one evening he had been in to assess Resident #57, and he had noticed Resident #57 had 2 spots on her skin as if somebody had grabbed her strong and a very large skin tear on her body. The Medical Director said he told the staff those were traction marks as if somebody had been holding her too tight. The Medical Director said he had told the staff they might have to use the Hoyer lift to transfer her. The Medical Director said the incident happened earlier in February 2024. Record review of Resident #57's order summary report dated 02/29/24, indicated Resident #57 had the following orders: (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Apixaban (anticoagulant medication) 2.5mg tablet by mouth twice a day related to atrial fibrillation with an order start date of 12/27/2023. During an interview on 02/29/2024 at 01:08 PM, ADON E said Resident #57's skin was so fragile. ADON E said on February 5, 2024, the MD came and got her because he wanted the DON and herself to look at Resident #57's skin since Resident #57 had different scattered bruising. She said Resident #57's legs were swollen and as a group he wanted them to see what they could do to care for Resident #57. ADON E said at the time of the findings they did not know how Resident #57 had sustained the injuries. ADON E said the bruising, hematoma, shearing, and skin tear were considered injuries of unknown origin and should have had been reported immediately to the Administrator. ADON E said the DON was in Resident #57's room with her and she was the co-abuse coordinator, so she felt she was aware. ADON E said she was unable to recall if she had reported those injuries to the administrator. ADON E said it was important to report injuries of unknown origin immediately and then investigate for resident safety. ADON E said she was unaware if the injuries of unknown origin were reported to the state agency. During an interview on 03/01/2024 at 01:53 PM, the DON said when an injury of unknown origin was found, the facility must notify the state agency and investigate it. The DON said Resident #57 constantly had bruising and said she was unable to recall if the injuries found on 02/05/2024 were a new discovery. The DON said she was unsure of how Resident #57 had sustained them but believed Resident #57 had constant multiple discolored areas due to her condition. The DON said she did not believe the bruising or injuries to Resident #57 were suspicious and were due to her condition so therefore did not believe they should have been reported to the state agency . During an interview on 03/02/24 at 08:50 AM, the Regional Compliance Nurse said Resident #57's injuries should have been reported to the state agency timely when they were found. The Regional Compliance Nurse said it was the responsibility of the Administrator to have reported it to the state agency for Resident #57's safety. 4) Record review of a face sheet dated 03/02/2024 indicated Resident #52 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia, unspecified severity, with other behavioral disturbance (deterioration of memory, language, and other thinking abilities with behaviors) , anxiety disorder, and depression. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #52 was usually able to understand others and was usually understood by others. The MDS assessment indicated Resident #52 had a BIMS score of 5, which indicated his cognition was severely impaired. The MDS assessment indicated Resident #52 had no physical, verbal, or other behaviors directed toward others. The MDS assessment indicated Resident #52 required setup or cleanup assistance with eating, supervision for oral, toileting, and personal hygiene, and partial to moderate assistance with showering and dressing. Record review of Resident #52's care plan last revised 02/02/2024 indicated Resident #52 had impaired cognitive function/dementia or impaired thought processes. Record review of Resident #52's progress notes indicated: (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o 02/19/2024 12:20 AM Resident #52 was very forgetful and usually confused. He was pacing, wandering, and coming in and out of his room. This resident was redirected numerous times back to his room and to bed. The last time resident was redirected back to his room, his roommate was cursing, repeatedly telling this resident, You son-of-a-bitch get out of my room! Which explained why Resident #52 would not stay in his room. CNA remained in the room with both residents until the DON and doctor were notified. DON notified immediately and stated to call the Medical Director. 12:35 AM both residents were separated with the roommate moved to another room. o Strike out note dated 2/23/2024, effective date for the note prior to strike out 02/19/2024 created by LVN C indicated, 12:20 AM the DON stated they did not have an abuse coordinator at the time, that their new administrator was supposed to start work that day (02/19/24). The DON stated to call the Medical Director and report it to him. During an observation and attempted interview on 02/23/2024 at 3:48 PM Resident #52 was observed walking down the hall with his rollator (walker with wheels). Resident #52 did not want to be interviewed at the time. During an interview on 02/26/2024 at 9:07 PM, LVN C said Resident #52 kept getting up and coming out of his room, and she kept telling him to go back to his room because it was in the middle of the night. LVN C said she finally decided to take him back to his room, and that was when she realized Resident #52's roommate, Resident #47, was yelling and cursing at Resident #52 to get out of the room and calling him a son of a bitch'. LVN C said this was really confusing Resident #52. LVN C said she called the DON, who was the abuse coordinator at the time, and she told her to keep them separated. LVN C said she called the Medical Director, and he told her to separate them and place them in 2 different rooms. Regarding the struck out note about the incident, LVN C said when she called the DON, she did not know the DON was the abuse coordinator. LVN C said the DON told her they currently did not have an abuse coordinator, but the new administrator was starting that day to notify the Medical Director. LVN C said she learned the DON was the abuse coordinator after talking to the DON on the phone. LVN C said one of her co-workers informed her if there was no administrator it automatically fell on the DON to be the abuse coordinator. LVN C said ADON E instructed her to correct her note to show that she did call the DON immediately. LVN C said after notifying the DON of the incident the night it occurred, the DON never talk to her about the incident again. LVN C said there had been a lot of changes in administrators and administration and they were not providing education on who was the abuse coordinator. LVN C said in the past she had called to report other incidents of abuse to who she thought was the abuse coordinator for them to tell her they were no longer employed at the facility. During an interview on 02/27/2024 at 8:46 AM, the DON said she was not able to recall any incident with Resident #47 and Resident #52. The DON said she did not remember an incident where Resident #47 cursed out Resident #52. The DON said the staff were supposed to report abuse to the Administrator and herself. The DON said the staff were notified when there were changes in administration one-on-one. The DON denied LVN C calling her to report when Resident #47 cursed at Resident #52. The DON said if the Administrator was not in the facility, she was the abuse coordinator. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/28/2024 at 3:33 PM, the Area Director of Operations said she was a consultant for the facility. The Area Director of Operations said she was there as a resource for the facility administration to reach out to her with assistance regarding the policies and procedures. The Area Director of Operations said the administrators were responsible for the facility and that is why when one administrator left an interim was put in place. The Area Director of Operations said she did not provide oversight for the facility that was the administrators responsibility because she had 10 other facilities, she was over. The Area Director of Operations said she made sure the facilities were in the green and monitored their spending to help them reach their financial goals. During an interview on 02/28/2024 at 9:24 PM, the Medical Director said there had been at least 5 administrators and half a dozen DONs and several ADONs in the past year. The Medical Director said there was no consistency, and the staff were unfamiliar with the residents and left often, which resulted in difficulty maintaining staff stability. The Medical Director said resident to resident altercations were a regular situation on the secured unit and was directly related to lack of supervision. The Medical Director said the residents should never have been left unsupervised. The Medical Director said the issue with the resident-to-resident altercations was staffing, and the facility being understaffed. The Medical Director said he had expressed his concerns regarding staffing to upper management. The Medical Director said amongst all the changes in administrators and DONs he did not know who was supposed to be keeping the facility together to prevent system failures, but he knew the Area Director of Operations was one of the major decision makers. The Medical Director said one evening he had been in to assess Resident #57, and he had noticed Resident #57 had 2 spots on her skin as if somebody had grabbed her strong and a very large skin tear on her body. The Medical Director said he told the staff those were traction marks as if somebody had been holding her too tight. The Medical Director said he had told the staff they might have to use the Hoyer lift to transfer her. The Medical Director said the incident happened earlier in February 2024 . During an interview on 03/01/2024 at 1:22 PM, the Administrator said he expected bruises to be automatically reported to him, and if not to him directly to the DON or nursing supervisor and they would report it to him. The Administrator said when he was notified of an injury of unknown injury, he would investigate it and report it within the 2 hours. The Administrator said he had not had a chance to look for Resident #44's soft file in his office (the soft file was never provided exit date 03/02/2024). The Administrator said they reviewed incidents and accidents every morning in the morning meetings and care plan the issues. The Administrator said if there was an injury of unknown origin, they should look at the last skin assessment to try to piece together a timeline, staff would be interviewed, the resident would be interviewed, if able to be interviewed. The Administrator said he expected the staff to call him and report to him any abuse concerns no matter the time of day. The Administrator said in his absence the staff should report to the DON, and the DON should report it per the requirements to HHSC and to him . During an interview on 03/01/2024 at 1:50 PM, the DON said she had started at the facility on January 13, 2024. The DON said if the nurses found a new bruise, she expected them to notify the Administrator or herself, so it could be reported to HHSC within 2 hours and investigated. The DON said the staff should report abuse to the abuse coordinator, the Administrator, and in his absence to her. During an interview on 03/02/2024 at 10:04 AM, Resident #52 said he did not remember his roommate (Resident #47) yelling and cursing at him. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Brentwood Terrace Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 Stillhouse Road Paris, TX 75460	
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/02/2024 at 5:36 PM, ADON E said she had been employed at the facility for 3 years, but she had been out for several months for medical reasons. ADON E said she had told LVN C to edit her note regarding notifying the DON about Resident #47 cursing at Resident #52 because the DON had denied LVN C notifying her about the incident. ADON E proceeded to say they called her and told her to tell LVN C to change her documentation. ADON E said she often gets called and instructed to tell the nurses to edit their documentation. ADON E said she could not remember who called her to instruct her to tell the nurses to edit their documentation. 5) Record review of a face sheet dated 03/02/2024 indicated Resident #179 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis of all four limbs, and the trunk of the body), congenital insufficiency of aortic valve (heart defect that prevents blood from flowing backward through the heart), neuromuscular dysfunction of the bladder (condition where a person lacks bladder control due to brain, spinal cord, or nerve problems), major depressive disorder recurrent (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks), and anxiety disorder. Record review of the Comprehensive MDS assessment dated [DATE], indicated Resident #179's speech was unclear, was sometimes able to make himself understood, and understood others. The MDS assessment indicated Resident #179 had a BIMS score of 12 which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #179 was dependent on staff for all ADLs. Record review of the care plan last revised 02/23/2024 indicated Resident #179 had quadriplegia to assist with ADLs and locomotion as required. During an observation and interview on 02/26/2024 at 10:46 AM, Resident #179 said he did not like it at night. Resident #179 said CNA B was mean to him, and she throws me around with the sheet. He said CNA B ignored his call light and did not provide incontinent care. Resident #179 became very emotional and started crying because he said CNA B said she was not going to take care of him, and he had to wait to be changed until 6 AM the next morning. Resident #179 said he was not able to remember the exact day of the incident, but he had told the DON one night she had worked on the floor. Resident #179 said the DON told him she would handle it, but she never returned to tell him how she handled it. Resident #179 said CNA B was still supposed to provide care for him, but she refused to provide care to him. Resident #179 remained tearful throughout the rest of the interview. During an interview on 02/26/2024 at 12:22 PM, the DON said she had worked on the floor on the night shift to help the CNAs provide ADL care (the DON did not specify the date). The DON said no residents had reported to her any abuse allegations. The DON said if a resident reported an abuse allegation to her, she would start an investigation, fill out a grievance, and notify the abuse coordinator, the AIT, immediately, and call the Social Worker. The DON said she had talked to Resident #179, and he was a bit hard to understand, but he had not notified her of any abuse or neglect allegations. The DON said no residents had complained about CNA B to her. The DON said Resident #179 could have reported the abuse to another staff member. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/27/2024 at 10:35 AM, CNA B said she had been employed at the facility since October 2022, and she worked the night shift. CNA B said she provided care to Resident #179. CNA B said she answered Resident #179's call light and denied any abuse towards Resident #179. CNA B said there were times when she was not able to provide the care required to the residents because the facility was shorthanded. CNA B said sometimes from 6 PM-10PM the facility only had 2 CNAs. CNA B said Resident #179 was needy. CNA B said Resident #179 was very needy, and he required 2 staff assist with his ADLs. CNA B said she could do what he asked her to do and ask him if he was satisfied, and when she walked out, he would turn his call light on. CNA B repeated that Resident #179 was very needy, and she would have to tell him that she had other people to take care of and he would say ok. During an observation and interview on 02/27/2024 at 4:40 PM, CNA EE and SNA O were in Resident #179's room. Upon entering room, surveyor noticed Resident #179 was crying uncontrollably and emotionally distraught. CNA EE and SNA O were attempting to reassure and comfort Resident #179. CNA EE said Resident #179 was crying because he did not want them to leave for the day (referring to the 6 AM-6PM shift) because the night shift would not turn him or answer his call light. Resident #179 started crying even more and said CNA OO had called him a rat for telling on CNA B, took his call light away, and told him nobody wanted to answer his call light the previous night (02/26/24). Resident #179 had not reported the incident to any other facility staff. During an interview on 03/02/2024 at 10:43 AM, CNA OO said Resident #179 was a high-risk care because he was a 2-person total assist with mobility and his ADLs. CNA OO said she had never had any issues with him, and she had not taken his call light away. CNA OO said generally when she went into Resident #179's room there was another staff member with her. CNA OO said she had not called Resident #179 a rat. 46892 46928		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based interview, and record review the facility failed to have evidence alleged violations were thoroughly investigated to prevent further abuse for 1 of 11 residents (Resident #44) reviewed for abuse. The facility failed to thoroughly investigate when Resident #44 was found to have a large bruise to her right inner thigh measuring 17 centimeters x approximately 11 centimeters that was painful on 6/21/2023. The facility failed to thoroughly investigate when Resident #44 was transferred to the local emergency room and found to have a new fracture and dislocation of the right trochanter (hip joint) on 6/21/2023. An IJ was identified on 3/01/2024. The IJ template was provided to the facility on [DATE] at 11:05 a.m. While the IJ was removed on 3/01/2024, the facility remained out of compliance due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk of not having allegations of abuse, neglect or exploitation investigated properly to prevent re-occurrence. Findings Included: Record review of a face sheet dated 2/27/2024 indicated Resident #44 was an [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia (memory loss), muscle weakness, reduced mobility, anxiety disorder. Record review of a Significant Change MDS dated [DATE] indicated Resident #44 was sometimes understood and usually understands others. The MDS indicated Resident #44 was unable to complete her BIMS exam due to her cognition. The MDS indicated Resident #44 had inattention and disorganized thinking being continuously present. The MDS indicated Resident #44 had no behavioral symptoms but wandered 1-3 days during the assessment period. The MDS indicated Resident #44 required extensive assistance of two staff for transfers, and extensive assistance of one staff member for bed mobility, and locomotion on and off the unit. The MDS indicated Resident #44 had a history of falls with fractures within the last 6 months. Record review of the comprehensive care plan dated 12/13/2023 and updated on 1/07/2024 indicated Resident #44 was at risk to fall related to unsteady gait/balance, generalized weakness, and poor safety awareness. The care plan indicated Resident #44 was at risk to wander related to a history of attempts to leave the facility related to poor safety awareness and resides on the secured unit. Record review of a Weekly Skin assessment dated [DATE] and documented by LVN CCC, indicated Resident #44's skin was normal with no bruising. The note indicated Resident #44's had a surgical incision to the right hip with staples and steri-strips in place with no drainage and no signs of infection. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a Fall Nurses Note dated 6/12/2023 and documented by LVN YY indicated Resident #44 had a fall with a bump on the right side of her head. Record review of a Weekly Skin assessment dated [DATE] documented by LVN DDD, indicated Resident #44's skin was normal with no bruising. Record review of a SBAR note dated 6/18/2024 documented by LVN YY indicated Resident #44 had swelling and pain to the right hip replacement. The note indicated Resident #44 was ordered a mild pain reliever and an x-ray to the right hip. Record review of a right hip x-ray dated 6/19/2023 indicated Resident #44's prosthetic right femoral head (hip joint) was in proper alignment. Resident #44's x-ray revealed there were no fractures or acute dislocation. The x-ray indicated Resident #44's prosthesis was properly situated without any loosening. The x-ray conclusion indicated the right hip arthroplasty (hip restoration) was intact. Record review of a progress note dated 6/21/2023 at 6:15 a.m., LVN YY documented Resident #44 had a bruise to the inner thigh on the right leg measuring 17 centimeters x approximately 11 centimeters with pain. LVN YY noted she administered a mild pain reliever to Resident #44. Record review of an Event Nurses' note dated 6/21/2023 at 6:15 a.m., LVN YY documented a bruise was found to Resident #44's right inner thigh measuring 17 centimeters x approximately 11 centimeters. The note indicated Resident #44's bruise was blue/purple and painful. LVN YY documented Resident #44 could not provide a statement related to her cognitive impairment. LVN YY said previous factors included previous falls. Record review of an incident note dated 6/21/2023 documented by LVN YY indicated Resident #44 had a large purple bruise on her inner right thigh (front) measuring 17 centimeters x approximately 11 centimeters. LVN YY said Resident #44 was unable to state what had happened. LVN YY documented there were no predisposing environmental factors, and the predisposing physiological factor was Resident #44 had memory impairment. Record review of a Weekly Skin assessment dated [DATE] indicated Resident #44 skin color was normal, temperature was normal, with a large purple bruise to the right inner thigh with a firm center with bruising to her knee. Record review of a Consultation note dated 6/21/2023 indicated the orthopedic physician documented he knew Resident #44. The physician said he had treated her femoral neck fracture(connection between the ball of the hip and the femur bone) a month previous. The physician wrote he had seen Resident #44 a week ago and the x-rays showed a well-fitted well-fixed bipolar hip. The physician wrote he had plans to surgically repair Resident #44's right hip by removing the prosthesis, wire her with cables then reimplant the prosthesis and then put a plate and screws with wires and screws around the periprosthetic fracture. During an interview on 2/29/2024 at 11:42 a.m., LVN YY said she was notified of Resident #44's by CNA K. LVN YY said she assessed and measured the bruising and notified the physician, family, DON, and Administrator (previous). LVN YY said she was unsure how Resident #44 sustained the bruise and unsure why no one else had seen the bruise. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/29/2024 at 3:22 p.m., CNA K said she had found the bruising to Resident #44's right leg and reported to LVN YY. CNA K said while she was providing incontinent care for Resident #44, she moved the pillow between Resident #44's legs when she found a large purple bruise. During an interview on 2/29/2023 at 3:40 p.m., the DON said she was not the DON during the incident on 6/21/2023 with Resident #44 but she indicated she would have investigated and report the bruising. During an interview on 03/01/2024 at 8:52 AM, previous Administrator ZZ said she always did an investigation when something was reported to her but depending on her investigation if she reported. Administrator ZZ said if she had not reported the incident with Resident #44's bruising/hip fracture it had to be for a reason. Administrator ZZ said she did not remember the specifics off the top of her head, and she kept a soft file in the administrator's office with her investigations. The soft file was not could not be located. Administrator ZZ said a bruise that was not correlated with an incident was considered an injury of unknown injury and should be reported within 2 hours of finding it or being notified. Record review of an Abuse/Neglect policy dated 3/29/2018 indicated the resident had a right to be free from abuse, neglect, misappropriation of property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the residents' medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals 3. All reports of abuse or suspicion of abuse/neglect or potentially criminal behavior will be investigated as per facility protocol. Investigations will be reviewed by the facility administrator and /or Abuse Preventionist within 24 hours of complaint. Appropriate notification to the state and home office will be the responsibility of the administrator and per policy. 4. The facility will be responsible to identify, correct, and intervene in situations of possible abuse/neglect, the facility has in place a method to identify events such as suspicious bruising of resident, occurrences, patterns, and trends that may constitute abuse. This was determined to be an Immediate Jeopardy (IJ) on 3/01/2024 at 11:05 a.m. The facility Administrator and assistant Administrator were notified. The Administrator was provided with the IJ templates on 3/01/2024 at 11:05 a.m. The facility's plan of removal was accepted on 03/01/2024 at 11:01 AM and included the following: Facility: Date: 3/1/24 Problem: Failure to thoroughly Investigate Abuse Interventions: 1. A head-to-toe skin assessment was completed on resident #44 on 3/1/24 by the Charge Nurse. No additional issues were noted. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. A pain assessment was completed on resident #44 on 3/1/24 by the Charge Nurse. No pain was voiced. 3. All residents in the facility have had a head-to-toe assessment completed as of 3/1/24 by the DON, ADON, and Charge Nurses. No signs or symptoms of injuries of unknown origin noted. 4. The Administrator and DON were in-serviced 1:1 on the Provider Letter and the Abuse/Neglect Policy by the Area Director of Operation on 3/1/24. The in-service included reporting injuries of unknown origin and conducting a thorough investigation. 5. A review of the Abuse and Neglect policy was reviewed by Corporate Management on 3/1/24. The policy included reporting and investigating events of abuse and neglect. No changes have been made to the policy. 6. The Medical Director was notified of the immediate jeopardy situation on 3/1/24 by the Administrator. 7. An ADHOC QAPI meeting was completed with QA committee to include the Medical Director on 3/1/24. 8. The following in-services were initiated by the Administrator, DON, and Regional Compliance Nurse as of 3/1/24 for all staff. All staff not present on 3/1/24 will be in-serviced prior to the start of next shift. All new hires will be in-serviced during orientation. All agency staff will be in-serviced prior to the start of their shift. Abuse and Neglect Policy to include reporting any signs of injury such as bruising, redness, swelling and pain. All allegations of abuse must be reported to the Administrator who is the abuse coordinator. In the absence of the administrator, allegations of abuse must be reported to the DON. On 03/01/2024 the surveyor conformed the facility implement their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Record review of Weekly Skin Assessment, dated 02/27/2024, revealed Resident #44 had a bruise to the right side of her forehead, which measured 2 cm x 3.3 cm. The assessment further revealed a bruise to her right forearm, which measured 3.5 cm x 2.1 cm. Record review of the pain assessment was completed for Resident #44, and she received a mild pain reliever acetaminophen 325 milligrams give two tablets every 4 hours as needed for pain. Record review of the skin assessments, completed on 02/27/2024, revealed no injuries of unknown origin. (continued on next page)		

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the In Service Training Attendance Roster, dated 03/01/2024 , revealed the Administrator and DON were provided education on the abuse and neglect policy, procedure, and the long-term care regulatory provider letter on abuse, neglect, exploitation, misappropriation of resident property, and other incidents that a nursing facility must report to the Health and Human Services Commission. During an interview on 3/01/2024 at 1:23 p.m., the Administrator said he expected all allegations of abuse, neglect to be reported to him promptly to ensure he had enough time to initiate an investigation to include when he called the allegation to the state agency. The Administrator said the alleged perpetrator would be suspended during the investigation. The Administrator said he in the past had used reviewing bath sheets, incident and accidents as a way to evaluate areas concerning abuse and neglect. During an interview on 3/01/2024 at 2:00 p.m., the DON said she expected the nurses to notify her and the Administrator with any injuries including bruises and fractures immediately. The DON said reporting immediately allows for a starting of an investigation to include when reporting to the state agency in the required time frame. Record review of the Off Cycle (ad hoc) QA Meeting Document, dated 02/01/2024, revealed an action plan was initiated and discussed. Record review of the In Service Training Attendance Roster, dated 03/01/2024, revealed LVN L, Cook M, the Administrator, MDS Coordinator N, SNA O, SNA P, DA UU, LVN Q, MDS Coordinator R, ADON S, the Marketing Coordinator, the Maintenance Supervisor, Housekeeper T, DA W, RN U, CNA V, the Medical Records, LVN W, the HR Coordinator, CNA K, CNA X, CNA Y, CNA Z, the BOM, CNA BB, CNA CC, the DON, LVN F, the DOR, LVN AA, RN DD, CNA EE, the Social Worker, CNA H, LVN C, LVN FF, COTA GG, the DM, LA HH, Housekeeper KK, and MA LL had been in-serviced on the abuse and neglect policy, to include reporting resident injuries immediately. The in-service further revealed education was provided on reporting allegations of abuse immediately to the Administrator, who was the abuse coordinator. The in-service stated, In the absence of the administrator, allegations of abuse must be reported to the DON. During interviews on 03/01/2024 between 12:33 PM and 4:38 PM, LVN L, Cook M, the Administrator, MDS Coordinator N, SNA O, SNA P, DA UU, LVN Q, MDS Coordinator R, ADON S, the Marketing Coordinator, the Maintenance Supervisor, Housekeeper T, DA W, RN U, CNA V, the Medical Records, LVN W, the HR Coordinator, CNA K, CNA X, CNA Y, CNA Z, the BOM, CNA BB, CNA CC, the DON, LVN F, the DOR, LVN AA, RN DD, CNA EE, the Social Worker, CNA H, LVN C, LVN FF, COTA GG, the DM, LA HH, Housekeeper KK, and MA LL had been provided education on abuse and neglect policy, to include reporting injuries immediately. The staff further indicated allegations of abuse must be reported immediately to the Administrator, who was the abuse coordinator. The staff indicated in the absence of an administrator the DON was the abuse coordinator. On 03/01/2024 at 5:10 p.m., the Administrator was informed the IJ was removed; however, the facility remained out of compliance due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observations, interviews, and record reviews the facility failed to ensure assessments accurately reflected the resident status for 1 of 24 residents (Resident #33) reviewed for MDS assessment accuracy. The facility inaccurately coded Resident #33's having received an antidepressant medication on his significant change in status MDS assessment dated [DATE]. This failure could place residents at risk for not receiving care and services to meet their needs. Findings included: Record review of Resident #33's face sheet dated 02/29/24, indicated a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #33's diagnoses included dementia (memory loss), unspecified protein calorie malnutrition (not consuming enough protein and calories), major depression, and bipolar disorder (serious mental illness characterized by extreme mood swings). Record review of Resident #33's comprehensive care plan dated 05/17/2019 and revised on 08/22/2019, indicated Resident #33 was taking antidepressant medication (Celexa) related to depression daily. The care plan interventions indicated to administer antidepressant medications as ordered by the physician. Record review of Resident #33's significant change in status MDS assessment dated [DATE], indicated Resident #33 was able to make himself understood and understood others. The MDS assessment indicated Resident #33's had a BIMS score of 13, which indicated his cognition was intact. The MDS assessment indicated Resident #33 had taken an antidepressant medication within the last 7 day look back period. Record review of Resident #33's order summary report dated 02/29/24, did not indicate Resident #33 had an order for an antidepressant medication. Record review of Resident #33's medication administration record for the month of January 2024, indicated Resident #33 received citalopram (Celexa) one time a day from 01/1/2024 until 01/16/2024 for diagnosis of major depressive disorder. The medication administration record indicated citalopram was discontinued on 01/27/2024. Record review of Resident #33's medication administration record for the month of February 2024, indicated Resident #33 did not receive any antidepressant medications for the month. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 03/01/2024 at 03:44 PM, MDS Coordinator N reviewed Resident #33's medical record and said Resident #33 MDS indicated he had received antidepressant medication within the 7-day look back period. MDS Coordinator N was observed reviewing Resident #33's orders and said Resident #33's Celexa was discontinued on 01/27/2024 and should not have been coded on his MDS assessment. MDS Coordinator N said he made an error and was unsure of how it happened. MDS Coordinator N said the Corporate MDS Coordinator audited the MDS assessments frequently. MDS Coordinator N said he was responsible for ensuring the MDS assessments were accurate. MDS Coordinator N said Resident #33 was at risk for having an inaccurate assessment. During an interview on 03/01/2024 at 03:54 PM, the DON said he expected the MDS assessments to be accurate. The DON said the MDS Coordinator was responsible for ensuring the MDS assessments were accurate. The DON said Resident #33 MDS assessment did not accurately reflect Resident #33's care. During an interview on 03/01/2024 at 03:58 PM, the RNC said the facility did not have a policy on MDS accuracy and that they followed the RAI (Resident Assessment Instrument) manual. During an attempted interview on 03/03/2024 at 09:44 AM, the Corporate MDS Coordinator did not answer the phone. During an interview on 03/02/2024 at 02:22 PM, the Interim Administrator said he expected the MDS assessments to be accurate. The Interim Administrator said the MDS Coordinator was responsible for ensuring the MDS assessments were accurate. The Interim Administrator said Resident #33 inaccurate MDS assessment could be looked as Resident #33 still received an antidepressant medication. During an interview on 03/02/2024 at 03:35 PM, the RNC said she expected the MDS assessments be accurate. The RNC said the MDS Coordinator was responsible for ensuring the MDS assessments were accurate. The RNC said inaccurate MDS assessments would not reflect an accurate picture of the resident's care. Record review of the Resident Assessment Instrument 3.0 User's Manual, last revised October 2023, indicated .Coding Instructions .N0145C1. Antidepressant: Check if any antidepressant medications was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).		

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NAME OF PROVIDER OR SUPPLIER Brentwood Terrace Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 Stillhouse Road Paris, TX 75460	
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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** 47612 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, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 24 (Resident #70) residents reviewed for care plans. The facility failed to provide fall mat at bedside for Resident #70, as indicated on the care plan. These failures could place the residents at increased risk of not having their individual needs met, injury, not receiving necessary services, and a decreased quality of life. Findings Included: Record review of Resident #70's face sheet dated 03/02/2024, indicate Resident # 70 was a [AGE] year-old male admitted to the facility on [DATE], with a diagnosis which include unspecified Dementia (mild cognitive impairment has yet to be diagnosed as a specific type of dementia), muscle weakness (a lack of muscle strength). Record review of Resident # 70's Quarterly MDS assessment dated [DATE], indicated Resident #70 had a BIMS score of 6, which indicated severe cognitive impairment. Resident # 70 was able to understand and make himself understood to others. The MDS Resident #70 uses a wheelchair and needs partial to moderate assistance with transfers. Record review of Resident #70's care plan dated 01/19/2024, indicated Resident #70 was at risk for falls, may use fall mat at bedside. Record review of Resident # 70's order summary dated 03/02/2024, indicated Resident #70 was to have a fall mat at bedside. During an observation on 02/26/2024 at 11:31 A.M., Resident #70 was sleeping with no fall mat at the bedside. During an observation on 02/26/2024 at 3:32 P.M., Resident #70 was in bed with no fall mat at the bedside. During an interview on 03/02/2024 at 2:01 P.M, CNA Z stated she was not aware Resident #70 needed a fall mat because the kiosk did not alert her. CNA Z stated all nursing staff was responsible for making sure Resident # 70 had a fall mat. CNA Z stated it was important for Resident#70 to have a fall mat so if he falls it would be on the mat and that was more cushion than the floor. CNA Z stated the harm was he could hurt himself if he fell . (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/02/2024 at 2:24 P.M, LVN L stated it was nursing responsibility to ensure Resident #70 had a fall mat at the bedside. LVN L stated someone must have moved the fall mat and not put it back. LVN L stated it was important for the fall mat to be in place to prevent injury. LVN L stated the harm could be an injury. During an interview on 03/02/2024 at 3:00 P.M, ADON E stated she expected resident who need a fall mat to have one. ADON E stated she was afraid the fall mat was moved and did not get put back. ADON E stated it was important for Resident # 70 to have a fall mat to prevent injury. ADON E stated the harm could be personal injury. During an interview on 03/02/2024 at 3:33 P.M, the ADM stated it was he expected Resident #70 to have a fall mat if he has an order. The ADM stated it was it was nursing responsibility to make sure residents has a fall mat at bedside. The ADM stated it was important for Resident #70 to have a fall mat so if he falls out of bed, he was not hitting the floor, he would hit padding and not a direct hit to the floor. The ADM stated the harm could be possible injury. The ADM stated he would monitor by making a list who has an order for fall mats and doing rounds. During an interview on 03/02/2024 at 4:15 P.M, the DON stated she expected the Resident #70 to have a fall mat at bedside. The DON stated it was important for Resident # 70 to have a fall mat to prevent injury. The DON stated Resident #70 could injure himself without a fall mat. If they refused or just did not remember. The DON state to ensure fall mat were in place she would pull up a list and do daily rounds. Record review of the undated Comprehensive Care Planning policy The facility will establish, document, and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review, the facility failed to ensure each resident's person-centered comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 3 of 24 residents (Residents #'s 33, 130 and 4), reviewed for care plans. 1. The facility failed to revise and update Resident #33's comprehensive care plan when his antidepressant was discontinued. 2. The facility failed to revise Resident #4's care plan after she fell on [DATE], 2/26/2024, and 2/27/2024. 3. The facility failed to revise Resident #130's care plan after he fell on [DATE] and 11/27/2023. These failures could affect residents of the facility by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings included: 1. Record review of Resident #33's face sheet dated 02/29/24, indicated a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #33's diagnoses included dementia (memory loss), unspecified protein calorie malnutrition (not consuming enough protein and calories), major depression, and bipolar disorder (serious mental illness characterized by extreme mood swings). Record review of Resident #33's comprehensive care plan dated 05/17/2019 and revised on 08/22/2019, indicated Resident #33 was taking antidepressant medication (Celexa) related to depression daily. The care plan interventions indicated to administer antidepressant medications as ordered by the physician. Record review of Resident #33's significant change in status MDS assessment dated [DATE], indicated Resident #33 was able to make himself understood and understood others. The MDS assessment indicated Resident #33's had a BIMS score of 13, which indicated his cognition was intact. The MDS assessment indicated Resident #33 had taken an antidepressant medication within the last 7 day look back period. Record review of Resident #33's order summary report dated 02/29/24, did not indicate Resident #33 had an order for an antidepressant medication. Record review of Resident #33's medication administration record for the month of January 2024, indicated Resident #33 received citalopram (Celexa) one time a day from 01/1/2024 until 01/16/2024 for diagnosis of major depressive disorder. The medication administration record indicated citalopram was discontinued on 01/27/2024. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #33's medication administration record for the month of February 2024, indicated Resident #33 did not receive any antidepressant medications for the month. During an interview on 03/01/2024 at 03:44 PM, MDS Coordinator N said since Resident #33's antidepressant was discontinued, then comprehensive care plan should have been updated to reflect as resolved. MDS Coordinator N said the MDS Coordinators were responsible for updating the comprehensive assessments when an MDS assessment was completed. MDS Coordinator N said the DON, ADON, and nurses were responsible for the acute care plans. MDS Coordinator N said by not revising and updating Resident #33's care plan when his antidepressant was discontinued, the person reading the care plan would not have accurate information. MDS Coordinator N said the comprehensive care plans were updated during their morning meeting for any acute changes. During an interview on 03/01/2024 at 3:54 PM, the DON said Resident #33's comprehensive care plan should have been updated and revised when his antidepressant medication was discontinued. The DON said the MDS Coordinator was responsible for updating and revising the care plans. The DON said failure to update Resident #33's care plan could have placed the resident at risk for receiving the antidepressant medication after it had been discontinued. During an interview on 03/02/2024 at 02:22 PM, the Interim Administrator said he expected Resident #33's comprehensive care plan to reflect he was no longer taking the antidepressant medication. The Interim Administrator said the IDT was responsible for updating and revising the care plans. The Interim Administrator said since Resident #33's care plan was not revised then it would have been assumed Resident #33 continued to receive antidepressant medication. 2. Record review of a face sheet dated 2/27/2024 indicated Resident #4 admitted on [DATE] and readmitted [DATE] with the diagnosis of diabetes, muscle weakness, lack of coordination, reduced mobility, repeated falls, dementia, and assistance with personal care. Record review of the comprehensive care plan dated 1/22/2024 and revised on 2/05/2024 indicated Resident #4 had an ADL self-care performance deficit. The goal of the care plan indicated Resident #4 would remain at her current level of function in transfers, and toileting. The care plan interventions included Resident #4 required one staff assistance with toileting. The comprehensive care plan indicated Resident #4 was at risk for falls related to weakness and impaired cognition. The goal of the care plan was Resident #4 would not sustain a serious injury. The care plan interventions included ensure Resident #4's call light was within reach dated 1/22/2024, ensure don't call fall sign at the foot of the bed visible by Resident #4 dated 1/31/2024, keep furniture in the lock position dated 1/22/2024, keep needed items, water in reach dated 1/22/2024, 1 staff to assist with transfers dated 1/22/2024, resident needs a safe environment dated 1/22/2024 and frequent visual checks while in bed dated 1/21/2024 ensure proper foot wear dated 2/4/2024. The comprehensive care plan failed to address interventions for Resident #4's falls on 2/24/2024, 2/26/2024, and 2/27/2024. Record review of an Admission MDS dated [DATE] indicated Resident #4 was usually understood and understands others. The MDS indicated Resident #4's cognition was moderately impaired. The MDS in section GG indicated Resident #4 required partial to moderate assistance with toileting, bed to chair transfers, toileting transfers and to sit and stand. Record review of a fall incident report dated 2/24/2024 at midnight, LVN D indicated Resident #4 ambulated without assistance and was not wearing any shoes or socks. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a progress note dated 2/24/2023 at midnight, LVN D documented Resident #4 was sitting in the hallway on her bottom with her legs straight in front of her. LVN D said Resident #4 said she had slipped down. LVN D documented Resident #4 was not wearing shoes or socks. LVN D documented Resident #4 complained of right foot pain. Record review of a fall incident report dated 2/26/2024 at 10:30 p.m., LVN C indicated no injuries were observed. The incident report was left blank. Record review of a Fall-Risk assessment dated [DATE] at 10:30 p.m., LVN C documented Resident #4 was at high risk to fall. LVN C documented Resident #4 was disoriented, had 3 or more falls in the past 3 months, required assistance with elimination, had problems with balance, and took 3-4 medications which could cause falls. Record review of a Fall Nurses Note dated 2/26/2024 at 10:46 a.m., LVN F documented Resident #4 had a fall without injury. LVN F documented fall interventions were the bed low, interval monitoring, neurological checks, frequent visual checks, encourage and educate use of the call light. Record review of a progress note dated 2/26/2024 at 11:30 p.m., LVN C indicated Resident #4 said she had fallen on the floor, and she had been pulling up her pants. Record review of an incident report dated 2/27/2023 at 11:45 p.m., LVN C documented Resident #4 had a fall with no injuries noted. The incident report had no further documentation within. Record review of an Event Nurses' Note-Fall dated 2/27/2024 at 11:45 p.m., LVN C documented Resident #4 had an unwitnessed fall. LVN C documented Resident #4 was found on the floor, indicated Resident #4 said legs gave out, and Resident #4 attempted to self-toilet. LVN C documented in the area of Nursing Description: Resident #4 indicated she got up to use the bathroom, failed to call for help, denied bumping her head, and was found sitting on the floor. During an interview on 3/02/2024 at 2:46 p.m., the DON said Resident #4 should have had interventions added to her care plan for each fall. The DON said the MDS nurses were responsible for updating the care plan. The DON said she was unsure why Resident #4's care plan had not been updated with the last falls in February 2024. The DON said she was unaware LVN F was not familiar with how to update a resident's care plan. The DON said she had seen other nurses updating the care plans. The DON said the CNAs would learn of the needed fall interventions for Resident #4 and other residents by word of mouth during report. 3. Record review of a face sheet dated 2/29/2024 indicated Resident #130 was a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia with behavioral disturbances, lack of coordination, and a need for assistance with personal care. Record review of the Comprehensive Care Plan dated 9/07/2023 and revised on 12/09/2023 indicated Resident #130 was a high risk for falls related to wandering. The goal of the care plan was Resident #130 would be free of falls. The care plan interventions included to anticipate and met Resident #130's needs, ensure his call light was within reach, encourage the use of the call light, and have prompt response to the request for assistance, and ensure Resident #130 wore appropriate footwear. The comprehensive care plan failed to have interventions after the falls on 11/26/2023 and 11/27/2023. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of an incident report dated 11/26/2023 at 10:00 p.m., LVN C indicated Resident #130 was found by the CNA on the floor, with no signs of pain. The note indicated Resident #130 was limping on the left leg and was sent to the local emergency room at 10:35 p.m. via the ambulance. Record review of a fall risk assessment completed by LVN C on 11/26/2023 indicated Resident #130 was disoriented at all times to person, place, and time. The assessment indicated Resident #130 had no previous falls, was ambulatory, continent, had balance problems, decreased muscular coordination, and gait pattern changes. Record review of an incident report dated 11/27/2023 at 5:30 p.m., indicated Resident #130 was found with his head lying against the closet door by LVN HHH. The note indicated Resident #130 had a bruise to his right shoulder and a skin tear to his left hand. The note indicated the conclusion was Resident #130 had an unwitnessed fall with injuries. The note indicated his bed was changed to a low bed. Record review of an Event Nurses-Note dated 11/27/2023 at 6:39 p.m., indicated Resident #130 was found by LVN HHH when she was passing dining trays. The note indicated Resident #130 was lying with his head against the closet door. The note indicated Resident #130 had a skin tear. The note indicated Resident #130 had a purple bruise to his right shoulder. The note indicated Resident #130 was in pain noted by his occasional moans or groans, and facial grimacing. The note indicated Resident #130's physical factors included previous fall, urinary tract infection, pain, and incontinence. The note indicated Resident #130 required 1 staff with bed mobility, toileting, transferring, and walking. The note indicated Resident #130 leaned forward. During an interview on 3/02/2024 at 2:07 p.m., LVN F said she had never updated a resident's care plan. LVN F said she would not even know how to start. LVN F said she had been a nurse for [AGE] years and never had to complete an acute care plan for falls or injuries. LVN F said she relied on the nurse managers to update the care plans and said until the care plans were updated, she would use the report process to ensure other staff knew the interventions. During an interview on 3/02/2024 at 4:00 p.m., the Administrator said he was unsure how the care planning process took place in this facility since he had only been here a week. The Administrator said the care plans should be looked at with each fall to review the fall and assess the needed interventions. The Administrator said in the past the MDS nurses were responsible for updating the care plan. The Administrator said the DON was responsible. The Administrator said when the care plans were not updated with each fall, another fall could occur. During an interview on 3/02/2024 at 4:22 p.m., MDS Coordinator R said updating the care plans were a team effort. MDS Coordinator R said the nurse managers, dietary, and the social worker each update the care plan with acute care plan needs. The MDS Coordinator R said normally the falls and other changes were discussed in the morning clinical meeting and at this time the care plan should be updated. The MDS Coordinator R nurse said when the care plan was not updated with interventions more falls could occur and even falls with major injury. During an interview on 3/02/2024 at 4:29 p.m., the Regional Compliance Nurse said the DON was responsible for updating the acute care plans. The Regional Compliance Nurse said the floor nurses had not been responsible for completing the care plans. The Regional Compliance Nurse said a staff member would have an inaccurate picture of a resident's care when the care plan was not updated. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of an undated Comprehensive Care Planning policy indicated: The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented. Interdisciplinary means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident. It does not mean that every goal must have an interdisciplinary approach. The mechanics of how the interdisciplinary team (IDT) meets its responsibilities in developing an interdisciplinary care plan (e.g., a face-to-face meeting, teleconference, written communication) is at the discretion of the facility. In instances where an IDT member participates in care plan development, review or revision via written communication, the written communication in the medical record will reflect involvement of the resident and resident representative, if applicable, and other members of the IDT, as appropriate. 33249		

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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** 46928 Based on observation, interview, and record review, the facility failed to ensure necessary services to maintain grooming and personal hygiene were provided for 7 of 9 residents reviewed for ADLs. (Resident #'s 9, 22, 36, 41, 57, 67, and 179) 1. The facility failed to ensure Resident #'s 9, 22, 36, 57, 67, and 179 were routinely showered/bathed. 2. The facility failed to ensure Resident # 41 was shaved. These failures could place residents at risk of not receiving services/care, decreased quality of life, and decreased self-esteem. Findings included: 1A. Record review of Resident #22's face sheet dated 02/29/2024, indicated an [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #22 had pneumonia (infection of the air sacs in one or both lungs), cerebral infarction (stroke), hemiplegia affecting left dominant side (left sided paralysis), open wound of unspecified buttock, and need for assistance with personal care. Record review of Resident #22's comprehensive care plan dated 02/19/2021, indicated Resident #22 had a self-care performance deficit related to late effects of CVA (stroke), Hemiplegia (paralysis)/hemiparesis (weakness) to left side. The care plan interventions indicated Resident #22 required extensive to total assistance of 1 to 2 staff members as indicated for bathing/showering. Record review of Resident #22's quarterly MDS assessment dated [DATE], indicated he was able to make himself understood and understood others. The MDS assessment indicated Resident #22 had a BIMS score of 12, which indicated his cognition was moderately impaired. The MDS assessment did not indicate Resident #22 had behaviors or refused care. The MDS assessment indicated Resident #22 was totally dependent on staff with toileting, bathing, and dressing. The MDS assessment indicated Resident #22 was incontinent of bowel and bladder and was at risk for developing pressure ulcers/injuries. The MDS assessment indicated Resident #22 had moisture associated skin damage. During an observation and interview on 02/26/2024 at 10:11 AM, Resident #22 was lying in bed and had approximately 0.5-inch facial hair. Resident #22 said he shaved himself. Resident #22 said he had not received a bed bath in 3 weeks. Resident #22 said he felt dirty for not receiving a bed bath as desired. Record review of Resident #22's progress notes dated 01/30/2024 to 03/01/2024 did not indicate Resident #22 had refused any baths. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #22's follow-up question report dated 02/01/2024-02/28/2024, indicated Resident #22 received a bed bath on 02/03/2024 and 02/17/2024. Resident #22's scheduled bath days were on Tuesday, Thursday, and Saturday on the 2:00 PM- 10:00 PM shift. The facility failed to provide Resident #22 a bath/shower on 02/13/2024, 02/15/2024, 02/20/2024, 02/22/2024, 02/24/2024, and 02/27/2024 (since his last readmission to the facility on [DATE]). 1B. Record review of Resident #67's face sheet dated 02/29/2024, indicated a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #67's diagnoses included muscle weakness, unspecified protein-calorie malnutrition (not consuming enough protein or calories), cerebrovascular disease (stroke), diabetes (condition when blood sugar is too high), and lung cancer. Record review of Resident #67's admission MDS assessment dated [DATE], indicated he was able to make himself understood and understood others. The MDS assessment indicated Resident #67 had a BIMS score of 12, which indicated his cognition was moderately impaired. The MDS assessment did not indicate Resident #67 had behaviors or refused care. The MDS assessment indicated Resident #67 required substantial/maximal assistance with bathing and partial/moderate assistance with toileting, dressing and personal hygiene. Resident #67 was at risk for developing pressure ulcers/injuries. Record review of Resident #67's comprehensive care plan dated 02/07/2024, indicated he had hemiplegia/hemiparesis left upper and lower extremities related to late effects of CVA with interventions to assist with ADLs/mobility as needed. During an observation and interview on 02/26/2024 at 10:05 AM, Resident # 67 was lying in bed. He appeared well groomed, and no odors were noted. However, Resident #67 said he did not know when he was scheduled to receive a bath/shower. Resident #67 said he had been receiving his baths/showers at least 2 times a week. Resident #67 said he would have liked to receive his showers/baths daily but was okay if he received them at least 3 times a week. Resident #67 said not receiving his showers/baths regularly made him feel unclean. Record review of Resident #67's progress notes dated 01/30/2024-03/01/2024 did not indicate Resident #67 had refused any showers/baths. Record review of Resident #67's follow-up question report dated 02/1/2024-02/28/2024 indicated Resident #67 received a bed bath on 02/16/2024, 02/21/2024 and 02/26/2024. Resident #67's scheduled bath days were on Monday, Wednesday, Friday on the 2:00 PM-10:00 PM shift. The facility failed to provide Resident #67 a bath/shower on 02/14/2024, 02/19/2024, and 02/23/2024 (since his last readmission to the facility on [DATE]). During an interview on 02/29/2024 at 4:11 PM, CNA BB said he worked from 2:00 PM- 6:00 PM on Resident #22's and Resident #67's hall. CNA BB said after that he went to work on another hall. He said resident shower schedules were in the resident electronic medical record. CNA BB said he provided a bath to Resident #22 a week ago. CNA BB said he had not given Resident #67 a bath. CNA BB said the nurse and the CNAs were responsible for ensuring the baths/showers were being provided as per their bath schedule. CNA BB said if a resident refused a bath/shower they would report it to the charge nurse. CNA BB said Resident #22 refused his baths at times. CNA BB said if a resident was not receiving their baths/showers regularly they were at risk for infection, skin issues and bed sores. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Brentwood Terrace Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 Stillhouse Road Paris, TX 75460	
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/29/2024 at 04:15 PM, SNA PPP said she worked the 6:00 AM- 6:00 PM shift and worked the hall where Resident #22 and #67 resided. SNA PPP said she was responsible for providing the showers/baths that were scheduled for 6:00 AM- 2:00 PM and was told to provide as many showers as possible for the residents that were scheduled on 2:00 PM - 10:00PM shift. SNA PPP said the 6:00 PM- 6:00 AM CAN was responsible for the showers that she could not complete on the 2:00 PM- 10:00 PM shift. SNA PPP said she had not given Resident #22 a bed bath since Resident #22 was scheduled to receive his showers/baths at night. SNA PPP said the 6:00 PM- 6:00AM shift usually did not have the staff to provide all the showers/baths that were scheduled for the 2:00 PM- 10:00 PM shift. SNA PPP said she sometimes had to work 2 halls by herself. SNA PPP said if a resident did not receive their baths/showers regularly they were at risk for buildup, urinary tract infections, skin issues and breakdown. SNA PPP said if a resident was to refuse a shower/bath after 3 times of encouraging them, she would notify the charge nurse. SNA PPP said she had given Resident #67 multiple bed baths for the month of February 2024, but if it was not documented then it did not happen. During an interview on 02/29/2024 at 04:18 PM, LVN QQQ said she was unsure of who was responsible for the residents that had baths scheduled for the 2:00 PM- 10:00 PM shift. LVN QQQ said the 6:00 AM- 6:00 PM CNAs provided as many showers/baths as possible to the residents that had their baths/showers scheduled for the 2:00 PM-10:00 PM shift. LVN QQQ said the 6:00 PM- 6:00 AM CNA was responsible for the showers/baths that the morning shift did not complete. LVN QQQ said she had questioned the previous administration staff on who was responsible for the 2:00- 10:00 PM baths previous and it was frustrating not knowing. LVN QQQ said if a resident did not receive their baths/showers as scheduled then it was a dignity issue and could cause the residents to have skin issues and breakdown. LVN QQQ said the nurse and the CNAs were responsible for ensuring the baths/showers were being provided. LVN QQQ said if the resident refused their showers/baths the resident and nurse signed the refusal sheet and be documented in their electronic medical record. LVN QQQ said Resident #22 refused his bed baths a lot of the time and Resident #67 would sometimes say he would like to wait until later that day. 1C. Record review of Resident #57's face sheet dated 02/29/24, indicated an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included heart failure (progressive heart disease that affects pumping action of the heart muscles), atrial fibrillation (abnormal heart rhythm), weakness, protein-calorie malnutrition (not consuming enough protein or calories), and anxiety. Record review of Resident #57's comprehensive care plan dated 12/28/2023 and revised on 02/22/2024 indicated Resident #57 had an ADL self-care performance deficit with interventions she required one staff member for assistance with bathing. Record review of Resident #57's quarterly MDS assessment dated [DATE], indicated Resident #57 was usually understood and usually understood others. The MDS assessment indicated Resident #57 had a BIMS score of 12 which indicated her cognition was moderately impaired. The MDS indicated Resident #57 required partial/moderate assistance with toileting, bathing, dressing, and personal hygiene. Resident #57 required substantial/maximal assistance with chair/bed to chair transfer. The MDS assessment indicated Resident #57 had one venous or arterial ulcers present and skin tears. The MDS assessment did not indicate Resident #57 had any behaviors or refused care. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/28/2024 at 09:00 AM, Resident #57's family member said Resident #57 was not on a bath schedule. Resident #57's family member said Resident #57 has had to ask for a bath in the past. Resident #57's family member said they would prefer for Resident #57's showers/baths to be somewhat consistent and it was not happening. Resident #57's family member said all they had asked for, from the facility staff, was for Resident #57 to be provided a reasonable level of care and for them to have the confidence that Resident #57 was being provided the care she deserved. During an interview on 02/28/24 at 11:45 AM, Resident #57's family member they were very involved in Resident #57's care. Resident #57's family member said they had thought of putting a sign in Resident #57's room as a reminder for staff of Resident #57's scheduled bath days. Resident #57's family member said they felt they needed to remind staff of when Resident #57's baths/showers were scheduled so her baths would not be missed. Resident #57's family member said they had voiced their concerns to the corporate staff and never received a follow up phone call. Resident #57's family member said they had also reported their concerns regarding Resident #57's care to the previous administrator and her response was we can help you find another facility. Record review of Resident #57's progress notes dated 01/30/2024-03/01/2024 did not indicate Resident #57 had refused any showers/baths. Record review of Resident #57's follow-up question report dated 02/01/2024-02/28/2024 indicated Resident #57 received a bath/shower on 02/02/24, 02/05/2024, 02/07/2024, 02/12/2024, 02/14/2024, 02/16/2024, 02/19/2024, 02/23/2024, and 02/28/2024. Resident #57's scheduled bath days were on Monday, Wednesday, Friday on the 6:00 AM- 2:00 PM shift. The facility failed to provide a bath/shower to Resident #57 on 02/09/2024, 02/21/2024, and 02/26/2024. During an interview on 03/02/2024 at 02:04 PM, the DON said she expected the baths/showers to be completed according to their bath schedule unless there was an extraneous circumstance the bath/shower could not be provided. The DON said she expected the resident to have a file if they refused their bath/shower. The DON said the charge nurses and aides were responsible for ensuring the baths/showers were being provided as scheduled. The DON said there was a report she could print to indicate if the showers were being completed but she did not review it. The DON said she believed the ADONs were responsible for reviewing the report. The DON said if a resident was not receiving their bath/showers as desired, they could become upset, and it could lead to skin issues. During an interview on 03/02/2024 at 02:22 PM, the Interim Administrator said he expected the residents to receive their showers/baths on their scheduled bath day. The Interim Administrator said if a resident was to refuse their bath/shower, he expected staff to ask again or get a staff member that had a better report with the resident to ask. The Interim Administrator said if the resident continued to refuse then he expected the staff to document the refusal. The Interim Administrator said he was unsure, if a resident was to receive their baths as scheduled, helped with skin breakdown, or preventing skin issues since he was not clinical. The Interim Administrator said residents not receiving their baths/showers as scheduled was an infection control issue. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1D. Record review of Resident #36's face sheet dated 02/27/2024, indicate Resident # 36 was a [AGE] year-old female admitted to the facility on [DATE], with a diagnosis which include Metabolic Encephalopathy (a problem in the brain), morbid severe obesity due to excess calories (BMI greater than 40, a BMI of greater than 35 with at least one serious obesity-related condition, or being more than 100 pounds over your recommended weight), abnormal posture (rigid body movements and chronic abnormal positions of the body), muscle weakness (commonly due to lack of exercise, aging, muscle injury) chronic obstructive pulmonary disease (disease that causes airflow blockage and breathing-related problems). Bipolar disorder, current episode depressed, severe, without psychotic features (depressed, as in severe depressive episode without psychotic symptoms, and has had at least one authenticated hypomanic, manic, or mixed affective episode in the past). Record review of Resident # 36's Quarterly MDS assessment dated [DATE], indicated Resident #36 was understood and was able to understand others. The MDS assessment indicated Resident #36 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #36 needs substantial or maximal assistance with showers. Record review of Resident #36's a care plan with dated 02/26/2024, indicated Resident #36 indicates Resident #36 prefers a bed bath on shower days. Staff will continue to encourage resident to utilize shower but will honor Resident #36 preference for bed bath. Record review of Resident #36's progress notes dated 02/27/2024, indicated Resident #36 requested showers on Monday, Wednesday, and Thursday between 6 AM to 2:00 PM on 2/12/2024. During an observation and interview on 02/26/204 at 10:23 A.M. Resident # 36 stated she gets her bath on Monday, Wednesday, and Friday when the facility had enough staff. Resident #36 stated she prefers a shower however it takes two staff members to use the Hoyer lift to get her up. Resident # 36 stated she prefers a shower to a bed bath because of her size. And she did not feel the staff got her clean when they gave her a bed bath. Resident #36 stated she spoke with the DON regarding getting her showers on time, but she could not remember when. 1E. Record review of Resident #9's face sheet dated 02/27/2024, indicate Resident # 9 was a [AGE] year-old female admitted to the facility on [DATE], with a diagnosis which include unspecified Dementia (mild cognitive impairment has yet to be diagnosed as a specific type of dementia), Diverticulitis of large intestine without perforation or abscess without bleeding (a complication that can affect people with diverticulosis, small pockets on the inside of their colon), type 2 Diabetes Mellitus without complication (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), muscle weakness (a lack of muscle strength). Record review of Resident # 9's Quarterly MDS assessment dated [DATE], indicated Resident #9 was understood and was able to understand others. The MDS assessment indicated Resident #9 had a BIMS score of 14, which indicated her cognition was intact. The MDS assessment indicated Resident #9 needed assistance with shower setup and supervision during shower time. Record review of Resident #9's a care plan with dated 08/01/2023, indicated Resident #9 was able to bathe with supervision for safety. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 02/26/2024 at 12:45 P.M., Resident # 9 stated she gets her bath on Tuesday, Thursday, and Saturday unless the CNAs were too busy then she would take a wash off. Resident # 9 stated she did not get a shower on Thursday or Saturday. Resident #9 stated has not had a bath since last Tuesday. During an observation and interview on 02/29/2024 at 2:00 P.M., Resident # 9 appeared well groomed but stated she still has not had a shower. During an interview on 03/02/2024 at 2:01 P.M, CNA Z stated the CNAs are responsible for the residents' showers. CNA Z stated she was responsible for her residents on her hall and will help with showers for the 6p to 6a shift when needed. CNA Z stated it was important for resident so get showers for personal hygiene and it makes them feel better. CNA Z stated she did not know why some residents was not getting showered and could not say what other CNA's do on their shift. CNA Z stated the harm could be infections or skin break down. During an interview on 03/02/2024 at 2:24 P.M, LVN L stated it was true the residents were not getting their showers on their shower days. LVN L stated it was the charge nurse's responsibility to make sure the CNAs gave the showers on time. LVN L stated it was almost impossible to get everyone showered with the staff scheduled and would report to the ADON. LVN L stated it was important for the residents to get their showers to feel clean and comfortable. LVN L stated it could cause emotional harm and skin break down. During an interview on 03/02/2024 at 3:00 P.M, ADON E stated it was the CNAs responsibility to shower the residents and the chare nurse was to follow up. ADON E stated she expected the residents to get their shower on the scheduled day, time and in between when needed. ADON E stated it was important to shower the residents to maintain skin integrity. ADON E stated the harm could be skin break down or wounds. During an interview on 03/02/2024 at 3:33 P.M, the Administrator stated it was he expected the CNAs to shower residents on their scheduled days. The Administrator stated it was it was nursing responsibility to make sure residents get their showers. The Administrator stated it was important for resident to get showers for cleanliness. The Administrator stated it was he was unsure of the harm. The Administrator stated he would monitor by making a list and doing rounds. During an interview on 03/02/2024 at 4:15 P.M, the DON stated she expected the residents to be showered according to their schedule or request. The DON stated showers were important for skin hygiene and identifying any skin issues. The DON stated she did not know why the residents were not getting showered. If they refused or just did not remember. The DON state she would pull up a list to monitor showers. The DON stated the harm could be skin issues. 1F Record review of a face sheet dated 03/02/2024 indicated Resident #179 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis of all four limbs, and the trunk of the body), congenital insufficiency of aortic valve (heart defect that prevents blood from flowing backward through the heart), neuromuscular dysfunction of the bladder (condition where a person lacks bladder control due to brain, spinal cord, or nerve problems). (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Comprehensive MDS assessment dated [DATE], indicated Resident #179's speech was unclear, was sometimes able to make himself understood, and understood others. The MDS assessment indicated Resident #179 had a BIMS score of 12 which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #179 was dependent on staff for all ADLs, including bathing. Record review of the care plan last revised 02/23/2024 indicated Resident #179 had quadriplegia to assist with ADLs and locomotion as required. The care plan indicated Resident #179 required 2 staff assistance for bathing. Record review of the Follow Up Question Report for Bathing dated 02/01/2024-02/29/2024 indicated Resident #179 was scheduled for his baths on Tuesday, Thursday, and Saturday on the 6 AM-2 PM shift. The report indicated Resident #179 received a bed bath on 02/14/2024, 02/15/2024, 02/22/2024, 02/24/2024, and 02/27/2024, which indicated he did not receive a bed bath on 02/16/2024, 02/19/2024, 02/21/2024, 02/23/2024, 02/26/2024. During an observation and interview on 02/26/2024 at 10:46 AM, Resident #179 said he was not getting his baths as scheduled. Resident #179 was noted to have musty body odor. During an interview on 02/29/2024 at 12:25 PM, ADON S said the CNAs documented the baths/showers in the resident's electronic health record. ADON S said there was not one person in charge of monitoring bathing. ADON S said she tried to make sure the residents were getting their baths/showers by getting out on the floor and checking the residents. ADON S said she checked through the documentation 2-3 times a week, and she had not noticed any missed baths. ADON S said the charge nurses and nurse management were responsible for ensuring the residents received their baths. ADON S said it was important for the residents to get their baths/showers for infection control, to make them feel better about themselves, and to prevent skin breakdown, rashes, odors, and the chances of illnesses. During an interview on 03/02/2024 at 2:08 PM, CNA EE said Resident #179 was scheduled for a bed bath on Tuesday, Thursday, and Saturday on the 6 AM-2 PM shift or the 2 PM to 10 PM shift. CNA EE said she had given Resident #179 a bed bath on Tuesday 02/27/2024. CNA EE said she had noticed sometimes Resident #179 did not get his bed baths as scheduled, and she would give him one when she noticed he had not received his bed bath. CNA EE said she had reported to management that she had noticed Resident #179 and other residents were not receiving their baths/showers as scheduled when she was not working. CNA EE said it was important for the residents to receive their bed baths/showers, so they did not have an odor, for them to be clean, and to prevent skin breakdown. During an attempted interview regarding Resident #179's baths on 03/02/2024 at 2:23 PM, CNA GGG did not answer the phone. During an interview on 03/02/2024 at 4:23 PM, the Administrator said nursing was responsible for ensuring the residents received their bathes/showers. The Administrator said it was important for the residents to receive their bathes/showers for hygiene purposes. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/02/2024 at 4:45 PM, LVN W said ultimately the charge nurses were responsible for ensuring the residents received their baths/showers, but the CNAs were supposed to know the schedule so they could provide the baths/showers. LVN W said she monitored to ensure the bathes were given by asking the residents, making observations of the residents, and asking the CNAs if they had given the baths/showers. LVN W said it was important for the residents to receive their baths/showers for their dignity and skin to prevent infections and skin breakdown. LVN W said showers/baths made the residents feel better and more comfortable. During an interview on 03/02/2024 at 5:15 PM, the DON said first the CNAs and the nurses were responsible for ensuring the residents received their baths/showers, and then the ADONs and herself. The DON said she monitored the bathing by checking the reports to ensure the residents were receiving their baths/showers weekly. The DON said on occasions she had noticed some of the baths were missed. The DON said she started asking the residents and making observations of the residents to see if they had received their baths/showers. The DON said it was important for the residents to receive their baths/showers to prevent skin breakdown, for cleanliness, and to prevent infection. 2. Record review of a face sheet dated 3/2/2024 indicated Resident #41 was an [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia with behavioral disturbances, the need for continuous supervision, and high blood pressure. Record review of a Significant Change MDS dated [DATE] indicated Resident #41 was usually understood and sometimes understands. The MDS indicated Resident #41's cognition was severely impaired. The MDS indicated in Section E Behaviors Resident #41 had not rejected care during the assessment period. The MDS in Section GG indicated Resident #41 required substantial to maximal assistance with his personal hygiene. Record review of the comprehensive care plan dated 8/08/2023 and revised on 9/08/2023 indicated Resident #41 had a self-care performance deficit. Resident #41's care planned goal was he would maintain or improve his current level of function with his ADLs. Resident #4's care plan failed to address his preferences and assistance need for shaving. During an observation on 2/26/2024 at 9:31 a.m., Resident #41 was lying in his bed his face had 1/4 inch growth of facial hair. Resident #41 said when asked if he enjoyed being clean shaven, he replied yes. Resident #41 said when asked if he shaved daily in the past, he replied yes. During an observation, and interview on 3/02/2024 at 1:59 p.m., Resident #41 was lying in his bed. CNA H viewed Resident #4's facial hair and said he needed to be shaved. CNA H said the staff had misplaced his electric razor. CNA H said the razor had been missing for approximately a week. CNA H said the care provider and responsible party was going to purchase another razor. During an interview on 3/02/2024 at 2:04 p.m., LVN F said she expected Resident #41 to be shaved on their shower days or as often as the resident desired. LVN F said the CNAs were responsible for the ADLs including personal hygiene. LVN F said Resident #41's razor had been stolen or lost was the reasoning why he had not been shaved. LVN F said she had not completed a grievance on behalf of Resident #41's lost razor. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/02/2024 at 2:36 p.m., the DON said the CNAs, and NAs were responsible for the personal hygiene tasks for the residents. The DON said the nurses were responsible for monitoring to ensure the ADLs were completed. The DON said the department heads completed champion rounds where they would report ADL concerns. The DON said a resident could become upset when their personal hygiene needs were not being met. During an interview on 3/02/2024 at 3:31 p.m., the Administrator said when a resident wanted to be shaved, he expected the resident to get help with this task. The Administrator said a resident could have skin issues arise when ADLs like shaving was not completed. The Administrator said the nursing department was responsible for ensuring ADLs were completed. The Administrator said the ADLs were monitored during rounds, champion rounds, and by monitoring data from the computerized systems. Record review of the facility's policy Bath, Tub/Shower dated 2003, indicated . Bathing by tub bath or shower is done to remove soil, dead epithelial cells, microorganisms from skin, and body odor to promote comfort, cleanliness, circulation, and relaxation . The frequency and type of bathing depends on resident preference, skin condition, tolerance, and energy level. The policy did no address shaving. 33249 46892 47612		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview and record review, the facility failed to provide an ongoing program of activities in accordance with the comprehensive assessment to meet the interests and the physical, mental, and psychosocial well-being for 1 of 24 residents (Resident #179) reviewed for activities. The facility failed to provide consistent and scheduled in-room activities for Resident #179 to meet his needs. These failures could place residents at risk for not having activities to meet their interests or needs and a decline in their physical, mental, and psychosocial wellbeing. Findings included: Record review of a face sheet dated 03/02/2024 indicated Resident #179 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis of all four limbs, and the trunk of the body), major depressive disorder recurrent (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks), and anxiety disorder. Record review of the Comprehensive MDS assessment dated [DATE], indicated Resident #179's speech was unclear, was sometimes able to make himself understood, and understood others. The MDS assessment indicated Resident #179 had a BIMS score of 12 which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #179 was dependent on staff for all ADLs. The staff assessment of daily and activity preferences indicated Resident #179 preferred choosing clothes to wear receiving shower, bed bath, sponge bath, staying up past 8:00 PM, family or significant other involvement in care discussions, use of phone in private, place to lock personal belongings, listening to music, keeping up with the news, doing things with groups of people, participating in favorite activities, and participating in religious activities or practices. Record review of the care plan with date initiated 02/23/2024 did not indicated Resident #179's had activities care planned. Record review of Resident #179's Activity assessment dated [DATE] indicated it was somewhat important to him to listen to music, be around animals such as pets, keep up with the news, do things with groups of people, do your favorite activities, to participate in religious services or practices, and it was very important to him to take care of his personal belongings or things, and to choose between a tub bath, shower, bed bath, or sponge bath, to have his family or a close friend involved in discussion about his care, to be able to use the phone in private, and to have a place to lock his things to keep them safe. Record review of the Activity Participation task in Resident #179's electronic health record for the past 30 days did not indicate any activities had been done. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Brentwood Terrace Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 Stillhouse Road Paris, TX 75460	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/02/2024 at 10:11 AM, the AD said her last day at the facility was Monday (02/26/2024), and prior to her last day she had been employed at the facility for 2 years. The AD said Resident #179 had recently admitted to the facility a couple of weeks ago, and she had visited with Resident #179 in his room a couple times. The AD said Resident #179 was supposed receive in-room activities. The AD said in-room activities should be performed 2-3 times a week with the residents. The AD said she did not have a schedule for in-room activities. The AD said she had not been able to provide in-room activities for Resident #179 2-3 times a week. The AD said she had gotten to the point where she just popped into the residents' rooms for the in-room activities because there was only one AD, and she was having to do 5-10 activities a day between the front of the building and the secured unit. The AD said when she performed in-room activities she documented it in the resident's electronic health record. The AD said it was important for the residents to receive in-room activities for social interaction and because activities gave the residents purpose. The AD said not doing the in-room activities could make the residents decline and depressed. The AD said she had mentioned to the previous administrators multiple times that she required assistance, and they told her the CNAs could help her when they were available. During an interview on 03/02/2024 at 4:21 PM, the Administrator said he would assume it was the AD responsibility to do in-room activities. The Administrator said he expected for activities to be provided so the residents were not just sitting there to give them something to do. During an interview on 03/02/2024 at 5:10 PM, Resident #179 said they were supposed to do in-room activities for him this week, but nobody had done them. Resident #179 said not having in-room activities made him sad and lonely. Resident #179 said in-room activities would give him the opportunity to have someone to talk to. Record review of the facility's Activity Policy & Procedure Manual 2011, titled Individualized Activity Programs, indicated, Standard: The Activity Director and staff will provide individual programming to meet individual needs and interests. Practice Guidelines: 1. The Activity Director determines the need for individual programming through the resident assessment process .one on one activities are provided regularly for those residents unable or unwilling to attend groups unless otherwise indicated by assessment. 4. Individual programs are coordinated by the Activity Director, or designee, maintained, and documented in the plan of care .		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 4 of 11 residents (Resident #'s 4, 44, 130, and 180) reviewed for accidents. The facility failed to ensure Resident #44 was provided with adequate supervision when she was physically assaulted by Resident #41 on [DATE]. The facility failed to ensure Resident #4 who required 1 person assistance with toileting was provided adequate supervision to prevent an unwitnessed fall on [DATE] at 10:30 p.m. The facility failed to ensure Resident #4 was not left unsupervised on the toilet on [DATE] and was able to self-transfer between the toilet and the wheelchair. The facility failed to ensure Resident #130 was not provided adequate supervision to prevent an unwitnessed fall on [DATE] and [DATE]. The facility failed to prevent incidents and accidents when Resident #180 sustained an unwitnessed fall with injury (moderate sized frontal scalp soft tissue hematoma (blood collected outside of the blood vessels due to injury or trauma to the right side of the forehead)) and expired on [DATE]. An IJ was identified on [DATE] at 3:39 PM. The IJ template was provided to the facility on [DATE] at 3:39 PM. While the IJ was removed on [DATE], the facility remained out of compliance due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk of harm, severe injury, and possible death to residents who require supervision. The findings included: 1)Record review of a face sheet dated [DATE] indicated Resident #44 was an [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia (memory loss), muscle weakness, reduced mobility, anxiety disorder. Record review of a Significant Change MDS dated [DATE] indicated Resident #44 was sometimes understood and usually understands others. The MDS indicated Resident #44 was unable to complete her BIMS exam due to her cognition. The MDS indicated Resident #44 had inattention and disorganized thinking being continuously present. The MDS indicated Resident #44 had no behavioral symptoms but wandered , d+[DATE] days during the assessment period. The MDS indicated Resident #44 required extensive assistance of two staff for transfers, and extensive assistance of one staff member for bed mobility, and locomotion on and off the unit. The MDS indicated Resident #44 had a history of falls with fractures within the last 6 months. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the comprehensive care plan dated [DATE] and updated on [DATE] indicated Resident #44 was at risk to fall related to unsteady gait/balance, generalized weakness, and poor safety awareness. The care plan indicated Resident #44 was at risk to wander related to a history of attempts to leave the facility related to poor safety awareness and as the intervention resides on the secured unit. Record review of the of an Event Nurses' note dated [DATE] at 6:30 p.m., indicated LVN D documented she was called to Resident #55's room. LVN D documented Resident #44 was lying on the floor beside the closet door on the floor on her back with Resident #41 standing over her. LVN D documented Resident #55 had an abrasion to her right temple area with bruising to her right inner arm. LVN D documented Resident #44 was unable to state what had happened but Resident #55 said Resident #41 pushed Resident #44 against the closet door. The event note indicated LVN D sent Resident #44 to the local hospital. The note in #17 interventions in place prior to this fall was none of the above. Record review of a progress note dated [DATE] at 7:30 p.m., LVN D wrote she was called to another resident room where she found Resident #44 was found on the floor bedside the closet door on her back with Resident #414 standing over her, and Resident #55 stated Resident #41 pushed Resident #44 against the closet door. Record review of a Fall-Risk assessment dated [DATE] documented by LVN D indicated Resident #44 had intermittent confusion, no falls in the past 3 months, was ambulatory, and was incontinent. LVN D documented Resident #44 had a balance problem while standing, balance problem while walking, decreased muscular coordination, and change in her gait pattern when walking through a doorway. Record review of a hospital Emergency Department History of Present Illness indicated Resident #44 was sent to the local emergency roiaognom on [DATE] with the chief complaint as assault. The note written by the physician indicated Resident #44 assessment revealed a head contusion (bruise) and a hematoma (a collection of blood outside of the vessel). The note indicated in the review of systems Resident #44 had a headache. The physical examination documented indicated Resident #44 was moderately distressed, had ecchymosis (bruising caused by injury), swelling, and tenderness to the right side of her head. Record review of a CT Head without Intravenous Contrast dated [DATE] indicated Resident #44's CT impression indicated she had a right parietal scalp hematoma (A scalp hematoma is a collection of blood (either flowing or clotted from ruptured blood vessels that will then collect in the area of space and tissue between the skull and skin). Record review of the of an Event Nurses' note dated [DATE] at 6:30 p.m., indicated LVN D documented she was called to Resident #55's room. LVN D documented Resident #44 was lying on the floor beside the closet door on the floor on her back with Resident #41 standing over her. LVN D documented Resident #55 had an abrasion to her right temple area with bruising to her right inner arm. LVN D documented Resident #44 was unable to state what had happened but Resident #55 said Resident #44 pushed Resident #44 against the closet door. The event note indicated LVN D sent Resident #44 to the local hospital. The note in #17 interventions in place prior to this fall was none of the above. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a progress note dated [DATE] at 7:30 p.m., LVN D wrote she was called to another resident room where she found Resident #44 was found on the floor bedside the closet door on her back with Resident #44 standing over her, and Resident #55 stated Resident #41 pushed Resident #44 against the closet door. Record review of a Fall-Risk assessment dated [DATE] documented by LVN D indicated Resident #44 had intermittent confusion, no falls in the past 3 months, was ambulatory, and was incontinent. LVN D documented Resident #44 had a balance problem while standing, balance problem while walking, decreased muscular coordination, and change in her gait pattern when walking through a doorway. Record review of a hospital Emergency Department History of Present Illness indicated Resident #44 was sent to the local emergency roiaognom on [DATE] with the chief complaint as assault. The note written by the physician indicated Resident #44 assessment revealed a head contusion (bruise) and a hematoma (a collection of blood outside of the vessel). The note indicated in the review of systems Resident #44 had a headache. The physical examination documented indicated Resident #44 was moderately distressed, had ecchymosis (bruising caused by injury), swelling, and tenderness to the right side of her head. Record review of a CT Head without Intravenous Contrast dated [DATE] indicated Resident #44's CT impression indicated she had a right parietal scalp hematoma (A scalp hematoma is a collection of blood (either flowing or clotted from ruptured blood vessels that will then collect in space and tissue between the skull and skin). During an observation and interview on [DATE] at 9:00 a.m., Resident #44 was sitting at the dining table with a large size raised area with bruising noted to her right side of her head in the temporal/parietal region. Resident #44 said she felt well but she denied having her head hurt. 2) Record review of a face sheet dated [DATE] indicated Resident #41 was an [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia with behavioral disturbances, the need for continuous supervision, and high blood pressure. Record review of a Significant Change MDS dated [DATE] indicated Resident #41 was usually understood and sometimes understands. The MDS indicated Resident #41's cognition was severely impaired. The MDS indicated Resident #41 had no physical, or verbal behaviors exhibited. The MDS indicated Resident #41 wandered daily. Record review of the comprehensive care plan dated [DATE] and revised on [DATE] indicated Resident #41 was at risk for mood problems and received medications. The goal of the care plan indicated Resident #41 would have an improved mood state. The care plan interventions included administer medications, behavioral health consults as needed, monitor and record mood to determine if problems seem to be related to external causes. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a progress note dated [DATE] at 6:00 p.m., LVN D documented she was called to a resident room by CNA A. LVN D documented Resident #41 was in Resident #55's room where she found Resident #44 on the floor beside the closet door. LVN D documented Resident #41 was standing over Resident #44. LVN D documented she asked Resident #41 and Resident #44 what had occurred, and neither could explain. LVN D documented Resident #55 said Resident #41 pushed Resident #55 against the closet door and she fell . LVN D documented Resident #41 was very uncooperative and had tried to hit CNA A and Resident #55. Record review of Behavior Nurses Note dated [DATE] at 6:30 p., LVN D documented she was called to the secured unit by the nurse aide. LVN D documented Resident #41 was in Resident #55's room. LVN D documented she found Resident #44 on the floor lying beside the closet door. LVN D documented Resident #41 was standing over Resident #44. LVN D documented Resident #55 said he pushed her up against the closet door and she fell . LVN D said Resident #41 and #44 was unable to indicate what had happened. LVN D said Resident #44 was very uncooperative and had tried to the hit the CNA on duty and Resident #55. Record review of an Event Nurses' note dated [DATE] at 6:30 p.m., indicated LVN D documented Resident #41 was found in another resident room. LVN D documented Resident #41 had displayed physical, and resident to resident behaviors with another resident injured. The Event Nurses' note indicated LVN D moved Resident #41's room and initiated every 15-minute checks. Record review of a Every 15 Minute Check sheet indicated Resident #41 was placed on every 15-minute checks starting on [DATE] at 6:30 p.m. The Every 15- minute checks at 0015 indicated LVN D documented at 12:15 a.m., Resident #44 was asleep. LVN D had only her initials beside the other every 15-minute checks starting at 12:30 a.m. - 5:45 a.m. on [DATE] there was no remarks indicating anything in regarding Resident #41. During an observation on [DATE] at 9:31 a.m., Resident #41 was lying in his bed asleep. During an interview on [DATE] at 4:17 p.m., the SW said she was notified by the DON regarding the incident with Resident #44 and Resident #41. The SW said upon her arrival Resident #44 was already at the local emergency room , and Resident #41 was wandering on the unit. The SW said Resident #41 and Resident #55 both were unable to recollect the recent incident. During an interview on [DATE] at 9:32 p.m., CNA A said she was alone on the secured unit gathering her supplies in the spa/communal shower room when she heard a loud scream. CNA A said she ran out of the spa room and ran toward the end of the hall where she believed the sound was heard from. CNA A said upon entering the room, Resident #44 was lying in the floor, Resident #55 said Resident #41 had thrown Resident #44 into the door. CNA A said Resident #41 was aggressive with her at the time and tried to swing at her. CNA A said she left Resident #55's room and ran the length of the secured unit, opened the door, and yelled for help. CNA A said she was alone on the secured unit and had no other recourse than to go for help. CNA A said LVN D was passing medications and another nurse responded to her call for help. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:46 a.m., the DON said on [DATE] CNA A heard a noise and responded to the noise. The DON said LVN D called and said Resident #41 was upset and wandering in other rooms. The DON said CNA A had said Resident #44 was on the floor. The DON said she was unsure of Resident #44 hitting her head although she had an abrasion to her head. The DON said Resident #44 was sent to the emergency room closer to midnight due to complaining her head was hurting. During an interview on [DATE] at 11:51 a.m., LVN D said she was called to the unit by CNA A. LVN D said Resident #44 was lying in the floor of Resident #55's room, with Resident #41 standing over Resident #44 around 6:30 p.m. on [DATE]. LVN D said Resident #55 said Resident #41 pushed Resident #44 against the closet and Resident #41 fell. LVN D said at the time of the incident Resident #44 had an abrasion to her right temple area and a bruise to her inner right arm. LVN D said Resident #41 was very uncooperative and attempted to hit others. LVN D said she was advised to place Resident #41 on every 15-minute checks by the DON. LVN D said although her documentation was not completed yet Resident #41 remained asleep. LVN D said CNA A had to leave Resident #44 to come for help. LVN D said she was not on the secured unit but was on hall 400 when the incident occurred. During an interview on [DATE] at 12:22 p.m., CNA H said CNA A had always worked the secured unit alone. CNA H said when CNA A was in the room with other residents who would be watching the other residents, or who would go for help. CNA H said there was no one was on the unit to get help when CNA A needed help. 3) Record review of a face sheet dated [DATE] indicated Resident #130 was a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia with behavioral disturbances, lack of coordination, and a need for assistance with personal care. Record review of the Comprehensive Care Plan dated [DATE] and revised on [DATE] indicated Resident #130 was a high risk for falls related to wandering. The goal of the care plan was Resident #130 would be free of falls. The care plan interventions included to anticipate and met Resident #130's needs, ensure his call light was within reach, encourage the use of the call light, and have prompt response to the request for assistance, and ensure Resident #130 wore appropriate footwear. The comprehensive care plan failed to have interventions after the falls on [DATE] and [DATE]. Record review of an incident report dated [DATE] at 10:00 p.m., LVN C indicated Resident #130 was found by the CNA on the floor, with no signs of pain. The note indicated Resident #130 was limping on the left leg and was sent to the local emergency room at 10:35 p.m. via the ambulance. Record review of an Event Nurses-Note dated [DATE] at 10:00 p.m., indicated Resident #130 had an unwitnessed fall in his room. LVN C documented Resident #130 was assisted up and was noted to be limping on the left leg. LVN C documented the physician was notified and Resident #130 was sent to the local hospital. The note indicated the interventions included interval monitoring (specify below) there was no documentation below. The note indicated in additional interventions there were interventions of a low bed and interval monitoring (again not specified). The note indicated Resident #130 was independent with bed mobility, toileting, and transferring. The note indicated Resident #130 was independent with bed mobility, toileting, and transferring. The note indicated Resident #130 had an unsteady gait, balance problem, and lack of mobility strength. The note indicated Resident #130 was wearing shoes or anti-slip socks. The note indicated Resident #130 had Ativan 0.5 milligrams twice daily started on [DATE]. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a fall risk assessment completed by LVN C on [DATE] indicated Resident #130 was disoriented at all times to person, place, and time. The assessment indicated Resident #130 had no previous falls, was ambulatory, continent, had balance problems, decreased muscular coordination, and gait pattern changes. Record review of a Medication Administration Record dated [DATE] - [DATE] indicated on [DATE] Resident #130 was administered Ativan 0.5 milligrams for anxiety or agitation. The record also indicated Resident #130 received the Ativan 0.5 milligrams twice daily on [DATE] and on the morning of [DATE]. Record review of an Event Nurses-Note dated [DATE] at 10:00 p.m., indicated Resident #130 had an unwitnessed fall in his room. LVN C documented Resident #130 was assisted up and was noted to be limping on the left leg. LVN C documented the physician was notified and Resident #130 was sent to the local hospital. The note indicated the interventions included interval monitoring (specify below) there was no documentation below. The note indicated in additional interventions there were interventions of a low bed and interval monitoring (again not specified). The note indicated Resident #130 was independent with bed mobility, toileting, and transferring. The note indicated Resident #130 had an unsteady gait, balance problem, and lack of mobility strength. The note indicated Resident #130 was wearing shoes or anti-slip socks. The note indicated Resident #130 had Ativan 0.5 milligrams twice daily started on [DATE]. Record review of an incident report dated [DATE] at 5:30 p.m., indicated Resident #130 was found with his head lying against the closet door by LVN HHH. The note indicated Resident #130 had a bruise to his right shoulder and a skin tear to his left hand. The note indicated the conclusion was Resident #130 had an unwitnessed fall with injuries. The note indicated his bed was changed to a low bed. Record review of an Event Nurses-Note dated [DATE] at 6:39 p.m., indicated Resident #130 was found by LVN HHH when she was passing dining trays. The note indicated Resident #130 was lying with his head against the closet door. The note indicated Resident #130 had a skin tear. The note indicated Resident #130 had a purple bruise to his right shoulder. The note indicated Resident #130 was in pain noted by his occasional moans or groans, and facial grimacing. The note indicated Resident #130's physical factors included previous fall, urinary tract infection, pain, and incontinence. The note indicated Resident #130 required 1 staff with bed mobility, toileting, transferring, and walking. The note indicated Resident #130 leaned forward. Record review of an e-Transfer Form dated [DATE] at 6:00 p.m., indicated Resident #130 was transferred to the local hospital due to a fall by LVN HHH. Record review of a Fall-Risk assessment dated [DATE] at 6:47 p.m. indicated Resident #130 was disoriented, has fallen 3 or more falls in the past 3 months, ambulatory, and incontinent. The assessment indicated Resident #130 had balance problems while standing and walking. Record review of the History of Present Illness from the local hospital on [DATE] indicated Resident #130 fell and was sent to the local emergency room . The note indicated Resident #130 had a right hip fracture. The note indicated Resident #130 was seen 24 hours prior to this visit related to multiple falls at the facilitydur . (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review from the hospital orthopedist report dated [DATE] indicated Resident #130 had fallen over the last couple of weeks at least ,d+[DATE] times. The orthopedist documented Resident #130 was in the emergency room the day before post a fall with negative x-rays at the time. The note indicated the CT results indicated a minimally impacted right femoral neck fracture. The note indicated the physician spoke to the family and the family wanted a non-operative treatment and return to the facility with palliative care. Record review of hospital records dated [DATE] indicated Resident #130 was admitted at 6:59 p.m. with the diagnosis of closed fracture of the right hip. The discharge records indicated Resident #130 was returned to the facility on hospice services. Resident #130's discharge orders included bedrest, non-weight bearing to the right leg, and pain management. Record review of the cat scan of the chest, abdomen, and pelvis dated [DATE] indicated right femoral neck fracture. Record review of a progress note dated [DATE] at 4:25 p.m., indicated the social worker documented Resident #130 returned from the hospital, admitted on a hospice service, and was made a do not resuscitate status. Record review of a physician's progress note dated [DATE] indicated Resident #130 had a fall with a fracture to the right hip and he was being treated conservatively. Record review of an Incident Report dated [DATE] at 3:30 p.m., completed by LVN YY indicated Resident #130 was observed sitting on the floor beside his bed with his back leaning on the mattress. The note indicated Resident #130's bed was in low position. The note indicated the predisposing physiological factors were confusion, incontinent, recent medication changes, and impaired memory. Record review of a progress note dated [DATE] at 8:00 p.m., LVN D documented Resident #130 had a fall slipped off of the bed. LVN D documented there were no injuries. LVN D documented she administered Tramadol 50 milligrams due to Resident #130 appeared in pain, and then he was assisted up to the recliner because he refused to rest in his bed. During an interview on [DATE] at 11:43 a.m., CNA H said she has had to work the secured unit alone. CNA H said she had voiced the inability to provide supervision to Resident #130 during the time his leg was fractured and to prevent him from trying to ambulate on his broken leg. During an observation and interview on [DATE] at 10:55 p.m., CNA K said she had to work the secured unit many times alone. CNA K said she could remember Resident #130 had a fall and fractured his hip. CNA K said she could not remember providing care to Resident #130. CNA K said she had told the DON, and ADONs previously the secured unit was not staffed enough to provide adequate supervision to the residents. During this interview there were 5 residents of the secured unit up and ambulating about the unit in and out of rooms. CNA K said she was having a difficulty time keeping the residents centrally located to ensure their safety. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:30 p.m., LVN C said she had cared for Resident #130. LVN C said she had voiced concern numerous times and threatened to call safe harbor due to the inability to provide adequate supervision and care to her assigned residents. LVN C said due to the lack of staff on the secured unit she was unable to ensure the residents remained safe. LVN C said it was not unusual to have only one staff member on the secured unit from 10:00 p.m. - 6:00 p.m. LVN C said she still had medication to administer to Resident #4, therefore she was on her way to the secured unit. 4) Record review of a face sheet dated [DATE] indicated Resident #4 admitted on [DATE] and readmitted [DATE] with the diagnosis of diabetes, muscle weakness, lack of coordination, reduced mobility, repeated falls, dementia, and assistance with personal care. Record review of the comprehensive care plan dated [DATE] and revised on [DATE] indicated Resident #4 had an ADL self-care performance deficit. The goal of the care plan indicated Resident #4 would remain at her current level of function in transfers, and toileting. The care plan interventions included Resident #4 required one staff assistance with toileting. The comprehensive care plan indicated Resident #4 was at risk for falls related to weakness and impaired cognition. The goal of the care plan was Resident #4 would not sustain a serious injury. The care plan interventions included ensure Resident #4's call light was within reach, ensure don't call fall sign (fall prevention sign) at the foot of the bed visible by Resident #4, and frequent visual checks while in bed. Record review of an Admission MDS dated [DATE] indicated Resident #4 was usually understood and understands others. The MDS indicated Resident #4's cognition was moderately impaired. The MDS in section GG indicated Resident #4 required partial to moderate assistance with toileting, bed to chair transfers, toileting transfers and to sit and stand. Record review of a Fall-Risk assessment dated [DATE] at midnight LVN D indicated Resident #4 had , d+[DATE] falls in the past, required assistance with elimination, and took ,d+[DATE] medications which could increase the risk of falls. The fall risk assessment indicated Resident #4 was at high risk to fall. Record review of a fall incident report dated [DATE] at midnight, LVN D indicated Resident #4 ambulated without assistance and was not wearing any shoes or socks. Record review of a progress note dated [DATE] at midnight, LVN D documented Resident #4 was sitting in the hallway on her bottom with her legs straight in front of her. LVN D said Resident #4 said she had slipped down. LVN D documented Resident #4 was not wearing shoes or socks. LVN D documented Resident #4 complained of right foot pain. Record review of a fall incident report dated [DATE] at 10:30 p.m., LVN C indicated no injuries were observed. The incident report was left blank. Record review of a Fall-Risk assessment dated [DATE] at 10:30 p.m., LVN C documented Resident #4 was at high risk to fall. LVN C documented Resident #4 was disoriented, had 3 or more falls in the past 3 months, required assistance with elimination, had problems with balance, and took ,d+[DATE] medications which could cause falls. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a Fall Nurses Note dated [DATE] at 10:46 a.m., LVN F documented Resident #4 had a fall without injury. LVN F documented fall interventions were the bed low, interval monitoring, neurological checks, frequent visual checks, encourage and educate use of the call light. Record review of a progress note dated [DATE] at 11:30 p.m., LVN C indicated Resident #4 said she had fallen on the floor, and she had been pulling up her pants. During an interview on [DATE] at 8:48 a.m., LVN C said CNA K was in another resident's room providing care when she heard Resident #4 calling for help. LVN C said CNA K was alone, so she had to hurriedly finish in the room to be able to assist Resident #4. LVN C said Resident #4 was lying on the bathroom floor when CNA C was able to get to her. LVN C said the secured unit was understaffed to provide adequate supervision for Resident #4 and other residents. During an observation and interview on [DATE] at 11:48 a.m., CNA H responded to the surveyor assisting Resident #4 with activating her call light for assistance to the bathroom. CNA H responded and assisted Resident #4 from her bed to the wheelchair, then from the wheelchair to the toilet. CNA H left Resident #4 alone on the toilet and went to get Resident #4's lunch tray. Upon returning to the room, Resident #4 was exiting the bathroom already in her wheelchair. CNA H said Resident #4 had a history of falls and was a fall risk. CNA H said she should have not left Resident #4 alone because of her risk to fall. Record review of an incident report dated [DATE] at 11:45 p.m., LVN C documented Resident #4 had a fall with no injuries noted. The incident report had no further documentation within. Record review of an Event Nurses' Note-Fall dated [DATE] at 11:45 p.m., LVN C documented Resident #4 had an unwitnessed fall. LVN C documented Resident #4 was found on the floor, indicated Resident #4 said legs gave out, and Resident #4 attempted to self-toilet. LVN C documented in the area of Nursing Description: Resident #4 indicated she got up to use the bathroom, failed to call for help, denied bumping her head, and was found sitting on the floor. 5) Record review of a face sheet dated [DATE] indicated Resident #180 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included fracture of the left lower leg, chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs), and heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #180 was understood and understood others. The MDS assessment indicated Resident #180 required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. The MDS assessment indicated Resident #180 was frequently incontinent of urine and occasionally incontinent of bowel. The MDS assessment indicated Resident #180 had not had any falls since admission/entry or reentry or the prior assessment. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the care plan last revised [DATE] indicated Resident #180 was at risk for falls related to weakness and confusion with a goal of Resident #180 will be free of falls through the review date. Interventions included to anticipate and meet her needs, be sure her call light was within reach and encourage the resident to use it for assistance as needed, bed in low position when care is not being provided, Resident #180 needed a safe environment, mechanical lift with 2 staff assistance with transfers, and to review information on past falls and attempt to determine the cause of the falls record possible root causes. The care plan indicated Resident #180 had bladder incontinence to provide incontinent care at least every 2 hours. The care plan indicated Resident #180 had bowl incontinence to check her every two hours and assist with toileting as needed and to provide peri care after each incontinent episode. The care plan indicated Resident #180 had an ADL self-care performance deficit and required a lift for all transfers, one staff assistance with bed mobility, dressing and two staff assistance for toileting. Record review of Resident #180's Order Summary report dated active orders as of [DATE] indicated she was admitted to hospice on [DATE] and resident was weight bearing as tolerated with walking boot on her left lower leg with a start date of [DATE]. Record review of Resident #180's progress notes indicated: [DATE] at 5:17 PM, late entry, 6:15 AM this morning RN U went down to assess patient and she had a change in her mental and respiratory status. Blood pressure was ,d+[DATE], heart rate 80, respirations 26, oxygen saturation 86% RN U immediately contacted EMS, the Medical Director, and her family member at 6:30 AM. The note indicated Resident #180 had diagnoses of congestive heart failure, cellulitis to both lower extremities and mild dementia and had oxygen ordered at 2 liters via nasal canula but apparently, she would take it off. RN U reapplied the oxygen 2 liters via nasal canula and Resident #180's oxygen saturation improved to 90%. RN U noted that fire and EMS arrived and pt started speaking more clearly and told them she was not going to the hospital. Resident #180 stated she would not die at the hospital she wanted to die at the facility. Resident #180 refused to go to the ER. RN U contacted Resident #180's family member and he stated to honor her wishes and she did not have to go to the hospital. RN U notified the doctor and noted she would monitor the patient every 15 minutes for 3 hours then every 30 minutes for 5 hours and every hour thereafter. [DATE] at 10:30 PM, late entry, LVN D documented Resident #180 returned from the ER at this time. Resident #180 was awake and appeared a little lethargic, [TRUNCATED]		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observation, interview, and record review, the facility failed to ensure a resident received appropriate treatment and services to prevent urinary tract infections for 2 of 2 residents (Resident #53 and Resident #179) reviewed for indwelling urinary catheters and incontinent care. 1. The facility failed to ensure Resident #179's urinary (foley) catheter was properly secured to his leg. 2. The facility failed to ensure Resident #53 was provided proper incontinent care. This failure could place residents with urinary catheters at risk for damage to the bladder, penis, or urethra (a hollow tube that lets urine leave your body), dislodging of the catheter, and urinary tract infections. Findings included: 1. Record review of a face sheet dated 03/02/2024 indicated Resident #179 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis of all four limbs, and the trunk of the body) and neuromuscular dysfunction of the bladder (condition where a person lacks bladder control due to brain, spinal cord, or nerve problems). Record review of the Comprehensive MDS assessment dated [DATE], indicated Resident #179's speech was unclear, was sometimes able to make himself understood, and understood others. The MDS assessment indicated Resident #179 had a BIMS score of 12 which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #179 was dependent on staff for all ADLs. The MDS assessment indicated Resident #179 had an indwelling catheter. Record review of the care plan last revised on 02/23/2024 indicated Resident #179 had a foley related to neurogenic bladder with a goal that he would show no signs and symptoms of urinary infection through the review date. Interventions included to place catheter bag and tubing below the level of the bladder in a privacy bag, check tubing for [NAME] and maintain the drainage bag off the floor during room rounds as needed, and to monitor/document pain/discomfort due to catheter, and monitor for signs and symptoms of infection. Record review of the Order Summary Report dated 02/26/2024 indicated Resident #179 had an order to ensure his catheter strap was in place and holding every shift change as needed with a start date of 02/13/2024. During an observation on 02/26/2024 at 10:46 AM, Resident #179's foley catheter was not secured to his leg. Resident #179 said he had asked one of the nurses about it and they had told him they did not have the supplies to secure it to his leg. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/02/2024 at 4:29 PM, the Administrator said the nurses were responsible for ensuring foley catheters were properly secured, and he expected them to do this. The Administrator said it was important for foley catheters to be properly secured, so they did not get caught on anything and get pulled. During an interview on 03/02/2024 at 4:44 PM, LVN W said the nurses were responsible for ensuring foley catheters were secured properly, and if the CNAs noticed they were not secured properly they should notify the nurse. LVN W said she did not know why Resident #179's foley catheter was not secured. She said she tried to ensure it was always secured to Resident #179's leg, but she could not answer for the other nurses. LVN W said it was important for the foley catheters to be secured properly because they did not want it to get pulled out and cause trauma. During an interview on 03/02/2024 at 5:14 PM, the DON said everyone that was responsible for taking care of Resident #179 should have ensured his foley catheter was secured properly. The DON said she provided oversight by making rounds on the residents frequently to ensure their catheters were properly secured. The DON said it was important for the foley catheters to be secured properly so it did not get pulled out or cause injury. 2. Record review of a face sheet dated 3/06/2024 indicated Resident #53 was an [AGE] year-old female who admitted on [DATE] with the diagnoses of dementia, need for assistance with personal care, and kidney disease. Record review of the Quarterly MDS dated [DATE] indicated Resident #53 was usually understood and usually understood others. The MDS indicated Resident #53's BIMS score was 2 indicating she had severe cognitive impairment. The MDS in section GG indicated Resident #53 required substantial/maximal assistance with toileting hygiene, and partial/moderate assistance for personal hygiene. The MDS indicated Resident #53 was always incontinent of bowel and bladder. Record review of the Comprehensive Care Plan dated 1/05/2023 indicated Resident #53 had a pressure ulcer to her sacrum and indicated the intervention of incontinent care after each episode and apply a moisture barrier. The comprehensive care plan provided failed to mention an ADL care deficit. Record review of a Wound Evaluation and Management Summary dated 2/26/2024 indicated Resident #53 had a Stage 3 pressure wound (full thickness skin loss, involves damage or death of subcutaneous tissue that may extend down to, but not through, underlying tissues and muscles, and presents clinically as a deep crater, with or without undermining of adjacent tissues) to her sacrum (large triangular bone at the base of the spine). (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 2/28/2024 at 11:37 a.m., ADON S and CNA G was prepared to administer wound care to Resident #53's sacral pressure injury when Resident #53 was rolled on to her left side and was found to have had a bowel movement. CNA G removed her gloves, exited the room, entered the spa room, obtained incontinent care items (wipes, gloves, and a brief) and returned to Resident #53's room. CNA G returned to the room, applied another pair of gloves, then taking some wipes she cleansed Resident #53's anal area with wiping twice, then CNA G raised to dressing covering Resident #53's wound and used the wipes and cleansed again front to back, folded the wipe and cleansed from front to back again. CNA G then rolled the brief up towards Resident #53 as she was pulling the brief out from underneath Resident #53. With the same gloves on CNA G then pulled the clean brief from the plastic bag and held the brief until ADON S was ready to place brief on Resident #53. After ADON S placed brief underneath Resident #53, CNA G assisted Resident #53 to roll to apply the brief. Using the same gloves CNA G repositioned Resident #53, applied her sheet and blanket, and even held Resident #53's hand for a few moments. CNA G then removed her soiled gloves and placed them in the plastic bag. CNA G then walked over to Resident #53's roommate to answer a question and placed her hand on her shoulder without performing hand hygiene. CNA G exited Resident #53's room without hand hygiene. CNA G stated she did pretty good when asked how she believed she performed incontinent care. CNA G said she was not aware even though her gloves were not visibly soiled she had to change gloves and perform hand hygiene between clean and dirty. CNA G said she failed to perform incontinent care on Resident #53's peri area. During an interview on 2/28/2024 at 11:55 a.m., ADON S said CNA G should have not brought in a whole package of wipes into Resident #53's room to perform incontinent care. ADON S said CNA G failed to cleanse Resident #53's peri area, failed to change gloves, and complete hand hygiene. ADON S said the provision of incontinent care incorrectly could lead to urinary tract infections, skin conditions, and affects infection control practices. ADON S said the CNAs have been checked off and she expected the CNAs to provide incontinent care correctly. During an interview on 3/02/2024 at 3:02 p.m., the DON said she expected incontinent care to be performed correctly. The DON said the ADONs perform skills check offs with the CNAs to ensure incontinent care and hand hygiene were performed correctly. The DON said incontinent care was monitored by rounds, and thru proficiency check offs. The DON said proper hand hygiene and incontinent care should be provided to prevent infections. During an interview on 3/02/2024 at 4:00 p.m., the Administrator said he expected staff to follow the facility's infection control policy. The Administrator said he expected glove changes to occur between dirty and clean to prevent urinary tract infections. The Administrator said the nursing management was responsible for monitoring the competency check offs for hand hygiene and incontinent care. During an interview on 3/02/2024 at 4:39 p.m., the Regional Compliance Nurse said CNA G was nervous performing incontinent care and hand hygiene because she was able to perform skills check offs within the hour and pass the skills. The Regional Compliance Nurse said when hand hygiene and incontinent care was not provided accurately there was a risk for infection. The Regional Compliance Nurse said the nursing management was responsible for ensure these skills monitored. During an interview with the Administrator on 03/02/2024 at 8:50 AM, the policy for foley catheters was requested and not received upon exit. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a CNA Proficiency Audit dated 2/20/2024 indicated NA G was checked off in the skills area of perineal care by ADON E: female and passed satisfactory skill level. Record review of a Nursing: personal Care-Perineal Care policy dated 5/11/2022 indicated: Purpose This procedure aims to maintain the resident dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition. 16) Wipe across the pubis area 17) Gently perform perineal care, wiping from clean, urethral area, to dirty, rectal area, to avoid contaminating the urethral area - CLEAN to DIRTY! ? Female resident: Working from front to back, wipe one side of the labia majora, the outside folds of perineal skin that protect the urinary meatus and the vaginal opening. Continue perineal care to the inner thigh. 18) If visibly moist, pat the areas dry with a clean, dry towel or washcloth 19) Note skin changes and apply moisture barrier cream as directed Back 20) Reposition the resident to their side 21) Gently perform care to the buttocks and anal area, working from front to back without contaminating the perineal area 22) If visibly moist, pat the areas dry with a clean, dry towel or washcloth 23) Note skin changes and apply moisture barrier cream as directed 24) Doff gloves and PPE 25) Perform hand hygiene . 31) Perform hand hygiene 33249		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise for 1 of 8 residents reviewed for nutritional status (Resident #33). The facility failed to obtain Resident #33 weekly weights as ordered by the physician. This failure could place residents at risk for malnourishment, illness, skin breakdown, and decreased quality of life. Findings included: Record review of Resident #33's face sheet dated 02/29/24, indicated a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #33's diagnoses included dementia (memory loss), unspecified protein calorie malnutrition (not consuming enough protein and calories), major depression, and bipolar disorder (serious mental illness characterized by extreme mood swings). Record review of Resident #33's comprehensive care plan dated 11/27/23 indicated Resident #33 had a significant unplanned/unexpected weight loss. The care plan interventions included to weigh the resident weekly for at least four weeks or until weight had stabilized. Record review of Resident #33's mini nutritional assessment dated [DATE], indicated Resident #33 was at risk for malnutrition. Record review of Resident #33's significant change in status MDS assessment dated [DATE], indicated Resident #33 was able to make himself understood and understood others. The MDS assessment indicated Resident #33's had a BIMS score of 13, which indicated his cognition was intact. The MDS assessment indicated Resident #33 required set up or clean up assistance for eating. The MDS assessment indicated Resident #33 had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. Record review of Resident #33's order summary report dated 02/29/2024, indicated Resident #33 had an order for weekly weights x 4 weeks every Tuesday related to protein calorie malnutrition with an order date of 02/02/2024. Record review of Resident #33's treatment administration record for the month of February 2024, indicated Resident #33's weekly weights were to be obtained on Tuesdays for 4 weeks. The treatment administration record did not indicate Resident #33's weight was obtained on 02/13/24 and 02/27/24. Record review of Resident #33's electronic medical record on 02/29/2024, indicated the Resident #33 weight was obtained on 02/02/24, 02/09/24 and 02/20/24. The facility failed to obtain Resident #33's weight on 02/13/24 and 02/27/24. Resident #33's weights obtained were as followed: (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* On 02/02/2024 Resident #33 weighed 211.8 lbs * On 02/09/2024 Resident #33 weighed 215.2 lbs * On 02/20/2024 Resident #33 weighed 218.8 lbs During an interview on 03/02/2024 at 02:04 PM, the DON said the transport aide was responsible for obtaining the resident's weights. The DON said it was important for weights to be obtained as ordered to monitor the resident's nutritional status. The DON said there was a weekly weight report that indicated the residents whose weights were to be obtained weekly. The DON said the dietician monitored the resident's weights monthly as well. During an interview on 03/02/2024 at 02:19 PM, LVN EEE said the aides or herself were responsible for ensuring the weights were obtained as ordered. LVN EEE said she was aware of Resident's #33's missing weights and said they were overlooked. LVN EEE said obtaining Resident #33's weight was important to ensure he was not losing weight. LVN EEE said she was unsure if management monitored the resident weights. During an interview on 03/02/2024 at 02:22 PM, the Interim Administrator said he expected the weights to be obtained as ordered. The Interim Administrator said it was important for weights to be obtained so they can monitor the residents appropriately and identify any issues. The Interim Administrator said he was unsure if the facility had a system in place to monitor the resident weights. During an attempted interview on 03/02/2024 at 05:15 PM, CNA V (who was also responsible for obtaining the resident's weights) did not answer the phone. Record review of the facility's policy dated 02/13/2007, titled, Resident Weight indicated . 1. Weights shall be obtained and documented at admission, readmission, and monthly unless ordered otherwise by the physician, or use less dictated more frequently by the resident's condition. Factors indicating the need for more frequent weights include significant weight loss .		

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 47006 Based on observation, interview, and record review the facility failed to ensure that residents requiring respiratory care were provided such care, consistent with professional standards of practices for 2 of 4 residents (Resident's #6 and #227) reviewed for respiratory care. 1. The facility failed to ensure Resident #6's nebulizer mask was stored in a bag when it was not in use. 2. The facility failed to administer Resident #227's oxygen as ordered by the physician. These failures could place residents who receive respiratory care at risk for developing respiratory complications and a decreased quality of care. The findings included: 1. Record review of the face sheet, dated 03/02/2024, revealed Resident #6 was an [AGE] year-old female who readmitted to the facility on [DATE] with a diagnosis of COPD (common, preventable, and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough). Record review of the quarterly MDS assessment, dated 02/21/2024, revealed Resident #6 had clear speech and was understood by others. The MDS revealed Resident #6 was able to understand others. The MDS revealed Resident #6 had a BIMS score of 14, which indicated no cognitive impairment. The MDS revealed Resident #6 had no behaviors or refusal of care. The MDS revealed Resident #6 had impairment on both upper extremities that interfered with daily functions. Record review of the comprehensive care plan, revised on 05/17/2023, revealed Resident #6 had COPD. The goal was Resident #6 will be free of signs or symptoms of respiratory infections through review date. The interventions included: give aerosol or bronchodilators as ordered .monitor, document, and report any signs of respiratory infection . Record review of the order summary report, dated 03/02/2024, revealed Resident #6 had an order, which started on 12/03/2023, to change nebulizer, date, and place in new bag every Sunday night . The orders further revealed an order, which started on 10/02/2023, for ipratropium-albuterol solution 0.5 - 2.5 mg / 3 mL (used to treat and prevent wheezing or shortness of breath caused by COPD) vial inhalation three times a day. Record review of the MAR, dated February 2024, revealed Resident #6 received nebulizer medication three times a day. During an observation on 02/28/2024 at 3:16 PM, Resident #6's nebulizer mask was laying on top of the nebulizer machine, uncovered and not in a bag. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/28/2024 beginning at 3:30 PM, LVN RRR stated nebulizer masks should have been in a bag when they were not being used. LVN RRR stated the last person to administer her breathing treatment did not put it back in the bag. LVN RRR stated nurses should have gone back and checked after Resident #6 was finished with her breathing treatment. LVN RRR stated she was going to replace the nebulizer mask, but it was normally changed every Sunday. LVN RRR stated it was important to ensure nebulizer masks were kept in bags so it would have been clean, and no bacteria got into Resident #6's lungs from inhaling, which could have caused bacterial pneumonia, or aspiration depending on what they inhaled. LVN RRR stated it was also important to ensure nebulizer masks were kept in bags when not in use to prevent infection. During an interview on 03/02/2024, beginning at 4:51 PM, the DON stated the charge nurses were responsible to ensure nebulizer masks were kept in a bag while not in use. The DON stated everyone was responsible for monitoring to ensure the nebulizer masks were kept in bags, when not in use. The DON stated it was important to ensure nebulizer masks were kept in bags when not in use to prevent infections, injury to the lungs, and exacerbation of disease process. During an interview on 03/02/2024 beginning at 5:04 PM, the Interim Administrator stated he expected all equipment to have been stored properly. The Interim Administrator stated he did not have a clinical background, so he was unsure why it was important to ensure nebulizer masks were stored in a bag when not in use. 2. Record review of Resident #227's face sheet dated 02/29/24, indicated a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (brain dysfunction), chronic obstructive pulmonary disease (a group of lung conditions that make it hard to breathe and limit airflow), anxiety, and shortness of breath. Record review of Resident #227's comprehensive care plan dated 02/23/2024 indicated Resident #227 had emphysema (enlargement of air sacs in the lungs)/COPD with interventions to give oxygen therapy as ordered by the physician. Record review of Resident #227's EMR on 02/29/2024 indicated the admission MDS assessment had not been completed due to his recent admission to the facility. Record review of Resident #227's order summary report dated 02/29/24, indicated Resident #227 had an order for oxygen at 2 liters per minute via nasal cannula every shift with a start date of 02/22/2024. Record review of Resident #227's treatment administration record for the month of February 2024, indicated he had been receiving oxygen at 2 liters per minute via nasal cannula every shift since 02/22/2024. During an observation on 02/26/2024 at 09:40 AM, Resident #227 was lying in bed and received oxygen at 3 l/min via nasal cannula. During an observation on 02/26/2024 at 05:07 PM, Resident #227 was lying in bed and received oxygen at 3 l/min via nasal cannula. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 02/29/2024 at 09:22 AM, Resident #227 was sitting up in his wheelchair and received oxygen at 3 l/min via nasal cannula. During an observation and interview on 02/29/2024 at 11:47 AM, Resident #227 was sitting up in his wheelchair and received oxygen at 3l/min via nasal cannula. Resident #227 said the nurse set the oxygen rate. Resident #227's family member was in the room and said Resident #227 was not able to adjust the rate himself. During an observation on 02/29/2024 at 02:51 PM, Resident #227 was lying in bed and received oxygen at 3 l/min via nasal cannula. During an observation and interview on 02/29/2024 at 02:38 PM, RN U said Resident #227's oxygen should be set at 3 l/min. RN U went to Resident #227 and confirmed Resident #227's oxygen was set at 3 l/min via nasal cannula. RN U reviewed Resident #227's orders and said his order read to administer oxygen at 2 l/min via NC. RN U said the MD had changed Resident #227's oxygen order to 3l/min via nasal cannula and she obviously did not correct it. RN U said it was her fault for not transcribing the order when it was received. RN U said it was her responsibility to update Resident #227's orders when new orders were received. RN U said Resident #227 was at risk for his respiratory rate to shut down because it was set at a higher rate than the ordered amount of 2 l/min. RN U said she ensured the oxygen was set at the prescribed rate during her morning rounds. During an interview on 03/02/2024 at 02:04 PM, the DON said she expected the residents to receive oxygen at the ordered rate. The DON said the charge nurse was responsible for ensuring residents received their oxygen as prescribed by the physician when they did their rounds or when they obtained vital signs. The DON said by not setting the oxygen at the ordered rate, the resident was at risk for not receiving enough oxygen or receiving too much. During an interview on 03/02/2024 at 02:22 PM, the Interim Administrator said he expected the oxygen to be set at the prescribed rate. The Interim Administrator said nursing was responsible for ensuring residents were receiving oxygen as prescribed during their rounds. The Interim Administrator said he was unsure of the risks of not having the oxygen set at the prescribed rate. Record review of the facility's policy titled Oxygen Administration revised on February 13, 2007, indicated . Oxygen therapy includes the administration of oxygen (O2) in liters/minute (l/min) by cannula or face mask to treat hypoxemic conditions cause by pulmonary or cardiac diseases. The amount of oxygen by percent of concentration or l/min, and the method of administration, is ordered by the physician. The administration, monitoring of responses, and safety precautions associated with it are performed by the nurse. The policy did not address storage of oxygen equipment.		

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview and record review, the facility failed to provide sufficient number of nursing staff on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans and the facility assessment for 9 of 24 residents (Residents #9, #4, #41, #36, #44, #57, #130, #180, and #179 and 1 of 1 facility reviewed for care and services. The facility failed to provide sufficient nursing staff to ensure adequate supervision and to prevent accidents involving Resident #44, who was physically assaulted on [DATE], Resident #4, had an unwitnessed fall on [DATE], Resident #4 was left unsupervised in the bathroom on [DATE] and self-transferred from the toilet to the wheelchair, Resident 180, sustained an unwitnessed fall with injury on [DATE] and expired on [DATE], and Resident #130 suffered unwitnessed falls on [DATE] and [DATE] in his room while only one CNA was available on the secured unit. The facility failed to provide sufficient nursing staff to ensure Resident #44, Resident #41, Resident #57, Resident #179, Resident #36, and Resident #9 did not receive their medications 1 to 6 hours late. The facility failed to ensure LVN D was able to complete her required nursing tasks timely allowing LVN D to work 24 hours on [DATE] - [DATE]. The facility failed to ensure LVN C was able to complete her required nursing tasks timely allowing LVN C to work 4 hours and 55 minutes over her scheduled shift. The facility failed to provide sufficient nursing staff to ensure ADON E did not remain on shift for over 24 hours on [DATE]-[DATE] due to excessive call offs. An Immediate Jeopardy (IJ) situation was identified on [DATE] at 2:50 PM. The IJ template was provided to the facility Administrator on [DATE] at 3:39 PM. While the IJ was removed on [DATE] at 3:44 PM, the facility remained out of compliance due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures place residents at risk of inadequate supervision, an unsafe environment, falls, serious harm and injury, exacerbations of disease processes, abuse, and death. Findings included: 1. Record review of a face sheet dated [DATE] indicated Resident #44 was an [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia (memory loss), muscle weakness, reduced mobility, anxiety disorder. (continued on next page)		

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of a Significant Change MDS dated [DATE] indicated Resident #44 was sometimes understood and usually understands others. The MDS indicated Resident #44 was unable to complete her BIMS exam due to her cognition. The MDS indicated Resident #44 had inattention and disorganized thinking being continuously present. The MDS indicated Resident #44 had no behavioral symptoms but wandered , d+[DATE] days during the assessment period. The MDS indicated Resident #44 required extensive assistance of two staff for transfers, and extensive assistance of one staff member for bed mobility, and locomotion on and off the unit. The MDS indicated Resident #44 had a history of falls with fractures within the last 6 months. Record review of the comprehensive care plan dated [DATE] and updated on [DATE] indicated Resident #44 was at risk to fall related to unsteady gait/balance, generalized weakness, and poor safety awareness. The care plan indicated Resident #44 was at risk to wander related to a history of attempts to leave the facility related to poor safety awareness and resides on the secured unit. Record review of the Consolidated Physician's orders dated February 2024 indicated Resident #44 was ordered Cephalexin 500 milligrams three times daily for a urinary tract infection. Record review of a Medication Administration Record dated February 2024 indicated Resident #44's Cephalexin was ordered for administration on [DATE] at 8:00 p.m., the medication administration record indicated Resident #44 received her antibiotic therapy Cephalexin at 2:51 a.m. on [DATE]. Record review of the of an Event Nurses' note dated [DATE] at 6:30 p.m., indicated LVN D documented she was called to Resident #55's room. LVN D documented Resident #44 was lying on the floor beside the closet door on the floor on her back with Resident #41 standing over her. LVN D documented Resident #55 had an abrasion to her right temple area with bruising to her right inner arm. LVN D documented Resident #44 was unable to state what had happened but Resident #55 said Resident #41 pushed Resident #44 against the closet door. The event note indicated LVN D sent Resident #44 to the local hospital. Record review of a progress note dated [DATE] at 7:30 p.m., LVN D wrote she was called to another resident room where she found Resident #44 was found on the floor bedside the closet door on her back with Resident #44 standing over her, and Resident #55 stated Resident #41 pushed Resident #44 against the closet door. Record review of a Fall-Risk assessment dated [DATE] documented by LVN D indicated Resident #44 had intermittent confusion, no falls in the past 3 months, was ambulatory, and was incontinent. LVN D documented Resident #44 had a balance problem while standing, balance problem while walking, decreased muscular coordination, and change in her gait pattern when walking through a doorway. Record review of a hospital Emergency Department History of Present Illness indicated Resident #44 was sent to the local emergency roiaognom on [DATE] with the chief complaint as assault. The note written by the physician indicated Resident #44 assessment revealed a head contusion (bruise) and a hematoma (a collection of blood outside of the vessel). The note indicated in the review of systems Resident #44 had a headache. The physical examination documented indicated Resident #44 was moderately distressed, had ecchymosis (bruising caused by injury), swelling, and tenderness to the right side of her head. (continued on next page)		

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of a CT Head without Intravenous Contrast dated [DATE] indicated Resident #44's CT impression indicated she had a right parietal scalp hematoma (A scalp hematoma is a collection of blood (either flowing or clotted from ruptured blood vessels that will then collect in space and tissue between the skull and skin). During an observation and interview on [DATE] at 9:00 a.m., Resident #44 was sitting at the dining table with a large size raised area with bruising noted to her right side of her head in the temporal/parietal region. Resident #44 said she felt well but she denied having her head hurt. 2. Record review of a face sheet dated [DATE] indicated Resident #41 was an [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia with behavioral disturbances, the need for continuous supervision, and high blood pressure. Record review of a Significant Change MDS dated [DATE] indicated Resident #41 was usually understood and sometimes understands. The MDS indicated Resident #41's cognition was severely impaired. The MDS indicated Resident #41 had no physical, or verbal behaviors exhibited. The MDS indicated Resident #41 wandered daily. Record review of the comprehensive care plan dated [DATE] and revised on [DATE] indicated Resident #41 was at risk for mood problems and received medications. The goal of the care plan indicated Resident #41 would have an improved mood state. The care plan interventions included administer medications, behavioral health consults as needed, monitor and record mood to determine if problems seem to be related to external causes. Record review of the Consolidated Physician's orders dated February 2024 Resident #41 was ordered Medpass 2.0 (supplement for weight loss) four times daily for protein-calorie malnutrition. Record review of the Medication Administration Audit Report Resident #41 was scheduled to receive the Medpass 2.0 supplement at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. Resident #41 received the ordered Medpass 2.0 on [DATE] at 12:56 a.m. and on [DATE] at 10:15 p.m. Record review of a progress note dated [DATE] at 6:00 p.m., LVN D documented she was called to a resident room by CNA A. LVN D documented Resident #41 was in Resident #55's room where she found Resident #44 on the floor beside the closet door. LVN D documented Resident #41 was standing over Resident #44. LVN D documented she asked Resident #41 and Resident #44 what had occurred, and neither could explain. LVN D documented Resident #55 said Resident #41 pushed Resident #55 against the closet door and she fell. LVN D documented Resident #41 was very uncooperative and had tried to hit CNA A and Resident #55. Record review of Behavior Nurses Note dated [DATE] at 6:30 p., LVN D documented she was called to the secured unit by the nurse aide. LVN D documented Resident #41 was in Resident #55's room. LVN D documented she found Resident #44 on the floor lying beside the closet door. LVN D documented Resident #41 was standing over Resident #44. LVN D documented Resident #55 said he pushed her up against the closet door and she fell. LVN D said Resident #41 and #44 was unable to indicate what had happened. LVN D said Resident #41 was very uncooperative and had tried to hit the CNA on duty and Resident #55. (continued on next page)		

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of an Event Nurses' note dated [DATE] at 6:30 p.m., indicated LVN D documented Resident #41 was found in another resident room. LVN D documented Resident #41 had displayed physical, and resident to resident behaviors with another resident injured. The Event Nurses' note indicated LVN D moved Resident #41's room and initiated every 15-minute checks. Record review of a Every 15 Minute Check sheet indicated Resident #41 was placed on every 15-minute checks starting on [DATE] at 6:30 p.m. The Every 15- minute checks at 0015 indicated LVN D documented at 12:15 a.m., Resident #44 was asleep. LVN D had only her initials beside the other every 15-minute checks starting at 12:30 a.m. - 5:45 a.m. on [DATE] there was no remarks indicating anything in regarding Resident #41. During an observation on [DATE] at 9:31 a.m., Resident #41 was lying in his bed asleep. During an interview on [DATE] at 4:17 p.m., the SW said she was notified by the DON regarding the incident with Resident #44 and Resident #41. The SW said upon her arrival Resident #44 was already at the local emergency room , and Resident #41 was wandering on the unit. The SW said Resident #41 and Resident #55 both were unable to recollect the recent incident. During an interview on [DATE] at 9:32 p.m., CNA A said she was alone on the secured unit gathering her supplies in the spa/communal shower room when she heard a loud scream. CNA A said she ran out of the spa room and ran toward the end of the hall where she believed the sound was heard from. CNA A said upon entering the room, Resident #44 was lying in the floor, Resident #55 said Resident #41 had thrown Resident #44 into the door. CNA A said Resident #41 was aggressive with her at the time and tried to swing at her. CNA A said she left Resident #55's room and ran the length of the secured unit, opened the door, and yelled for help. CNA A said she was alone on the secured unit and had no other recourse than to go for help. CNA A said LVN D was passing medications and another nurse responded to her call for help. During an interview on [DATE] at 11:46 a.m., the DON said on [DATE] CNA A heard a noise and responded to the noise. The DON said LVN D called and said Resident #41 was upset and wandering in other rooms. The DON said CNA A had said Resident #44 was on the floor. The DON said she was unsure of Resident #44 hitting her head although she had an abrasion to her head. The DON said Resident #44 was sent to the emergency room closer to midnight due to complaining her head was hurting. During an interview on [DATE] at 11:51 a.m., LVN D said she was called to the unit on [DATE] at 6:30 p.m. by CNA A. LVN D said Resident #44 was lying in the floor of Resident #55's room, with Resident #41 standing over Resident #44 around 6:30 p.m. on [DATE]. LVN D said Resident #55 said Resident #41 pushed Resident #44 against the closet and Resident #41 fell . LVN D said at the time of the incident Resident #44 had an abrasion to her right temple area and a bruise to her inner right arm. LVN D said Resident #41 was very uncooperative and attempted to hit others. LVN D said she was advised to place Resident #41 on every 15-minute checks by the DON. LVN D said although her documentation was not completed yet Resident #41 remained asleep. LVN D said CNA A had to leave Resident #44 and Resident #55 to come for help. LVN D said she was not on the secured unit but was on hall 400 when the incident occurred. LVN D said she was late with administering the medications due to being called to the secured unit during the medication administering time. (continued on next page)		

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 12:22 p.m., CNA H said CNA A had always worked the secured unit alone. CNA H said when CNA A was in the room with other residents who would be watching the other residents, or who would go for help. CNA H said there was no one was on the unit to get help when CNA A needed help. During an interview on [DATE] at 10:54 a.m., LVN F said Resident #44 was discharged to the hospital and Resident #41 was on every 15-minute checks for aggressive behaviors. LVN F said after she reviewed Resident #44's electronic medical record and said there was not a progress note, a SBAR (situation, background, assessment, recommendation) note, a transfer note, or an incident report. LVN F said the electronic medical record should have had those assessments completed by the nurse on duty at the time of the incident. 3. Record review of a face sheet dated [DATE] indicated Resident #4 admitted on [DATE] and readmitted [DATE] with the diagnosis of diabetes, muscle weakness, lack of coordination, reduced mobility, repeated falls, dementia, and assistance with personal care. Record review of the comprehensive care plan dated [DATE] and revised on [DATE] indicated Resident #4 had an ADL self-care performance deficit. The goal of the care plan indicated Resident #4 would remain at her current level of function in transfers, and toileting. The care plan interventions included Resident #4 required one staff assistance with toileting. The comprehensive care plan indicated Resident #4 was at risk for falls related to weakness and impaired cognition. The goal of the care plan was Resident #4 would not sustain a serious injury. The care plan interventions included ensure Resident #4's call light was within reach, ensure don't call fall sign at the foot of the bed visible by Resident #4, and frequent visual checks while in bed. Record review of an Admission MDS dated [DATE] indicated Resident #4 was usually understood and understands others. The MDS indicated Resident #4's cognition was moderately impaired. The MDS in section GG indicated Resident #4 required partial to moderate assistance with toileting, bed to chair transfers, toileting transfers and to sit and stand. Record review of a Fall-Risk assessment dated [DATE] at midnight LVN D indicated Resident #4 had , d+[DATE] falls in the past, required assistance with elimination, and took ,d+[DATE] medications which could increase the risk of falls. The fall risk assessment indicated Resident #4 was at high risk to fall. Record review of a fall incident report dated [DATE] at midnight, LVN D indicated Resident #4 ambulated without assistance and was not wearing any shoes or socks. Record review of a progress note dated [DATE] at midnight, LVN D documented Resident #4 was sitting in the hallway on her bottom with her legs straight in front of her. LVN D said Resident #4 said she had slipped down. LVN D documented Resident #4 was not wearing shoes or socks. LVN D documented Resident #4 complained of right foot pain. Record review of a fall incident report dated [DATE] at 10:30 p.m., LVN C indicated no injuries were observed. The incident report was left blank. (continued on next page)		

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of a Fall-Risk assessment dated [DATE] at 10:30 p.m., LVN C documented Resident #4 was at high risk to fall. LVN C documented Resident #4 was disoriented, had 3 or more falls in the past 3 months, required assistance with elimination, had problems with balance, and took ,d+[DATE] medications which could cause falls. Record review of a Fall Nurses Note dated [DATE] at 10:46 a.m., LVN F documented Resident #4 had a fall without injury. LVN F documented fall interventions were the bed low, interval monitoring, neurological checks, frequent visual checks, encourage and educate use of the call light. Record review of a progress note dated [DATE] at 11:30 p.m., LVN C indicated Resident #4 said she had fallen on the floor, and she had been pulling up her pants. During an interview on [DATE] at 8:48 a.m., LVN C said CNA K was in another resident's room providing care when she heard Resident #4 calling for help. LVN C said CNA K was alone, so she had to hurriedly finish in the room to be able to assist Resident #4. LVN C said Resident #4 was lying on the bathroom floor when CNA C was able to get to her. LVN C said the secured unit was understaffed to provide adequate supervision for Resident #4 and other residents. During an observation and interview on [DATE] at 11:48 a.m., CNA H responded to the surveyor assisting Resident #4 with activating her call light for assistance to the bathroom. CNA H responded and assisted Resident #4 from her bed to the wheelchair, then from the wheelchair to the toilet. CNA H left Resident #4 alone on the toilet and went to get Resident #4's lunch tray. Upon returning to the room, Resident #4 was exiting the bathroom already in her wheelchair. CNA H said Resident #4 had a history of falls and was a fall risk. Record review of an incident report dated [DATE] at 11:45 p.m., LVN C documented Resident #4 had a fall with no injuries noted. The incident report had no further documentation within. Record review of an Event Nurses' Note-Fall dated [DATE] at 11:45 p.m., LVN C documented Resident #4 had an unwitnessed fall. LVN C documented Resident #4 was found on the floor, indicated Resident #4 said legs gave out, and Resident #4 attempted to self-toilet. LVN C documented in Nursing Description: Resident #4 indicated she got up to use the bathroom, failed to call for help, denied bumping her head, and was found sitting on the floor. 4. Record review of a face sheet dated [DATE] indicated Resident #130 was a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia with behavioral disturbances, lack of coordination, and a need for assistance with personal care. Record review of the Comprehensive Care Plan dated [DATE] and revised on [DATE] indicated Resident #130 was a high risk for falls related to wandering. The goal of the care plan was Resident #130 would be free of falls. The care plan interventions included to anticipate and met Resident #130's needs, ensure his call light was within reach, encourage the use of the call light, and have prompt response to the request for assistance, and ensure Resident #130 wore appropriate footwear. The comprehensive care plan failed to have interventions after the falls on [DATE] and [DATE]. Record review of an incident report dated [DATE] at 10:00 p.m., LVN C indicated Resident #130 was found by the CNA on the floor, with no signs of pain. The note indicated Resident #130 was limping on the left leg and was sent to the local emergency room at 10:35 p.m. via the ambulance. (continued on next page)		

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of a fall risk assessment completed by LVN C on [DATE] indicated Resident #130 was always disoriented. The assessment indicated Resident #130 had no previous falls, was ambulatory, continent, had balance problems, decreased muscular coordination, and gait pattern changes. Record review of a Medication Administration Record dated [DATE] - [DATE] indicated on [DATE] Resident #130 was administered Ativan 0.5 milligrams for anxiety or agitation. The record also indicated Resident #130 received the Ativan 0.5 milligrams twice daily on [DATE] and on the morning of [DATE]. Record review of an Event Nurses-Note dated [DATE] at 10:00 p.m., indicated Resident #130 had an unwitnessed fall in his room. LVN C documented Resident #130 was assisted up and was noted to be limping on the left leg. LVN C documented the physician was notified and Resident #130 was sent to the local hospital. The note indicated the interventions included interval monitoring (specify below) there was no documentation below. The note indicated in additional interventions there were interventions of a low bed and interval monitoring (again not specified). The note indicated Resident #130 was independent with bed mobility, toileting, and transferring. The note indicated Resident #130 had an unsteady gait, balance problem, and lack of mobility strength. The note indicated Resident #130 was wearing shoes or anti-slip socks. The note indicated Resident #130 had Ativan 0.5 milligrams twice daily started on [DATE]. Record review of an incident report dated [DATE] at 5:30 p.m., indicated Resident #130 was found with his head lying against the closet door by LVN HHH. The note indicated Resident #130 had a bruise to his right shoulder and a skin tear to his left hand. The note indicated the conclusion was Resident #130 had an unwitnessed fall with injuries. The note indicated his bed was changed to a low bed. Record review of an Event Nurses-Note dated [DATE] at 6:39 p.m., indicated Resident #130 was found by LVN HHH when she was passing dining trays. The note indicated Resident #130 was lying with his head against the closet door. The note indicated Resident #130 had a skin tear. The note indicated Resident #130 had a purple bruise to his right shoulder. The note indicated Resident #130 was in pain noted by his occasional moans or groans, and facial grimacing. The note indicated Resident #130's physical factors included previous fall, urinary tract infection, pain, and incontinence. The note indicated Resident #130 required 1 staff with bed mobility, toileting, transferring, and walking. The note indicated Resident #130 leaned forward. Record review of an e-Transfer Form dated [DATE] at 6:00 p.m., indicated Resident #130 was transferred to the local hospital due to a fall by LVN HHH. Record review of a Fall-Risk assessment dated [DATE] at 6:47 p.m. indicated Resident #130 was disoriented, has fallen 3 or more falls in the past 3 months, ambulatory, and incontinent. The assessment indicated Resident #130 had balance problems while standing and walking. Record review of the History of Present Illness from the local hospital on [DATE] indicated Resident #130 fell and was sent to the local emergency room. The note indicated Resident #130 had a right hip fracture. The note indicated Resident #130 was seen 24 hours prior to this visit related to multiple falls at the facility. (continued on next page)		

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review from the hospital orthopedist report dated [DATE] indicated Resident #130 had fallen over the last couple of weeks at least ,d+[DATE] times. The orthopedist documented Resident #130 was in the emergency room the day before post a fall with negative x-rays at the time. The note indicated the CT results indicated a minimally impacted right femoral neck fracture. The note indicated the physician spoke to the family and the family wanted a non-operative treatment and return to the facility with palliative care. Record review of hospital records dated [DATE] indicated Resident #130 was admitted at 6:59 p.m. with the diagnosis of closed fracture of the right hip. The discharge records indicated Resident #130 was returned to the facility on hospice services. Resident #130's discharge orders included bedrest, non-weight bearing to the right leg, and pain management. Record review of the cat scan of the chest, abdomen, and pelvis dated [DATE] indicated right femoral neck fracture. Record review of a progress note dated [DATE] at 4:25 p.m., indicated the social worker documented Resident #130 returned from the hospital, admitted on a hospice service, and was made a do not resuscitate status. Record review of a physician's progress note dated [DATE] indicated Resident #130 had a fall with a fracture to the right hip and he was being treated conservatively. Record review of an Incident Report dated [DATE] at 3:30 p.m., completed by LVN YY indicated Resident #130 was observed sitting on the floor beside his bed with his back leaning on the mattress. The note indicated Resident #130's bed was in low position. The note indicated the predisposing physiological factors were confusion, incontinent, recent medication changes, and impaired memory. Record review of a progress note dated [DATE] at 8:00 p.m., LVN D documented Resident #130 had a fall slipped off the bed. LVN D documented there were no injuries. LVN D documented she administered Tramadol 50 milligrams due to Resident #130 appeared in pain, and then he was assisted up to the recliner because he refused to rest in his bed. Record review of a Daily Census form dated [DATE] indicated on Hall 400 resided 24 residents and on the secured unit there were 15 residents. During an interview on [DATE] at 11:51 p.m., LVN D said she worked the 6:00 p.m. - 6:00 a.m. shift as the nurse for the secured unit and Hall 400. LVN D said her job duties on this shift was to pass the assigned residents their medications, provide nursing care, and assist with nurse aide care as needed. LVN D said on this night she had Resident #44 was assaulted by Resident #41 in the room of Resident #55. LVN D said she had to stop the tasks she was completing to assess the situation, send Resident #44 to the local emergency room , place Resident #41 on 1:1 oversight, and then complete all the tasks this associated with this incident. LVN D said CNA A was alone in the unit when Resident #41 assaulted Resident #44 according to Resident #55's statement. LVN D said CNA A tried to separate Resident #41 and Resident #55 but Resident #41 was too aggressive. During an observation and interview on [DATE] at 6:15 p.m., LVN D was at the nursing desk when she said she had a bit more to complete on the tasks from her shift before leaving. LVN D said she had been at the facility now 24 hours. (continued on next page)		

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 8:48 a.m., LVN C said she was not able to physically able to visualize Resident #41 but relied on the CNA to do 1:1 with Resident #41. LVN C said due to having only ,d+[DATE] CNAs on the 6:00 p.m. to 6:00 a.m. shift she was unable to complete her resident care tasks including administration of medications timely according to the orders. LVN C said she had many times informed the nursing management she would have to invoke Safe Harbor to ensure resident safety. LVN C said only when she would tell management she would invoke Safe Harbor would she get extra help to pass medications at least to the assigned Hall 400. LVN C said she had also notified the Medical Director of the nursing duties she was unable to complete timely. LVN C said in the secured unit the CNA was most often working alone and she would assist as she could. LVN C said CNA K was in a room with another resident when Resident #44 fell . During an interview on [DATE] at 10:55 a.m., LVN C said she had not completed all the tasks from her shift regarding resident care but was told by nursing management she had to leave because she was scheduled for her next shift at 6:00 p.m. Record review of the Schedule Sheet dated [DATE] indicated the census was 81 and the facility had scheduled: 6:00 a.m. - 6:00 p.m.: 2 student nurse aides, and 3 CNAs with one a no call no show status; 2 RNs and 1 LVN 6:00 p.m. - 6:00 a.m.: 2 CNAs and 1 student nurse aide who called off; and 1 RN and 1 LVN 6:00 a.m. - 2:00 p.m. 1 MA was scheduled 2:00 p.m. - 10:00 p.m. 1 CNA who called off. 10:00 p.m. - 6:00 a.m. 1 CNA Record review of the Employee Punch Report dated [DATE] - [DATE] indicated: LVN YY, RN U, LVN EEE, and LVN RRR worked 6:00 a.m. - 6:00 p.m. shift on [DATE]. LVN D and RN DD worked 6:00 p.m. -6:00 a.m. shift, on [DATE]. ADON E worked 7:47 p.m. - 11:11 p.m. on [DATE]. ADON WW worked 7:19 p.m. - 11:17 p.m. on [DATE]. CNA Y, CNA GGG, SNAs RR and PPP worked 6:00 a.m. - 6:00 p.m. shift on [DATE]. CNA SSS worked 6:00 p.m. - 6:00 a.m. shift on [DATE]. CNA H worked 5:00 a.m. - 5:00 p.m. shift on [DATE]. CNA K worked 10:00 p.m. - 6:00 p.m. shift on [DATE]. CNA A worked 6:00 p.m. - 9:00 p.m. shift on [DATE]. (continued on next page)		

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of the Budgeted PPD on the facility assessment indicated, (based on a census of 77) 0.41 was required, which is equivalent to 31.57 hours (for CNAs) of budgeted time was unused. This indicated there was a shortage of approximately 3 CNAs on [DATE] when the incident with Resident #41 and Resident #44 occurred. During an interview on [DATE] at 8:28 AM, ADON WW stated she was at the facility working on [DATE]. ADON WW said she went to work at 5:23 AM and stayed until 1 PM then returned to the facility and worked from 7 PM to 11 PM. ADON WW stated she was administering medications on the ,d+[DATE] Hall in the morning and that evening returned due to the incident that occurred on the secured unit. During an interview on [DATE] at 8:39 AM, ADON E said she had 5 call-ins on the morning of [DATE] when she got to work and ADON WW was at the facility working. ADON E stated she had worked all day on [DATE] and into the early morning on [DATE] (24 hours). She stated they had 2 nurses on the floor and 2 aides (DON included). ADON E stated she had contacted the Area Director of Operations and stated to offer bonuses, but she had already called everyone, and they refused to come in. She stated she volunteered to stay over for 24 hours because it was easier than to come back in the morning. She stated she had gotten complaints about being short staffed and she had to work it. She stated she had worked night shifts and having 2 nurses was doable, but it was rough. She stated it was easier when everyone pitched in and all the CNAs that were scheduled were there because they were the backbone, and they were the first to notice any changes. She stated there should be a minimum of 3 CNAs up front and 1 in the back (secured unit). ADON E said it was important to ensure sufficient staff was in the facility for resident safety. During an interview on [DATE] at 10:59 AM, the Regional Compliance Nurse said there was no policy on sufficient staffing. The Regional Compliance Nurse stated there was not a true staffing issue. The Regional Compliance Nurses stated when a nurse was at the nursing station for over an hour then this becomes a time management problem. During an interview on [DATE] at 11:43 a.m., CNA H said she has had to work the secured unit alone. CNA H said she had voiced the inability to provide supervision to Resident #130 and prevent him from trying to ambulate on his broken leg. During an observation and interview on [DATE] at 10:55 p.m., CNA K said she had to work the secured unit many times alone. CNA K said she could remember Resident #130 had a fall and fractured his hip. CNA K said she could not remember providing care to Resident #130. CNA K said she had told the DON, and ADONs previously the secured unit was not staffed enough to provide adequate supervision to the residents. During this interview there were 5 residents of the secured unit up and ambulating about the unit in and out of rooms. CNA K said she was having a difficult time keeping the residents centrally located to ensure their safety. During an interview on [DATE] at 11:30 p.m., LVN C said she had cared for R [TRUNCATED]		

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 46892 Based on interview, observation, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 9 of 24 residents (Resident #9, Resident #36, Resident #41, Resident #44, Resident #45, Resident #57, Resident #71, Resident #127 and Resident #179) and 1 of 1 medication storage room reviewed for pharmacy services. 1. The facility failed to ensure Resident #45's hospital discharge orders were reconciled accurately to include his Lantus (long-acting insulin used to lower blood sugar) 10 units every hour of sleep, Humalog (short acting insulin used to lower blood sugar) per sliding scale before meals, Farxiga 10 mg (used to control high blood sugar) daily, and Augmentin 875 mg-125 mg (antibiotic) after his discharge on [DATE] which resulted in his hospitalization for metabolic encephalopathy (condition in which brain function is disturbed due to different diseases or toxins in the body) and hyperglycemia (elevated blood sugar at 926) on [DATE]. 2. The facility failed to ensure Resident #127 received his Vesicare as ordered after being admitted on [DATE]. 3. The facility failed to ensure Resident #179 was administered his antidepressant, antianxiety and pain medications timely on [DATE] and [DATE]. 4. The facility failed to ensure Resident #36's Sertraline (anxiety), Keppra (seizures), Diltiazem (anti-hypertension), Hydralazine (anti-hypertension) were administered at the prescribed time. 5. The facility failed to ensure Resident #9's Lisinopril (ant- hypertension), Trazadone (insomnia), Atorvastatin (hyperlipidemia), Clonazepam (anxiety), and Valproate Sodium Solution (bipolar and depression) were administered at the prescribed time. 6. The facility failed to ensure Resident #57's antihypertensive, antidepressant, anticoagulant, antihyperlipidemic, diuretic, supplemental and pain medications during [DATE]-[DATE] were provided timely. 7. The facility failed to ensure Resident #71's blood pressure met the parameters for the administration of an anti-hypertensive medication. 8. The facility failed to ensure Resident #44 received the ordered Cephalexin an antibiotic medication to treat her urinary tract infection timely. 9. The facility failed to ensure Resident #41 received the ordered weight loss supplement to treat weight loss timely. (continued on next page)		

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Immediate Jeopardy (IJ) situation was identified on [DATE] at 3:50 PM. The IJ template was provided to the facility on [DATE] at 4:19 PM. While the IJ was removed on [DATE] at 5:10 PM, the facility remained out of compliance due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. 10. The facility failed to discard 9 bottles of We Care Enema Saline laxative expired on ,d+[DATE] in the medication storage room on [DATE]. These failures could place residents at risk of serious harm, not receiving their medications as ordered, illnesses, hospitalization s, exacerbation of their disease processes, coma, and death. Findings included: 1. Record review of a face sheet dated [DATE] indicated Resident #45 was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Alzheimer's disease (progressive disease that destroys memory and other important mental functions) and type 2 diabetes mellitus with ketoacidosis without coma (chronic condition that affects the way the body processes blood sugar resulting in high blood sugars). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #45 was rarely/never understood and sometimes understood others. Resident #45 required supervision for eating and substantial/maximal assistance with shower/bathe self, upper body dressing, and personal hygiene. The MDS assessment did not indicate Resident #45 received insulin. Record review of the care plan last revised [DATE] indicated Resident #45 had diabetes and would refuse his blood sugars and insulin at times. The goal was for Resident #45 to have no complications related to diabetes through the review date. Interventions included Diabetes medication as ordered by doctor, blood sugar checks as ordered by doctor, if infection is present, consult doctor regarding any changes in diabetic medications. Record review of the Order Summary Report dated [DATE]-[DATE] did not indicate orders for Resident #45's Lantus (long-acting insulin used to lower blood sugars), Humalog (short acting used to lower blood sugars) Farxiga 10 mg (used to control high blood sugar) daily, or Augmentin 875 mg-125 mg (antibiotic). Record review of Resident #45's [DATE] MAR indicated: Farxiga 10 mg one tablet by mouth in the morning discontinued on [DATE]. Farxiga was administered from [DATE]-[DATE]. Check blood sugar at bedtime for hyper/hypoglycemia (high or low blood sugars) discontinued on [DATE]. [DATE] blood sugar was 239, [DATE] blood sugar was 169, [DATE] blood sugar was 210, [DATE] blood sugar was 266, [DATE] blood sugar was 209, [DATE] blood sugar was 345, [DATE] blood sugar was 434, [DATE] blood sugar was 190, [DATE] blood sugar was 134, [DATE] blood sugar was 258, [DATE] blood sugar was 324, [DATE] blood sugar was 106, [DATE] blood sugar check refused, [DATE] blood sugar was 315, [DATE] blood sugar was 120, [DATE] hospitalized . (continued on next page)		

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Lantus SoloStar Pen-injector 100 unit/ml inject 40 units subcutaneously (under the skin) every morning discontinued [DATE] [DATE] medication not given due to low blood sugar, [DATE] administered, [DATE] administered, [DATE] not administered due to low blood sugar, [DATE]-[DATE] administered, [DATE] not administered due to low blood sugar, [DATE]-[DATE] administered, [DATE] not administered due to low blood sugar, [DATE] administered, [DATE] medication refused. Fasting Blood Sugar twice a day discontinued [DATE]. 6:30 AM [DATE] blood sugar was 66, [DATE] blood sugar was 175, [DATE] blood sugar was 163, [DATE] blood sugar was 72, [DATE] blood sugar was 72, [DATE] blood sugar was 220, [DATE] blood sugar was 201, [DATE] blood sugar was 180, [DATE] blood sugar was 88, [DATE] blood sugar was 118, [DATE] blood sugar was 107, [DATE] blood sugar was 134, [DATE] blood sugar was 79, [DATE] blood sugar was 58, [DATE] blood sugar was 88, [DATE] refused. 4:30 PM [DATE] blood sugar was 148, [DATE] blood sugar was 367, [DATE] blood sugar was 328, [DATE] blood sugar was 293, [DATE] resident sleeping, [DATE] blood sugar was 198, [DATE] blood sugar was 148, [DATE] blood sugar was 249, [DATE] blood sugar was 242, [DATE] blood sugar was 235, [DATE] blood sugar was 102, [DATE] refused, [DATE] blood sugar was 71, [DATE] blood sugar was 268, [DATE] blood sugar was 290, [DATE] resident sleeping. Humalog Injection Solution 100 unit/ml Inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12 units 450 and greater give the 12 units and call MD, subcutaneously before meals may only use 3 times a day discontinue date [DATE]. Humalog was administered per sliding scale from [DATE]-[DATE]. Record review of Resident #45's February 2024 MAR did not indicate the administration of Farxiga, Lantus or Humalog. Resident #45's February 2024 MAR did not indicate his blood sugar was checked. Record review of Resident #45's progress notes from [DATE]-[DATE] indicated: [DATE] at 11:00 AM Resident #45 was transferred to the behavioral hospital. Documented by LVN HHH. The progress notes did not include documentation of Resident #45's readmission on [DATE] or that Resident #45's orders were reconciled with the Medical Director. The progress notes did not include documentation regarding Resident #45's discontinuation of his insulins or blood sugar checks. [DATE] at 1:05 PM, CNA reported Resident #45 was not acting like his normal self. Upon entering residents room resident was found lethargic lying horizontally across the bed, eyes looked glossy, resident's speech was incoherent, he was clammy upon touch. Blood pressure was ,d+[DATE], heart rate 86, oxygen saturation 96%, respirations 18, temperature 98.7 F, fingerstick blood sugar too high to read. NP was notified and order was given to send to the ER for evaluation. 1:20 PM 911 contacted for transport 1:25 PM report given to the RN in the ER. EMS arrived on the seen fingerstick blood sugar per EMS was 568. 1:43 PM residents responsible party was notified 2:20 PM the DON and the AIT were notified. Documented by LVN RRR. Record review of the Readmission Nurses' Note effective date [DATE] completed by LVN W on [DATE] indicated Resident #45 was readmitted to the facility on [DATE] the area for blood glucose indicated if not diabetic enter N/A (not applicable), N/A was documented. There was no documentation to indicate Resident #45's orders were reconciled with the Medical Director. (continued on next page)		

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #45's Discharge Medication Summary for Patient (in bold) dated [DATE] indicated do not continue these medications at home (noted in big letters across the page) Lantus (also known as insulin glargine) 100 units/ml 40 units under skin once daily, Namenda (also known as memantine used to treat confusion related to Alzheimer's) 10 mg twice a day, Farxiga (also known as dapagliflozin used to treat high blood glucose) 10 mg once daily. The Discharge Medication Summary for Patient continued Medications to take after discharge (in bold letters at the top of the page) buspirone (also known as buspar dividose medication for anxiety) 30 mg twice a day, Trileptal (also known as oxcarbazepine used to treat mood disorders) 150 mg twice a day, Zoloft (also known as sertraline used to treat depression) 100 mg once daily, Desyrel (also known as trazadone used to treat insomnia) 25 mg at bedtime as needed. The behavioral hospitals discharge papers for Resident #45 continued Discharge/Aftercare Instructions-Nursing (bold print at the top of the page): amoxicillin-clavulanate (antibiotic) 875 mg-125 mg 1 tablet by mouth every 12 hours buspirone (anxiety medication) 30 mg by mouth twice daily donepezil (used to treat confusion related to Alzheimer's disease) 10 mg by mouth every hour of sleep Farxiga 10 mg by mouth daily Ferrous sulfate (iron supplement) 325 mg by mouth daily Glucagon injectable (raises blood sugar when it is low) 1 mg intramuscular (in the muscle) injection every 1 hour for blood glucose less than 70 and not able to drink orange juice Humalog per sliding scale subcutaneously before meals Lantus 10 units subcutaneously every hour of sleep Namenda 10 mg by mouth daily Multivitamin 1 tablet by mouth daily Zoloft 100 mg by mouth daily (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Brentwood Terrace Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 Stillhouse Road Paris, TX 75460	
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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Desyrel 25 mg by mouth every hour of sleep as needed Trilepta 300 mg by mouth twice daily Vitamin B-12 500 mcg by mouth daily Tylenol 650 mg by mouth every 8 hours for pain or fever Mylanta (used to treat upset stomach, heartburn and indigestion) 30 ml by mouth every 6 hours as needed. During an observation and interview on [DATE] at 8:45 PM, Resident #45 was in the hospital in the ICU resting in his hospital bed. Resident #45 was unable to answer questions appropriately. Resident #45's nurse at the hospital said he was awaiting transfer to the medical surgical floor but there were no beds available. Resident #45's nurse said when he arrived to the ER they had to obtain his blood glucose level by a blood specimen due to it not reading on the hospital glucometer. Resident #45's blood glucose level was 929. Resident #45's nurse said when he arrived at the ER he was not alert, he was lethargic and it had taken him ,d+[DATE] hours to return to his baseline (normal). Resident #45 was being administered Humalog and Lantus during his hospitalization . Record review of Resident #45's undated hospital medical records indicated he admitted on [DATE] arrived to the ER via EMS from the local nursing home due to altered mental status and elevated glucose. In the emergency room his blood glucose was in excess of 900. Resident #45 had other metabolic abnormalities and was worrisome for UTI. The nursing home staff reported that Resident #45 had been out of his insulin for 1 month because the medication was on backorder. The nursing home staff said there was no replacement for his insulin since that time. Resident #45's problem list included acute metabolic encephalopathy (condition in which brain function is disturbed due to different diseases or toxins in the body), hyperosmolar hyperglycemic state (life threatening complication of diabetes characterized by severe high blood glucose, extreme dehydration and altered consciousness), sepsis (condition as a result of an infection that can lead to organ failure and death if not treated quickly), urinary tract infection, volume depletion (blood plasma is too low and causes rapid heartbeat, weak pulse, confusion and loss of consciousness), lactic acidemia (too much lactic acid buildup in the body), acute kidney injury on chronic kidney disease, hypernatremia (high sodium levels), dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), atrial fibrillation with rapid ventricular response (rapid, irregular heartbeat). During an interview on [DATE] at 11:14 AM, ADON S said when residents came back from a hospitalization , they were readmitted into the computer system. ADON S said the admitting nurse was responsible for reconciling the admitting medication orders with the medical director, and the ADONS looked over them to ensure accuracy. ADON S said she was responsible for monitoring the orders for Halls 1 and 2, ADON WW was responsible for Halls 3 and 4, and the secured unit was split between the 2 of them. ADON S said it was important to accurately reconcile the admitting orders to ensure the medications were correct, allergies were discussed, and to discuss with the doctor new medication orders and dosages and ensure the administration times were appropriate. ADON S said if medications were not accurately reconciled upon admission residents could miss a scheduled medication. (continued on next page)		

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:25 AM, the DON said when a resident readmitted to the facility the nurses should call the doctor to reconcile medications with him. The DON said the orders were then reviewed the next day in the morning meetings to double check the residents received the right medications. The DON said the ADONs and herself were responsible for reviewing the orders the day after a resident admitted . The DON said generally ADON S was responsible for checking the orders the day after a resident's admission. The DON said it was important for the medications to be reconciled on admission to ensure the residents received the proper medications and were getting what was necessary and to keep the residents safe. The DON said if medications were not reconciled appropriately this could lead to the residents not receiving the necessary medications. The DON said she was not familiar with Resident #45. During an interview on [DATE] at 11:42 AM, the NP said Resident #45 had been a resident at the facility for quite some time. The NP said she was aware he was diabetic, and she thought he had readmitted to the facility in [DATE], but she could not recall for sure. The NP said she had not spoken to the nurses upon his readmission to the facility. The Medical Director was the one notified of his readmission. The NP said the facility notified her of the issue with Resident #45's insulin this week. The NP said when a resident readmitted to the facility the nurses were supposed to call the Medical Director or herself with the changes and ask if they wanted to reconcile and continue previous orders and what changes should be made. The NP said a lot of times the hospital or the behavioral health units will stop residents' insulin because they do not want to take the risk of hypoglycemia (low blood sugars). The NP said if medications were not reconciled appropriately on admission residents could not get medications that they would need, and this could lead to hyperglycemia (high blood sugars), hypertension (high blood pressure) depending on the disease process. The NP said not receiving necessary medications could lead to exacerbation of the residents' disease processes. During an attempted interview on [DATE] at 11:49 AM, ADON WW did not answer the phone. During an interview on [DATE] at 12:21 PM, the Administrator said he expected for the nurses to follow the discharge orders. The Administrator said he had only been at the facility for about a week, and typically the IDT in the morning meetings reviewed the admissions orders together the day after a resident admitted to ensure the orders were correct and so multiple eyes could verify the orders were correct. The Administrator said in other places the DON and ADON were responsible for reviewing orders after a resident's admission, but he was not sure at the facility what the process was. The Administrator said it was important for the medication orders to be reconciled upon a resident's admission to ensure they were getting the correct medications to treat the diagnoses that the residents had. During an interview on [DATE] at 12:26 PM, Pharmacist XX said when a resident was out of the facility past midnight, the residents' medication orders were discontinued. Pharmacist XX said when the resident returned to the facility there was a renew button in the computer system that the nurses clicked and then they could reconcile the residents' previous orders with the new orders. Pharmacist XX said once the orders were reconciliated they were transmitted, and medications sent out to the facility. (continued on next page)		

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 12:33 PM, LVN W said she was aware Resident #45 was diabetic. LVN W said she had done part of the readmission orders for Resident #45. LVN W said there were no orders for Resident #45's insulin, and she had questioned the orders and notified the Medical Director, but he provided instructions to not restart Resident #45's insulin at that time because his blood sugars were running low, and he was not eating much. LVN W said the Medical Director had not given orders to monitor blood sugars, and she had asked him, but he said no. LVN W said to be honest Resident #45 was not acting like he was having problems with his blood sugars. LVN W said he was active and did not think he required blood sugar checks. LVN W said she had called the behavioral unit to ask them about the insulin orders and the nurse that had given her report said they had been holding Resident #45's insulin because he was not eating. LVN W said she had not seen Resident #45's insulin orders on his discharge paperwork. LVN W said it was important for medications to be reviewed and reconciled upon a resident's admission because if a mistake was made the residents would not get medications they required. LVN W said more than one person should have reviewed Resident #45's orders upon his admission because she was human and could miss things. LVN W said Resident #45 not receiving his insulin could hurt his kidneys and liver. LVN W said she had placed Resident #45's orders in the file box for the ADON to review the orders and to audit them. LVN W said she assumed the ADON was the one responsible for reviewing the medications orders, but there had been a lot of changes and there were other people also reviewing the orders. During an interview on [DATE] at 3:33 PM, the Area Director of Operations said her expectations when a resident admitted to the facility were for the nurses to follow the physician orders, review the hospital records and put in the medications order and review the medication orders with the physician. The Area Director of Operations said she was a consultant for the facility. The Area Director of Operations said she was there as a resource for the facility administration to reach out to her with assistance regarding the policies and procedures. The Area Director of Operations said the administrators were responsible for the facility that is why when one administrator left an interim was put in place. The Area Director of Operations said she did not provide oversight for the facility that was the administrators responsibility because she had 10 other facilities she was over. The Area Director of Operations said she made sure the facilities were in the green and monitored their spending to help them reach their financial goals. (continued on next page)		

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 9:24 PM, the Medical Director said there had been at least 5 administrators and half a dozen DONs and several ADONs in the past year. The Medical Director said there was no constancy, and the staff were unfamiliar with the residents and left often, which resulted in difficulty maintaining staff stability. The Medical Director said then there was the human factor, and if they had , d+[DATE] loose links it destroyed everything. The Medical Director said he was at the facility almost every night spending hours trying to figure out mistakes with medication management issues. The Medical Director said staffing had become a big challenge for the facility that they had major staffing issues. The Medical Director said the staffing shortage was contributing to the falls, worsening wounds, nutrition issues, medication administration issues. The Medical Director said he reconciled the orders with the nurses on admission by phone call because he was not always in the facility when a resident admitted . The Medical Director said with Resident #45 nursing had miscommunicated the information regarding his insulin orders to him. The Medical Director said he was not aware that both of Resident #45's insulins (the short acting and long acting) had been stopped. The Medical Director said stopping both insulins resulted in Resident #45 having high blood sugars, which could lead to severe dehydration and a coma. The Medical Director said he was not able to physically look at the discharge orders from the behavioral health unit. The Medical Director said Resident #45's blood sugars should have been checked three times a day because he was diabetic. The Medical Director said amongst all the changes in administrators and DONs he did not know who was supposed to be keeping the facility together to prevent system failures, but he knew the Area Director of Operations was one of the major decision makers. During an interview on [DATE] at 3:26 PM, the Pharmacy Consultant said she preferred not to answer general questions regarding the risks of administering medications late or the effects of not administering insulin, and she was not currently in her office, so she had no access to resident information. During an attempted interview on [DATE] at 5:02 PM, LVN RRR did not answer the phone. During an interview on [DATE] at 5:32 PM, the DON said the reconciliation for Resident #45 was not done properly. The DON said there was confusion with the discharge orders, and the nurse should have made sure the reconciliation of meds was done properly when Resident #45 readmitted . The DON said she was not employed at the facility when Resident #45 readmitted . The DON said when residents were readmitted /admitted the nurse reconciled the orders with the physician and then the orders would be reviewed in the morning meeting by nurse management. The DON said medications not being reconciled properly could lead to exacerbation of conditions and injury to the residents. Record review of the EvenCare G2 blood glucose monitoring system's user guide indicated on page 50 a HI(high) reading on the glucometer was seen it means your blood glucose if above 600. 2. Record review of a face sheet dated [DATE] indicated Resident #127 was an [AGE] year-old male who admitted on [DATE] with the diagnoses of dementia, and overactive bladder. Record review of the admission papers dated [DATE] provided by the Resident #127's primary physician indicated Resident #127 had an overactive bladder requiring medication management. Resident #127's active medication regimen provided included Vesicare (Solifenacin) 5 milligrams daily with a start date of [DATE] (active medication). (continued on next page)		

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the February 2024 Medication Administration Record indicated Solifenacin Succinate (Vesicare) oral tablet 5 milligrams daily was ordered on [DATE] and discontinued on [DATE] with no administrations provided to Resident #127. Record review of the Admission MDS dated [DATE] indicated Resident #127 was understood and understands others. The Admission MDS indicated Resident #127 had moderate cognitive impairment. The MDS indicated Resident #127 was occasionally incontinent of urine. Record review of the Order Summary Report dated [DATE] failed to include the medication Vesicare on the facility orders. Record review of the Comprehensive Care Plan dated [DATE] failed to indicate Resident #127 had an overactive bladder requiring medication management or his occasional incontinence. During an observation and interview on [DATE] at 3:56 p.m., Resident #127 was sitting in the dining room/ day room with his peers. Resident #127 was unsure if he was taking any medications for his overactive bladder. 3. Record review of a face sheet dated [DATE] indicated Resident #179 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis of all four limbs, and the trunk of the body), congenital insufficiency of aortic valve (heart defect that prevents blood from flowing backward through the heart), neuromuscular dysfunction of the bladder (condition where a person lacks bladder control due to brain, spinal cord, or nerve problems), major depressive disorder recurrent (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks), and anxiety disorder. Record review of the Comprehensive MDS assessment dated [DATE], indicated Resident #179's speech was unclear, was sometimes able to make himself understood, and understood others. The MDS assessment indicated Resident #179 had a BIMS score of 12 which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #179 was dependent on staff for all ADLs. The MDS assessment indicated Resident #179 had pain almost constantly and it frequently interfered with his ability to sleep. The MDS assessment indicated Resident #179 received antianxiety, antidepressant, and opioids in the last 7 days. Record review of the care plan last revised on [DATE] indicated Resident #179 required antidepressant medication to give medications as ordered. The care plan indicated Resident #179 had a potential for uncontrolled pain to evaluate pain interventions. The care plan indicated Resident #179 was on pain medication therapy to administer medications as ordered. Record review of the Order Summary Report dated [DATE] indicated Resident #179 had the following medication orders: Buspirone (medication for anxiety) 15 mg give 1 tablet via g-tube two times a day with a start date of [DATE]. Trazodone 50 mg (medication for depression) give 1 tablet via g-tube two times a day with a start date of [DATE]. (continued on next page)		

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Pregabalin (medication for nerve pain) 75 mg give 1 capsule via g-tube three times a day with a start date of [DATE]. Hydrocodone (pain medication) ,d+[DATE] mg give 1 tablet via g-tube four times a day with a start date of [DATE]. Gabapentin (medication for nerve pain) 100 mg give 1 capsule via g-tube three times a day with a start date of [DATE]. Record review of Resident #179's medication administration audit report dated [DATE]-[DATE] indicated the following: On [DATE] the following medications were scheduled to be received at 8:00 PM were administered over 6 hours late, after the 1-hour grace period: Pregabalin 75 mg give 1 capsule via g-tube three times a day administered at 3:58 AM Gabapentin 100 mg give 1 capsule via g-tube three times a day administered at 5:33 AM Trazodone 50 mg give 1 tablet via g-tube two times a day administered at 5:33 AM Hydrocodone ,d+[DATE] mg give 1 tablet via g-tube four times a day for pain administered at 5:33 AM On [DATE] the following medications were scheduled to be received at 8:00 PM were administered over 1 hour late, after the 1-hour grace period: Hydrocodone ,d+[DATE] mg give 1 tablet via g-tube four times a day for pain administered at 10:28 PM Buspirone 15 mg give 1 tablet via g-tube two times a day administered at 10:28 PM Trazadone 50 mg give 1 tablet via g-tube two times a day administered at 10:29 PM Pregabalin 75 mg give 1 capsule via g-tube three times a day administered at 1:26 AM During an interview on [DATE] at 10:46 AM, Resident #179 said his night medications were due at 8 PM and sometimes he was not receiving them until midnight. Resident #179 said he had asked the nurses about his medications being administered late, and they had said it was because they were short staffed on the night shift. (continued on next page)		

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Record review of Resident #36's face sheet dated [DATE], indicate Resident # 36 was a [AGE] year-old female admitted to the facility on [DATE], with a diagnosis which include Metabolic Encephalopathy (a problem in the brain), morbid severe obesity due to excess calories (BMI greater than 40, a BMI of greater than 35 with at least one serious obesity-related condition, or being more than 100 pounds over your recommended weight), abnormal posture (rigid body movements and chronic abnormal positions of the body), muscle weakness (commonly due to lack of exercise, aging, muscle injury) chronic obstructive pulmonary disease (disease that causes airflow blockage and breathing-related problems). Bipolar disorder, current episode depressed, severe, without psychotic features (depressed, as in severe depressive episode without psychotic symptoms, and has had at least one authenticated hypomanic, manic, or mixed affective episode in the past) hypertension (when the pressure in your blood vessels is too high (,d+[DATE]mmhg or higher), heart failure (progressive disease that affects pumping action of the heart muscle), type 2 Diabetes Mellitus (a disease of inadequate control of blood levels of glucose) other seizures (convulsion, sensory disturbance, or loss of consciousness). Record review of Resident #36's a care plan with dated [DATE], indicated Resident #36 had the following problems: *Resident #36 had hypertension (high blood pressure) with interventions to give antihypertensive medications as ordered and to monitor for side effects such as orthostatic hypotension (blood pressure drops after sitting or lying down) and increased heart rate. *Resident #36 had diabetes mellitus (high blood sugar) with interventions to give medications as ordered and to monitor for side effects. *Resident #36 required antidepressant medications (Doxepin and Zoloft) with interventions to administer medications as ordered by the physician. Resident #36 had a potential for pain and took routine pain medications (Tylenol with Codeine) with interventions to administer medications as per orders. Record review of Resident # 36's Quarterly MDS assessment dated [DATE], indicated Resident #36 was understood and was able to understand others. The MDS assessment indicated Resident #36 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #36 had received antidepressant, and insulin dur [TRUNCATED]		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview and record review the facility failed to ensure the resident's drug regimen was free from unnecessary psychotropic drugs for 2 of 5 residents (Resident #52, and Resident #179) reviewed for unnecessary psychotropic drugs. 1. The facility failed to ensure Resident #179 was monitored for side effects and behaviors related to the use of Buspirone (anxiety medication), Clonazepam (anxiety medication), Lexapro (antidepressant), and Trazodone (used to treat depression) since his admission on 02/13/2024. 2. The facility failed to ensure Resident #52's PRN Clonazepam was administered with an adequate indication for its use on 02/23/24 and 02/24/24. These failures could place residents at risk of receiving unnecessary psychotropic medications with possible medication side effects, adverse consequences, decreased quality of life and dependence on unnecessary medications. Findings included: 1. Record review of a face sheet dated 03/02/2024 indicated Resident #179 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis of all four limbs, and the trunk of the body), congenital insufficiency of aortic valve (heart defect that prevents blood from flowing backward through the heart), neuromuscular dysfunction of the bladder (condition where a person lacks bladder control due to brain, spinal cord, or nerve problems), major depressive disorder recurrent (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks), and anxiety disorder. Record review of the Comprehensive MDS assessment dated [DATE], indicated Resident #179's speech was unclear, was sometimes able to make himself understood, and understood others. The MDS assessment indicated Resident #179 had a BIMS score of 12 which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #179 was dependent on staff for all ADLs. The MDS assessment indicated Resident #179 received antianxiety and antidepressants in the last 7 days. Record review of the care plan last revised on 02/23/2024 indicated Resident #179 required antidepressant medication to give medications as ordered. The care plan indicated Resident #179 used anti-anxiety medications, Buspirone and Clonazepam, to monitor/document side effects and effectiveness. The care plan indicated Resident #179 required antidepressant medications, Trazodone and Lexapro, to monitor side effects and effectiveness. Record review of the Order Summary Report dated 02/26/2024 indicated Resident #179 had the following medication orders: Buspirone 15 mg give 1 tablet via g-tube two times a day with a start date of 02/23/2024. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Trazodone 50 mg give 1 tablet via g-tube two times a day with a start date of 02/14/2024. Lexapro 10 mg give 1 tablet via g-tube one time a day with a start date of 02/14/2024. Clonazepam 1 mg give 1 tablet via g-tube every 8 hours with a start date of 02/14/2024. Record review of Resident #179's MAR for February 2024 indicated Resident #179 received his Buspirone, Trazodone, Lexapro, and Clonazepam as ordered since 02/14/2023. Record review of Resident #179's TAR for February 2024, did not indicate Resident #179 was being monitored for behaviors or side effects for the use of his Buspirone, Clonazepam, Lexapro, and Trazodone. 2. Record review of a face sheet dated 03/02/2024 indicated Resident #52 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia, unspecified severity, with other behavioral disturbance(deterioration of memory, language, and other thinking abilities with behaviors) , anxiety disorder, and depression. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #52 was usually able to understand others and was usually understood by others. The MDS assessment indicated Resident #52 had a BIMS score of 5, which indicated his cognition was severely impaired. The MDS assessment indicated Resident #52 had no physical, verbal, or other behaviors directed toward others. The MDS assessment indicated Resident #52 required setup or cleanup assistance with eating, supervision for oral, toileting, and personal hygiene, and partial to moderate assistance with showering and dressing. The MDS assessment indicated Resident #52 received antianxiety in the last 7 days. Record review of Resident #52's care plan indicated he used anti-anxiety medications with a goal of Resident #52 will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. Interventions included Resident #52 was taking anti-anxiety meds which were associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia, falls, broken hips and legs to monitor him frequently for safety, give anti-anxiety medications ordered by physician, monitor for side effects and effectiveness anti-anxiety side effects included drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision, mania, hostility and rage, aggressive or impulsive behaviors, hallucinations. Record review of Resident #52's Order Summary Report dated 03/02/2024 indicated orders for: Behavior Monitoring Enter the code - 0.None 1.Panic 2.Agitated 3.Angry 4.Anxiety 5.Biting 6.Compulsive 7. Crying 8.Pacing 9.Screaming/yelling 10.Pull IV line/tubes 11.Poor eye contact 12.Depressed withdrawn 13. Extreme fear 14.False beliefs 15.Fighting 16.Finger painting feces 17. Hallucinations/paranoia/delusion 18. Head banging 19. Insomnia 20.Jittery 21.Kicking 22.Noisy 23.Pinching 24.Restless 25.Scratching 26. Slapping 27. Suspiciousness 28.Throwing objects 29.Wandering 30.Other see progress notes every shift if any behaviors are noted, document details in a progress note with a start date of 06/13/2023. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/02/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Terrace Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 Stillhouse Road Paris, TX 75460	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clonazepam 0.5 MG give 1 tablet by mouth every 24 hours as needed for anxiety related only give from 6 AM to 12 noon do not give after 12 noon per his family member with a start date of 02/20/2024. Record review of Resident #52's February 2024 TAR indicated Clonazepam 0.5 mg was administered on 02/23/2024 and 02/24/2024 by LVN RRR. The TAR indicated no behaviors for 02/23/2024 and 02/24/2024 when the Clonazepam was administered. Record review of Resident #52's progress notes indicated: 02/23/2024 at 6:15 PM, PRN administration of Clonazepam was ineffective resident continued to wander facility anxiously and appeared frustrated and did not seem to understand where he was or why he repeatedly asked to call his family member, after just having spoken with her a few minutes prior, resident was extremely forgetful and had short term memory problems encouraged resident to relax and reminded him of his recent conversations with his daughters however he did not show understanding no distress noted and no signs and symptoms of pain or discomfort will continue to monitor completed by LVN RRR. There were no other notes to indicate what interventions were attempted prior to the administration of the Clonazepam or the indication for administering the Clonazepam. 02/24/2024 at 4:14 PM, PRN administration of Clonazepam was effective resident appeared less anxious throughout the shift completed by LVN RRR. There were no other notes to indicate what was the indication for administering the Clonazepam or what interventions were attempted prior to the administration of the Clonazepam. During an interview on 03/02/2024 at 4:24 PM, the Administrator said the nurses were responsible for monitoring for behaviors and side effects and administering the appropriate medications. The Administrator said appropriate monitoring of behaviors and side effects was important to ensure medications were administered appropriately and no side effects were experienced. During an attempted phone interview on 03/02/2024 at 5:02 PM, LVN RRR did not answer the phone. During an interview on 03/02/2024 at 5:19 PM, the DON said the nurses were responsible for doing the behavior monitoring and side effect monitoring. The DON said the ADONs and herself provided oversight by running weekly reports. The DON said the person inputting the medication order should put the behavior and side effect monitoring on the resident's MAR. The DON said she was not aware Resident #179 did not have behavior or side effect monitoring in place for his medications. The DON said it was important to complete the behavior monitoring to monitor for changes in behavior and to ensure the medications were adequate for them. The DON said it was important to monitor for side effects from medications to ensure the residents did not experience oversedation or negative side effects. The DON said if Resident #52 was having no behaviors the nurse should speak with the doctor for readjusting the medication and a PRN medication should not be administered. The DON said prior to administering an anxiety medication the nurse should attempt other interventions. The DON said administering PRN anxiety medications without the appropriate behaviors placed the residents at risk for injury. (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/02/2024 at 05:22 PM, LVN W said all psychotropic medications should have behavior monitoring and side effect monitoring in place. LVN W said the nurse that received the order for antianxiety or antidepressant medications was responsible for ensuring that the behavior and side effect monitoring was in place. LVN W said before a PRN psychotropic medication, for example an antianxiety medication, was given the nurse should have had provided the resident with interventions such redirecting, offering them food or fluids, assessing for pain, and toileting. Those interventions should have been documented as completed prior to administration of an anti-anxiety medication. LVN W said if the nurse did not document all interventions provided then she would assume the medication was given for their convenience. LVN W said the nurse was responsible for administering all PRN medications. LVN W said if a resident was to receive a psychotropic medication with no documented interventions the resident was at risk for being knocked out for no reason and could get themselves hurt or injured if they became groggy and tried to get up. Record review of the facility's Pharmacy Policy & Procedure Manual 2003 policy titled, Medication Administration Procedures, indicated, .All PRN medication orders must specify the reason and frequency for use. PRN medications are to be charted on the medication administration record. An explanation as to symptoms prior to administration and results are to be documented. Complete documentation of PRN administration is to be noted in nurses notes, or in the area provided for PRN documentation on the medication administration record . Record review of the facility's Pharmacy Policy & Procedure Manual revised 10/25/2017, titled, Psychotropic Drugs, indicated, The intent of this policy is that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial wellbeing, the facility implements gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety . Nurses will continually monitor for behaviors, adverse consequences and/or side effects and utilizing the Psychotropic Medication Behavior/Side Effect Monitoring forms generated by PCC, the nurse will document the behavior and/or side effect using charting by exception (only charting when the occurrence is observed or assessed) . Based on interview and record review the facility failed to ensure the resident's drug regimen was free from unnecessary psychotropic drugs for 2 of 5 residents (Resident #52, and Resident #179) reviewed for unnecessary psychotropic drugs. 1. The facility failed to ensure Resident #179 was monitored for side effects and behaviors related to the use of Buspirone (anxiety medication), Clonazepam (anxiety medication), Lexapro (antidepressant), and Trazodone (used to treat depression) since his admission on 02/13/2024. 2. The facility failed to ensure Resident #52's PRN Clonazepam was administered with an adequate indication for its use on 02/23/24 and 02/24/24. These failures could place residents at risk of receiving unnecessary psychotropic medications with possible medication side effects, adverse consequences, decreased quality of life and dependence on unnecessary medications. (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings included: 1. Record review of a face sheet dated 03/02/2024 indicated Resident #179 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis of all four limbs, and the trunk of the body), congenital insufficiency of aortic valve (heart defect that prevents blood from flowing backward through the heart), neuromuscular dysfunction of the bladder (condition where a person lacks bladder control due to brain, spinal cord, or nerve problems), major depressive disorder recurrent (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks), and anxiety disorder. Record review of the Comprehensive MDS assessment dated [DATE], indicated Resident #179's speech was unclear, was sometimes able to make himself understood, and understood others. The MDS assessment indicated Resident #179 had a BIMS score of 12 which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #179 was dependent on staff for all ADLs. The MDS assessment indicated Resident #179 received antianxiety and antidepressants in the last 7 days. Record review of the care plan last revised on 02/23/2024 indicated Resident #179 required antidepressant medication to give medications as ordered. The care plan indicated Resident #179 used anti-anxiety medications, Buspirone and Clonazepam, to monitor/document side effects and effectiveness. The care plan indicated Resident #179 required antidepressant medications, Trazodone and Lexapro, to monitor side effects and effectiveness. Record review of the Order Summary Report dated 02/26/2024 indicated Resident #179 had the following medication orders: Buspirone 15 mg give 1 tablet via g-tube two times a day with a start date of 02/23/2024. Trazodone 50 mg give 1 tablet via g-tube two times a day with a start date of 02/14/2024. Lexapro 10 mg give 1 tablet via g-tube one time a day with a start date of 02/14/2024. Clonazepam 1 mg give 1 tablet via g-tube every 8 hours with a start date of 02/14/2024. Record review of Resident #179's MAR for February 2024 indicated Resident #179 received his Buspirone, Trazodone, Lexapro, and Clonazepam as ordered since 02/14/2023. Record review of Resident #179's TAR for February 2024, did not indicate Resident #179 was being monitored for behaviors or side effects for the use of his Buspirone, Clonazepam, Lexapro, and Trazodone. 2. Record review of a face sheet dated 03/02/2024 indicated Resident #52 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia, unspecified severity, with other behavioral disturbance(deterioration of memory, language, and other thinking abilities with behaviors) , anxiety disorder, and depression. (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #52 was usually able to understand others and was usually understood by others. The MDS assessment indicated Resident #52 had a BIMS score of 5, which indicated his cognition was severely impaired. The MDS assessment indicated Resident #52 had no physical, verbal, or other behaviors directed toward others. The MDS assessment indicated Resident #52 required setup or cleanup assistance with eating, supervision for oral, toileting, and personal hygiene, and partial to moderate assistance with showering and dressing. The MDS assessment indicated Resident #52 received antianxiety in the last 7 days. Record review of Resident #52's care plan indicated he used anti-anxiety medications with a goal of Resident #52 will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. Interventions included Resident #52 was taking anti-anxiety meds which were associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia, falls, broken hips and legs to monitor him frequently for safety, give anti-anxiety medications ordered by physician, monitor for side effects and effectiveness anti-anxiety side effects included drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision, mania, hostility and rage, aggressive or impulsive behaviors, hallucinations. Record review of Resident #52's Order Summary Report dated 03/02/2024 indicated orders for: Behavior Monitoring Enter the code - 0.None 1.Panic 2.Agitated 3.Angry 4.Anxiety 5.Biting 6.Compulsive 7. Crying 8.Pacing 9.Screaming/yelling 10.Pull IV line/tubes 11.Poor eye contact 12.Depressed withdrawn 13. Extreme fear 14.False beliefs 15.Fighting 16.Finger painting feces 17. Hallucinations/paranoia/delusion 18. Head banging 19. Insomnia 20.Jittery 21.Kicking 22.Noisy 23.Pinching 24.Restless 25.Scratching 26. Slapping 27. Suspiciousness 28.Throwing objects 29.Wandering 30.Other see progress notes every shift if any behaviors are noted, document details in a progress note with a start date of 06/13/2023. Clonazepam 0.5 MG give 1 tablet by mouth every 24 hours as needed for anxiety related only give from 6 AM to 12 noon do not give after 12 noon per his family member with a start date of 02/20/2024. Record review of Resident #52's February 2024 TAR indicated Clonazepam 0.5 mg was administered on 02/23/2024 and 02/24/2024 by LVN RRR. The TAR indicated no behaviors for 02/23/2024 and 02/24/2024 when the Clonazepam was administered. Record review of Resident #52's progress notes indicated: 02/23/2024 at 6:15 PM, PRN administration of Clonazepam was ineffective resident continued to wander facility anxiously and appeared frustrated and did not seem to understand where he was or why he repeatedly asked to call his family member, after just having spoken with her a few minutes prior, resident was extremely forgetful and had short term memory problems encouraged resident to relax and reminded him of his recent conversations with his daughters however he did not show understanding no distress noted and no signs and symptoms of pain or discomfort will continue to monitor completed by LVN RRR. There were no other notes to indicate what interventions were attempted prior to the administration of the Clonazepam or the indication for administering the Clonazepam. (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/24/2024 at 4:14 PM, PRN administration of Clonazepam was effective resident appeared less anxious throughout the shift completed by LVN RRR. There were no other notes to indicate what was the indication for administering the Clonazepam or what interventions were attempted prior to the administration of the Clonazepam. During an interview on 03/02/2024 at 4:24 PM, the Administrator said the nurses were responsible for monitoring for behaviors and side effects and administering the appropriate medications. The Administrator said appropriate monitoring of behaviors and side effects was important to ensure medications were administered appropriately and no side effects were experienced. During an attempted phone interview on 03/02/2024 at 5:02 PM, LVN RRR did not answer the phone. During an interview on 03/02/2024 at 5:19 PM, the DON said the nurses were responsible for doing the behavior monitoring and side effect monitoring. The DON said the ADONs and herself provided oversight by running weekly reports. The DON said the person inputting the medication order should put the behavior and side effect monitoring on the resident's MAR. The DON said she was not aware Resident #179 did not have behavior or side effect monitoring in place for his medications. The DON said it was important to complete the behavior monitoring to monitor for changes in behavior and to ensure the medications were adequate for them. The DON said it was important to monitor for side effects from medications to ensure the residents did not experience oversedation or negative side effects. The DON said if Resident #52 was having no behaviors the nurse should speak with the doctor for readjusting the medication and a PRN medication should not be administered. The DON said prior to administering an anxiety medication the nurse should attempt other interventions. The DON said administering PRN anxiety medications without the appropriate behaviors placed the residents at risk for injury. During an interview on 03/02/2024 at 05:22 PM, LVN W said all psychotropic medications should have behavior monitoring and side effect monitoring in place. LVN W said the nurse that received the order for antianxiety or antidepressant medications was responsible for ensuring that the behavior and side effect monitoring was in place. LVN W said before a PRN psychotropic medication, for example an antianxiety medication, was given the nurse should have had provided the resident with interventions such redirecting, offering them food or fluids, assessing for pain, and toileting. Those interventions should have been documented as completed prior to administration of an anti-anxiety medication. LVN W said if the nurse did not document all interventions provided then she would assume the medication was given for their convenience. LVN W said the nurse was responsible for administering all PRN medications. LVN W said if a resident was to receive a psychotropic medication with no documented interventions the resident was at risk for being knocked out for no reason and could get themselves hurt or injured if they became groggy and tried to get up. Record review of the facility's Pharmacy Policy & Procedure Manual 2003 policy titled, Medication Administration Procedures, indicated, .All PRN medication orders must specify the reason and frequency for use. PRN medications are to be charted on the medication administration record. An explanation as to symptoms prior to administration and results are to be documented. Complete documentation of PRN administration is to be noted in nurses notes, or in the area provided for PRN documentation on the medication administration record . (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Pharmacy Policy & Procedure Manual revised 10/25/2017, titled, Psychotropic Drugs, indicated, The intent of this policy is that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial wellbeing, the facility implements gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety . Nurses will continually monitor for behaviors, adverse consequences and/or side effects and utilizing the Psychotropic Medication Behavior/Side Effect Monitoring forms generated by PCC, the nurse will document the behavior and/or side effect using charting by exception (only charting when the occurrence is observed or assessed) .		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observation, interview, and record review the facility failed to ensure residents were free of any significant medication errors for 9 of 24 residents (Resident #9, Resident #36, Resident #41, Resident #44, Resident #45, Resident #57, Resident #71, Resident #127 and Resident #179) residents reviewed for medication errors. 1. The facility failed to ensure Resident #45's hospital discharge orders were implemented to include his Lantus (long-acting insulin used to lower blood sugar) 10 units every hour of sleep, Humalog (short acting insulin used to lower blood sugar) per sliding scale before meals, Farxiga 10 mg (used to control high blood sugar) daily, and Augmentin 875 mg-125 mg (antibiotic) every 12 hours after his discharge on 01/29/2024 which resulted in his hospitalization for metabolic encephalopathy (condition in which brain function is disturbed due to different diseases or toxins in the body) and hyperglycemia (elevated blood sugar at 926) on 02/25/2024. 2. The facility failed to ensure Resident #127 received his Vesicare as ordered after being admitted on [DATE]. 3. The facility failed to ensure Resident #179 was administered his antidepressant, antianxiety and pain medications timely. 4. The facility failed to ensure Resident #36's Sertraline (anxiety), Keppra (seizures), Diltiazem (anti-hypertension), Hydralazine (anti-hypertension) were administered at the prescribed time. 5. The facility failed to ensure Resident #9's Lisinopril (ant- hypertension), Trazadone (insomnia), Atorvastatin (hyperlipidemia), Clonazepam (anxiety), and Valproate Sodium Solution (bipolar and depression) were administered at the prescribed time. 6. The facility failed to ensure Resident #57's antihypertensive, antidepressant, anticoagulant, antihyperlipidemic, diuretic, supplemental and pain medications during 02/01/2024-02/27/2024 were provided timely. 7. The facility failed to ensure Resident #71's blood pressure met the parameters for the administration of an anti-hypertensive medication. 8. The facility failed to ensure Resident #44 received the ordered Cephalexin an antibiotic medication to treat her urinary tract infection timely. 9. The facility failed to ensure Resident #41 received the ordered weight loss supplement to treat weight loss timely. An Immediate Jeopardy (IJ) situation was identified on 02/28/2024 at 3:50 PM. The IJ template was provided to the facility on [DATE] at 4:19 PM. While the IJ was removed on 03/01/2024 at 5:10 PM, the facility remained out of compliance due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	These failures could place residents who require medications administered by the facility at risk of not receiving their medications as ordered, illness, hospitalization s, exacerbation of their disease processes, and death. Findings included: 1. Record review of a face sheet dated 02/28/2024 indicated Resident #45 was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Alzheimer's disease (progressive disease that destroys memory and other important mental functions) and type 2 diabetes mellitus with ketoacidosis without coma (chronic condition that affects the way the body processes blood sugar resulting in high blood sugars). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #45 was rarely/never understood and sometimes understood others. Resident #45 required supervision for eating and substantial/maximal assistance with shower/bathe self, upper body dressing, and personal hygiene. The MDS assessment did not indicate Resident #45 received insulin. Record review of the care plan last revised 10/20/2023 indicated Resident #45 had diabetes and would refuse his blood sugars and insulin at times. The goal was for Resident #45 to have no complications related to diabetes through the review date. Interventions included Diabetes medication as ordered by doctor, blood sugar checks as ordered by doctor, if infection is present, consult doctor regarding any changes in diabetic medications. Record review of the Order Summary Report dated 01/01/2024-02/29/2024 did not indicate orders for Resident #45's Lantus (long-acting insulin used to lower blood sugars), Humalog (short acting used to lower blood sugars) Farxiga 10 mg (used to control high blood sugar) daily, or Augmentin 875 mg-125 mg (antibiotic). Record review of Resident #45's January 2024 MAR indicated: o Farxiga 10 mg one tablet by mouth in the morning discontinued on 01/27/2024. Farxiga was administered from 01/01/2024-01/16/2024. o Check blood sugar at bedtime for hyper/hypoglycemia (high or low blood sugars) discontinued on 01/27/2024. 01/1/2024 blood sugar was 239, 01/02/2024 blood sugar was 169, 01/03/2024 blood sugar was 210, 01/04/2024 blood sugar was 266, 01/05/2024 blood sugar was 209, 01/06/2024 blood sugar was 345, 01/07/2024 blood sugar was 434, 01/08/2024 blood sugar was 190, 01/09/2024 blood sugar was 134, 01/10/2024 blood sugar was 258, 01/11/2024 blood sugar was 324, 01/12/2024 blood sugar was 106, 01/13/2024 blood sugar check refused, 01/14/2024 blood sugar was 315, 01/15/2024 blood sugar was 120, 01/16/2024 hospitalized . o Lantus SoloStar Pen-injector 100 unit/ml inject 40 units subcutaneously (under the skin) every morning discontinued 01/27/2024 01/01/2024 medication not given due to low blood sugar, 01/02/2024 administered, 01/03/2024 administered, 01/04/2024 not administered due to low blood sugar, 01/05/2024-01/08/2024 administered, 01/09/2024 not administered due to low blood sugar, 01/10/2024-01/13/2024 administered, 01/14/2024 not administered due to low blood sugar, 01/15/2024 administered, 01/16/2024 medication refused. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Fasting Blood Sugar twice a day discontinued 01/27/2024. 6:30 AM 01/1/2024 blood sugar was 66, 01/02/2024 blood sugar was 175, 01/03/2024 blood sugar was 163, 01/04/2024 blood sugar was 72, 01/05/2024 blood sugar was 72, 01/06/2024 blood sugar was 220, 01/07/2024 blood sugar was 201, 01/08/2024 blood sugar was 180, 01/09/2024 blood sugar was 88, 01/10/2024 blood sugar was 118, 01/11/2024 blood sugar was 107, 01/12/2024 blood sugar was 134, 01/13/2024 blood sugar was 79, 01/14/2024 blood sugar was 58, 01/15/2024 blood sugar was 88, 01/16/2024 refused. 4:30 PM 01/1/2024 blood sugar was 148, 01/02/2024 blood sugar was 367, 01/03/2024 blood sugar was 328, 01/04/2024 blood sugar was 293, 01/05/2024 resident sleeping , 01/06/2024 blood sugar was 198, 01/07/2024 blood sugar was 148, 01/08/2024 blood sugar was 249, 01/09/2024 blood sugar was 242, 01/10/2024 blood sugar was 235, 01/11/2024 blood sugar was 102, 01/12/2024 refused, 01/13/2024 blood sugar was 71, 01/14/2024 blood sugar was 268, 01/15/2024 blood sugar was 290, 01/16/2024 resident sleeping. o Humalog Injection Solution 100 unit/ml Inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12 units 450 and greater give the 12 units and call MD, subcutaneously before meals may only use 3 times a day discontinue date 01/27/2024. Humalog was administered per sliding scale from 01/01/2024-01/16/2024. Record review of Resident #45's February 2024 MAR did not indicate the administration of Farxiga, Lantus or Humalog. Resident #45's February 2024 MAR did not indicate his blood sugar was checked. Record review of Resident #45's progress notes from 12/29/2023-02/29/2024 indicated: o 01/16/2024 at 11:00 AM Resident #45 was transferred to the behavioral hospital. Documented by LVN HHH. o The progress notes did not include documentation of Resident #45's readmission on 01/29/2024 or that Resident #45's orders were reconciled with the Medical Director. The progress notes did not include documentation regarding Resident #45's discontinuation of his insulins or blood sugar checks. o 02/25/2024 at 1:05 PM, CNA reported Resident #45 was not acting like his normal self. Upon entering residents room resident was found lethargic lying horizontally across the bed, eyes looked glossy, resident's speech was incoherent, he was clammy upon touch. Blood pressure was 128/76, heart rate 86, oxygen saturation 96%, respirations 18, temperature 98.7 F, fingerstick blood sugar too high to read. NP was notified and order was given to send to the ER for evaluation. 1:20 PM 911 contacted for transport 1:25 PM report given to the RN in the ER. EMS arrived on the seen fingerstick blood sugar per EMS was 568. 1:43 PM residents responsible party was notified 2:20 PM the DON and the AIT were notified. Documented by LVN RRR. Record review of the Readmission Nurses' Note effective date 01/29/2024 completed by LVN W on 01/30/2024 indicated Resident #45 was readmitted to the facility on [DATE] the area for blood glucose indicated if not diabetic enter N/A (not applicable), N/A was documented. There was no documentation to indicate Resident #45's orders were reconciled with the Medical Director. Record review of Resident #45's Discharge Medication Summary for Patient (in bold) dated 01/29/2024 indicated do not continue these medications at home (noted in big letters across the page) o Lantus (also known as insulin glargine) 100 units/ml 40 units under skin once daily, (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Brentwood Terrace Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 Stillhouse Road Paris, TX 75460	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Namenda (also known as memantine used to treat confusion related to Alzheimer's) 10 mg twice a day, o Farxiga (also known as dapagliflozin used to treat high blood glucose) 10 mg once daily. The Discharge Medication Summary for Patient continued Medications to take after discharge (in bold letters at the top of the page) o buspirone (also known as buspar dividose medication for anxiety) 30 mg twice a day, o Trileptal (also known as oxcarbazepine used to treat mood disorders) 150 mg twice a day, o Zoloft (also known as sertraline used to treat depression) 100 mg once daily, o Desyrel (also known as trazadone used to treat insomnia) 25 mg at bedtime as needed. The behavioral hospitals discharge papers for Resident #45 continued Discharge/Aftercare Instructions-Nursing (bold print at the top of the page): o amoxicillin-clavulanate (antibiotic) 875 mg-125 mg 1 tablet by mouth every 12 hours o buspirone (anxiety medication) 30 mg by mouth twice daily o donepezil (used to treat confusion related to Alzheimer's disease) 10 mg by mouth every hour of sleep o Farxiga 10 mg by mouth daily o Ferrous sulfate (iron supplement) 325 mg by mouth daily o Glucagon injectable (raises blood sugar when it is low) 1 mg intramuscular (in the muscle) injection every 1 hour for blood glucose less than 70 and not able to drink orange juice o Humalog per sliding scale subcutaneously before meals o Lantus 10 units subcutaneously every hour of sleep o Namenda 10 mg by mouth daily o Multivitamin 1 tablet by mouth daily o Zoloft 100 mg by mouth daily o Desyrel 25 mg by mouth every hour of sleep as needed o Trilepta 300 mg by mouth twice daily o Vitamin B-12 500 mcg by mouth daily (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Tylenol 650 mg by mouth every 8 hours for pain or fever o Mylanta (used to treat upset stomach, heartburn and indigestion) 30 ml by mouth every 6 hours as needed. During an observation and interview on 02/28/2024 at 8:45 PM, Resident #45 was in the hospital in the ICU resting in his hospital bed. Resident #45 was unable to answer questions appropriately. Resident #45's nurse at the hospital said he was awaiting transfer to the medical surgical floor but there were no beds available. Resident #45's nurse said when he arrived to the ER they had to obtain his blood glucose level by a blood specimen due to it not reading on the hospital glucometer. Resident #45's blood glucose level was 929. Resident #45's nurse said when he arrived at the ER he was not alert, he was lethargic and it had taken him 24-48 hours to return to his baseline (normal). Resident #45 was being administered Humalog and Lantus during his hospitalization . Record review of Resident #45's undated hospital medical records indicated he admitted on [DATE] arrived to the ER via EMS from the local nursing home due to altered mental status and elevated glucose. In the emergency room his blood glucose was in excess of 900. Resident #45 had other metabolic abnormalities and was worrisome for UTI. The nursing home staff reported that Resident #45 had been out of his insulin for 1 month because the medication was on backorder. The nursing home staff said there was no replacement for his insulin since that time. Resident #45's problem list included acute metabolic encephalopathy (condition in which brain function is disturbed due to different diseases or toxins in the body), hyperosmolar hyperglycemic state (life threatening complication of diabetes characterized by severe high blood glucose, extreme dehydration and altered consciousness), sepsis (condition as a result of an infection that can lead to organ failure and death if not treated quickly), urinary tract infection, volume depletion (blood plasma is too low and causes rapid heartbeat, weak pulse, confusion and loss of consciousness), lactic acidemia (too much lactic acid buildup in the body), acute kidney injury on chronic kidney disease, hypernatremia (high sodium levels), dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), atrial fibrillation with rapid ventricular response (rapid, irregular heartbeat). During an interview on 02/28/2024 at 11:14 AM, ADON S said when residents came back from a hospitalization , they were readmitted into the computer system. ADON S said the admitting nurse was responsible for reconciling the admitting medication orders with the medical director, and the ADONS looked over them to ensure accuracy. ADON S said she was responsible for monitoring the orders for Halls 1 and 2, ADON WW was responsible for Halls 3 and 4, and the secured unit was split between the 2 of them. ADON S said it was important to accurately reconcile the admitting orders to ensure the medications were correct, allergies were discussed, and to discuss with the doctor new medication orders and dosages and ensure the administration times were appropriate. ADON S said if medications were not accurately reconciled upon admission residents could miss a scheduled medication. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 02/28/2024 at 11:25 AM, the DON said when a resident readmitted to the facility the nurses should call the doctor to reconcile medications with him. The DON said the orders were then reviewed the next day in the morning meetings to double check the residents received the right medications. The DON said the ADONs and herself were responsible for reviewing the orders the day after a resident admitted . The DON said generally ADON S was responsible for checking the orders the day after a resident's admission. The DON said it was important for the medications to be reconciled on admission to ensure the residents received the proper medications and were getting what was necessary and to keep the residents safe. The DON said if medications were not reconciled appropriately this could lead to the residents not receiving the necessary medications. The DON said she was not familiar with Resident #45. During an interview on 02/28/2024 at 11:42 AM, the NP said Resident #45 had been a resident at the facility for quite some time. The NP said she was aware he was diabetic, and she thought he had readmitted to the facility in October 2023, but she could not recall for sure. The NP said she had not spoken to the nurses upon his readmission to the facility. The Medical Director was the one notified of his readmission. The NP said the facility notified her of the issue with Resident #45's insulin this week. The NP said when a resident readmitted to the facility the nurses were supposed to call the Medical Director or herself with the changes and ask if they wanted to reconcile and continue previous orders and what changes should be made. The NP said a lot of times the hospital or the behavioral health units will stop residents' insulin because they do not want to take the risk of hypoglycemia (low blood sugars). The NP said if medications were not reconciled appropriately on admission residents could not get medications that they would need, and this could lead to hyperglycemia (high blood sugars), hypertension (high blood pressure) depending on the disease process. The NP said not receiving necessary medications could lead to exacerbation of the residents' disease processes. During an attempted interview on 02/28/2024 at 11:49 AM, ADON WW did not answer the phone. During an interview on 02/28/2024 at 12:21 PM, the Administrator said he expected for the nurses to follow the discharge orders. The Administrator said he had only been at the facility for about a week, and typically the IDT in the morning meetings reviewed the admissions orders together the day after a resident admitted to ensure the orders were correct and so multiple eyes could verify the orders were correct. The Administrator said in other places the DON and ADON were responsible for reviewing orders after a resident's admission, but he was not sure at the facility what the process was. The Administrator said it was important for the medication orders to be reconciled upon a resident's admission to ensure they were getting the correct medications to treat the diagnoses that the residents had. During an interview on 02/28/2024 at 12:26 PM, Pharmacist XX said when a resident was out of the facility past midnight, the residents' medication orders were discontinued. Pharmacist XX said when the resident returned to the facility there was a renew button in the computer system that the nurses clicked and then they could reconcile the residents' previous orders with the new orders. Pharmacist XX said once the orders were reconciliated they were transmitted, and medications sent out to the facility. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 02/28/2024 at 12:33 PM, LVN W said she was aware Resident #45 was diabetic. LVN W said she had done part of the readmission orders for Resident #45. LVN W said there were no orders for Resident #45's insulin, and she had questioned the orders and notified the Medical Director, but he provided instructions to not restart Resident #45's insulin at that time because his blood sugars were running low, and he was not eating much. LVN W said the Medical Director had not given orders to monitor blood sugars, and she had asked him, but he said no. LVN W said to be honest Resident #45 was not acting like he was having problems with his blood sugars. LVN W said he was active and did not think he required blood sugar checks. LVN W said she had called the behavioral unit to ask them about the insulin orders and the nurse that had given her report said they had been holding Resident #45's insulin because he was not eating. LVN W said she had not seen Resident #45's insulin orders on his discharge paperwork. LVN W said it was important for medications to be reviewed and reconciled upon a resident's admission because if a mistake was made the residents would not get medications they required. LVN W said more than one person should have reviewed Resident #45's orders upon his admission because she was human and could miss things. LVN W said Resident #45 not receiving his insulin could hurt his kidneys and liver. LVN W said she had placed Resident #45's orders in the file box for the ADON to review the orders and to audit them. LVN W said she assumed the ADON was the one responsible for reviewing the medications orders, but there had been a lot of changes and there were other people also reviewing the orders. During an interview on 02/28/2024 at 3:33 PM, the Area Director of Operations said her expectations when a resident admitted to the facility were for the nurses to follow the physician orders, review the hospital records and put in the medications order and review the medication orders with the physician. The Area Director of Operations said she was a consultant for the facility. The Area Director of Operations said she was there as a resource for the facility administration to reach out to her with assistance regarding the policies and procedures. The Area Director of Operations said the administrators were responsible for the facility that is why when one administrator left an interim was put in place. The Area Director of Operations said she did not provide oversight for the facility that was the administrators responsibility because she had 10 other facilities she was over. The Area Director of Operations said she made sure the facilities were in the green and monitored their spending to help them reach their financial goals. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 02/28/2024 at 9:24 PM, the Medical Director said there had been at least 5 administrators and half a dozen DONs and several ADONs in the past year. The Medical Director said there was no constancy, and the staff were unfamiliar with the residents and left often, which resulted in difficulty maintaining staff stability. The Medical Director said then there was the human factor, and if they had 1-2 loose links it destroyed everything. The Medical Director said he was at the facility almost every night spending hours trying to figure out mistakes with medication management issues. The Medical Director said staffing had become a big challenge for the facility that they had major staffing issues. The Medical Director said the staffing shortage was contributing to the falls, worsening wounds, nutrition issues, medication administration issues. The Medical Director said he reconciled the orders with the nurses on admission by phone call because he was not always in the facility when a resident admitted. The Medical Director said with Resident #45 nursing had miscommunicated the information regarding his insulin orders to him. The Medical Director said he was not aware that both of Resident #45's insulins (the short acting and long acting) had been stopped. The Medical Director said stopping both insulins resulted in Resident #45 having high blood sugars, which could lead to severe dehydration and a coma. The Medical Director said he was not able to physically look at the discharge orders from the behavioral health unit. The Medical Director said Resident #45's blood sugars should have been checked three times a day because he was diabetic. The Medical Director said amongst all the changes in administrators and DONs he did not know who was supposed to be keeping the facility together to prevent system failures, but he knew the Area Director of Operations was one of the major decision makers. During an interview on 03/02/2024 at 3:26 PM, the Pharmacy Consultant said she preferred not to answer general questions regarding the risks of administering medications late or the effects of not administering insulin, and she was not currently in her office, so she had no access to resident information. During an attempted interview on 03/02/2024 at 5:02 PM, LVN RRR did not answer the phone. During an interview on 03/02/2024 at 5:32 PM, the DON said the reconciliation for Resident #45 was not done properly. The DON said there was confusion with the discharge orders, and the nurse should have made sure the reconciliation of meds was done properly when Resident #45 readmitted. The DON said she was not employed at the facility when Resident #45 readmitted. The DON said when residents were readmitted /admitted the nurse reconciled the orders with the physician and then the orders would be reviewed in the morning meeting by nurse management. The DON said medications not being reconciled properly could lead to exacerbation of conditions and injury to the residents. Record review of the EvenCare G2 blood glucose monitoring system's user guide indicated on page 50 a HI(high) reading on the glucometer was seen it means your blood glucose if above 600. 2. Record review of a face sheet dated 3/02/2024 indicated Resident #127 was an [AGE] year-old male who admitted on [DATE] with the diagnoses of dementia, and overactive bladder. Record review of the admission papers dated 2/09/2024 provided by the Resident #127's primary physician indicated Resident #127 had an overactive bladder requiring medication management. Resident #127's active medication regimen provided included Vesicare (Solifenacin) 5 milligrams daily with a start date of 1/05/2024 (active medication). (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the February 2024 Medication Administration Record indicated Solifenacin Succinate (Vesicare) oral tablet 5 milligrams daily was ordered on 2/12/2024 and discontinued on 2/27/2024 with no administrations provided to Resident #127. Record review of the Admission MDS dated [DATE] indicated Resident #127 was understood and understands others. The Admission MDS indicated Resident #127 had moderate cognitive impairment. The MDS indicated Resident #127 was occasionally incontinent of urine. Record review of the Order Summary Report dated 3/02/2024 failed to include the medication Vesicare on the facility orders. Record review of the Comprehensive Care Plan dated 2/13/2024 failed to indicate Resident #127 had an overactive bladder requiring medication management or his occasional incontinence. During an observation and interview on 2/26/2024 at 3:56 p.m., Resident #127 was sitting in the dining room/ day room with his peers. Resident #127 was unsure if he was taking any medications for his overactive bladder. 3. Record review of a face sheet dated 03/02/2024 indicated Resident #179 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis of all four limbs, and the trunk of the body), congenital insufficiency of aortic valve (heart defect that prevents blood from flowing backward through the heart), neuromuscular dysfunction of the bladder (condition where a person lacks bladder control due to brain, spinal cord, or nerve problems), major depressive disorder recurrent (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks), and anxiety disorder. Record review of the Comprehensive MDS assessment dated [DATE], indicated Resident #179's speech was unclear, was sometimes able to make himself understood, and understood others. The MDS assessment indicated Resident #179 had a BIMS score of 12 which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #179 was dependent on staff for all ADLs. The MDS assessment indicated Resident #179 had pain almost constantly and it frequently interfered with his ability to sleep. The MDS assessment indicated Resident #179 received antianxiety, antidepressant, and opioids in the last 7 days. Record review of the care plan last revised on 02/23/2024 indicated Resident #179 required antidepressant medication to give medications as ordered. The care plan indicated Resident #179 had a potential for uncontrolled pain to evaluate pain interventions. The care plan indicated Resident #179 was on pain medication therapy to administer medications as ordered. Record review of the Order Summary Report dated 02/26/2024 indicated Resident #179 had the following medication orders: Buspirone (medication for anxiety) 15 mg give 1 tablet via g-tube two times a day with a start date of 02/23/2024. Trazodone 50 mg (medication for depression) give 1 tablet via g-tube two times a day with a start date of 02/14/2024. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Pregabalin (medication for nerve pain) 75 mg give 1 capsule via g-tube three times a day with a start date of 02/25/2024. Hydrocodone (pain medication) 10-325 mg give 1 tablet via g-tube four times a day with a start date of 02/13/2024. Gabapentin (medication for nerve pain) 100 mg give 1 capsule via g-tube three times a day with a start date of 02/13/2024. Record review of Resident #179's medication administration audit report dated 02/01/2024-02/27/2024 indicated the following: On 02/25/2024 the following medications were scheduled to be received at 8:00 PM were administered over 6 hours late, after the 1-hour grace period: Pregabalin 75 mg give 1 capsule via g-tube three times a day administered at 3:58 AM Gabapentin 100 mg give 1 capsule via g-tube three times a day administered at 5:33 AM Trazodone 50 mg give 1 tablet via g-tube two times a day administered at 5:33 AM Hydrocodone 10-325 mg give 1 tablet via g-tube four times a day for pain administered at 5:33 AM On 02/26/2024 the following medications were scheduled to be received at 8:00 PM were administered over 1 hour late, after the 1-hour grace period: Hydrocodone 10-325 mg give 1 tablet via g-tube four times a day for pain administered at 10:28 PM Buspirone 15 mg give 1 tablet via g-tube two times a day administered at 10:28 PM Trazadone 50 mg give 1 tablet via g-tube two times a day administered at 10:29 PM Pregabalin 75 mg give 1 capsule via g-tube three times a day administered at 1:26 AM During an interview on 02/26/2024 at 10:46 AM, Resident #179 said his night medications were due at 8 PM and sometimes he was not receiving them until midnight. Resident #179 said he had asked the nurses about his medications being administered late, and they had said it was because they were short staffed on the night shift. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Record review of Resident #36's face sheet dated 02/27/2024, indicate Resident # 36 was a [AGE] year-old female admitted to the facility on [DATE], with a diagnosis which include Metabolic Encephalopathy (a problem in the brain), morbid severe obesity due to excess calories (BMI greater than 40, a BMI of greater than 35 with at least one serious obesity-related condition, or being more than 100 pounds over your recommended weight), abnormal posture (rigid body movements and chronic abnormal positions of the body), muscle weakness (commonly due to lack of exercise, aging, muscle injury) chronic obstructive pulmonary disease (disease that causes airflow blockage and breathing-related problems). Bipolar disorder, current episode depressed, severe, without psychotic features (depressed, as in severe depressive episode without psychotic symptoms, and has had at least one authenticated hypomanic, manic, or mixed affective episode in the past) hypertension (when the pressure in your blood vessels is too high (140/90mmhg or higher), heart failure (progressive disease that affects pumping action of the heart muscle), type 2 Diabetes Mellitus (a disease of inadequate control of blood levels of glucose) other seizures (convulsion, sensory disturbance, or loss of consciousness). Record review of Resident #36's a care plan with dated 02/26/2024, indicated Resident #36 had the following problems: *Resident #36 had hypertension (high blood pressure) with interventions to give antihypertensive medications as ordered and to monitor for side effects such as orthostatic hypotension (blood pressure drops after sitting or lying down) and increased heart rate. *Resident #36 had diabetes mellitus (high blood sugar) with interventions to give medications as ordered and to monitor for side effects. *Resident #36 required antidepressant medications (Doxepin and Zoloft) with interventions to administer medications as ordered by the physician. Resident #36 had a potential for pain and took routine pain medications (Tylenol with Codeine) with interventions to administer medications as per orders. Record review of Resident # 36's Quarterly MDS assessment dated [DATE], indicated Resident #36 was understood and was able to understand others. The MDS assessment indicated Resident #36 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #36 had received antidepressant, and insulin during the 7-day look back period. Record review of Resident #36's order summary dated 02/27/2024, indicated Resident #36 should have received: *Aspirin 8		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47612 Based on observation, interview and record review the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel, and labeled and dated correctly for 1 of 1 nurse treatment carts reviewed for drugs and biologicals and storage of medications. The facility failed to ensure Nurse treatment cart were secured and unable to be accessed by unauthorized personnel on 2/27/2024. This failure could place residents at risk of misuse of medications, drug diversions, and not receiving the therapeutic benefit of medications. Findings Included: During an observation and interview on 02/27/2024 at 11:45 P.M., LVN Q was observed walking down hall 100 away from the nurse's station leaving the nurse treatment cart unlocked. LVN Q stated the cart should be locked and the nurse should keep the key with them. LVN Q stated she did not know who the last person in the nurse treatment cart was. LVN Q stated it was important to keep the nurse treatment cart locked so residents do not get into it and get stuff out that was unsafe. LVN Q stated residents could take something and have an adverse reaction. During an observation and interview on 02/27/2024 at 12:00 A.M., observed keys laying to the side on top the nurse treatment cart. LVN Q stated the cart should be locked and the nurse should keep the key with them. LVN Q stated she did not know who the last person in the nurse treatment cart was. LVN Q stated it was important to keep the nurse treatment cart locked so residents do not get into it and get stuff out that was unsafe. LVN Q stated residents could take something and have an adverse reaction. During an interview on 03/02/2024 at 3:00 P.M, ADON E stated she expected all the medication carts and the nurse treatment cart to be locked. ADON E stated it was the nursing staff responsibility to ensure the nurse treatment cart was locked. ADON E stated it was important to keep the nurse treatment cart locked because of harmful wound care supplies. ADON E stated the harm was a resident could get into the nurse treatment cart and drink or eat something that could cause major or minor issues. During an interview on 03/02/2024 at 3:33 P.M., the ADM stated he expected the nurses to lock the nurse treatment carts. The ADM stated the reason for the cart not being locked must had been a lapse of judgement or forgetfulness. The ADM state it was important to lock the nurse treatment cart to ensure no one has access that was not supposed to have access. The ADM stated the harm would depend on what someone got out of the nurse treatment cart. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Brentwood Terrace Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 Stillhouse Road Paris, TX 75460	
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/02/2024 at 4:15 P.M, the DON stated she expected the nurse treatment cart to be locked and the keys should be with the nurse. The DON stated it was the nursing staff responsibility to ensure the nurse treatment cart was locked. The DON stated it was important to keep the nurse treatment cart locked so no one could get into it. The DON stated the harm would depend on what they got out of the cart. The DON stated she would monitor by doing rounds and in-service. Record review of the Medication Administration policy, undated, revealed .After the medication administration process was completed, the medication cart must be completely locked, or otherwise secure .		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 47006 Based on observation, interviews, and record reviews, the facility failed provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service for 1 out of 1 kitchen reviewed for sufficient support personnel. 1. The facility failed to ensure the food temperatures for the chicken fried chicken patties, mechanical soft chicken fried chicken, pureed chicken fried chicken, pureed green beans and potatoes, and the mashed potatoes were held at a temperature outside the danger zone (135 degrees Fahrenheit or higher) while on the steam table. The facility did not reheat the food prior to serving. 2. The facility failed to ensure the lunch meal on 02/26/2024, 02/27/2024, and 02/28/2024 were served on time. There were 2 scheduled staff members each day. This failure could place residents at risks who consume food prepared in the kitchen at risk of foodborne illness. The findings included: Record review of the Meal Service Times, undated, revealed lunch meal was started at 12:00 PM for the secured unit, 12:15 PM for the dining room, and 12:20 PM for the hall trays. During an interview on 02/26/2024 beginning at 9:32 AM, Cook M stated the lunch meal was served at 12 PM. During an observation on 02/26/2024 between 12:19 PM and 12:59 AM, first trays were wheeled to the secured unit at 12:19 PM. The first dining room trays were served at 12:21 PM. The last trays on 400 Hall were served at 12:59 PM. During an observation on 02/27/2024 at 1:19 PM, the last meal tray was served at 1:19 PM on 400 Hall. During an observation and interview on 02/28/2024 between 12:05 PM and 12:17 PM, Cook M was checking the temperatures of the lunch meal that was held on the steam table. The temperatures were as follows: 1. The chicken fried chicken patties were held at 125 degrees Fahrenheit. 2. The mechanical soft chicken fried chicken was held at 130 degrees Fahrenheit. 3. The pureed chicken fried chicken was held at 132 degrees Fahrenheit. 4. The pureed green beans and potatoes were held at 128 degrees Fahrenheit. 5. The mashed potatoes were held at 125 degrees Fahrenheit. (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Cook M stated the temperatures should have been between 140- and 160-degrees Fahrenheit. The DM was observing Cook M check the temperatures at the steamtable. The DM stated the temperatures on the steamtable should have been greater or equal to 165 degrees Fahrenheit. The DM stated if the temperatures on the steam table were below 165 degrees Fahrenheit, the facility policy was to reheat the food. During an observation on 02/28/2024 beginning at 12:23 PM, Cook M began serving the lunch meal, while the DM called out the diet consistency needed for the meal plate. Cook M nor the DM reheated the food prior to serving. The last trays were served after 1 PM on the 400 Hall. During an interview on 02/28/2024 beginning at 1:21 PM, Cook M stated the process in the kitchen for checking temperatures was to check the temperature of the food as soon as it was finished cooking, and then just before the food was served on the steam table. Cook M stated she was made aware of what the temperatures should have been by reading it. Cook M stated if she was unsure what the temperature should have been, she was supposed to have asked the DM. Cook M stated she has not asked the DM what the temperatures should have been on the steam table. Cook M stated she knew the things on the steam table were below temperatures and she should have heated them up before she served. Cook M stated she was stressed in the kitchen because she was the only cook and she had been working every other day double shifts. Cook M stated the other cook walked out and her help did not show up. Cook M stated she did not have the time to reheat the food and serve the food on time. Cook M stated the steam table did not work properly to regulate the temperatures. Cook M stated the food has been served late because of the lack of staff and available help in the kitchen. Cook M stated she tried to take her time because she did not want to serve sloppy plates to the residents. Cook M stated it was important to ensure food was served on time and at the proper temperatures to ensure resident did not become sick and enjoyed their food. During an interview on 03/02/2024 beginning at 4:28 PM, the DM stated reason meals had been served late during the week was because the staffing in the kitchen. The DM stated she had one cook that had been hired but until she had finished her orientation training, she was not allowed to start. The DM stated the steam table has had issues for years. The DM stated the steam table has had all kinds of repairs and still does not work sometimes. The DM stated she had no way to regulate the temperatures so she kept it as hot as she could and hoped for the best. The DM stated the week had been stressful because of the lack of staffing. The DM stated Cook M had been stressed because she was new to the cook position and had been working doubles all week because of the staffing problems. The DM stated it was important to ensure food was served on time and kept and served at the appropriate temperatures because the residents nutrition was important, and it affected their health and behaviors. The DM stated it was also important to ensure food was served on time and at appropriate temperatures because they were a highly susceptible age group, and it could have caused illness. During an interview on 03/02/2024 beginning at 5:04 PM, the Interim Administrator stated he expected the dietary staff to ensure food was served at the correct temperatures and cooked all the way through. The Interim Administrator stated hot food should have been hot and cold food should have been cold. The Interim Administrator stated he expected the dietary staff to ensure food was reheated per the facility policy. The Interim Administrator stated he believed the dietary staff had sufficient staffing. The Interim Administrator stated he had been in other buildings with that many staff members and they did it without issues. The Interim Administrator stated he expected the dietary staff to ensure meals were served on time and at appropriate temperatures with the number of staff the facility had. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the Philosophy and Accountability of the Dietary Department policy, undated, revealed Sufficient Dietary Service personnel will be employed, oriented, trained and their working hours scheduled to provide for the nutritional needs of the residents. There must be sufficient personnel to maintain dietetic service areas. Record review of the Handling of Potential Hazardous Foods policy, undated, revealed When serving a tray line or buffet, keep .hot foods at least 140 degrees Fahrenheit . Record review of the Daily Food Temperature Control policy, undated, revealed all hot foods shall be cooked and held for service at temperatures of 140 degrees Fahrenheit or above. Record review of the Food Safety policy, undated, revealed Potential hazardous food shall be maintained at:140 degrees or above .		

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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** 47006 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen reviewed for kitchen sanitation. The facility did not ensure: 1. Meat was thawing in the appropriate container and sink under constant flow of cool, running water during the initial tour on 02/26/2024. 2. The three-compartment-sink was properly used while preparing the pureed food for the lunch meal on 02/28/2024. 3. Unpasteurized eggs were used for sunny-side up and over easy eggs. 4. Food temperatures for the chicken fried chicken patties, mechanical soft chicken fried chicken, pureed chicken fried chicken, pureed green beans and potatoes, and the mashed potatoes were held at a temperature outside the danger zone (135 degrees Fahrenheit or higher) while on the steam table for the lunch meal on 02/28/2024. These failures could place residents at risk for cross contamination and food-borne illness. The findings included: During an initial tour observation in the kitchen on 02/26/2024 between 9:32 AM and 9:43 AM, there were two 10-pound packages of ground hamburger meat floating in approximately 12 inches of cool water in the sanitization sink on the three-compartment sink. During an observation and interview on 02/28/2024 at 9:36 AM, a brown cardboard box with certified eggs and an [NAME] Farms logo printed on the side was opened. Inside the box were approximately 4 crates of hard-shelled, white eggs with no P located on the eggs. There were approximately 2 crates (approximately 24 eggs per crate) missing from the opened box. Cook M stated she believed the eggs were pasteurized but was unable to show the surveyor where it stated that on the box or eggs. The DM stated the hard-shelled eggs were pasteurized and stated she was going to pull the order logs. The DM stated the order logs did not say if the eggs were pasteurized so she was going to call the food [NAME] where she ordered the eggs for confirmation. The DM stated several residents received sunny-side up and over easy eggs for breakfast. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 02/28/2024 between 11:44 AM and 12:05 PM, Cook M pureed the food for the lunch meal, which included the chicken fried chicken patties, green beans and potatoes, and a roll. Between each pureed dish, Cook M placed the blender parts in the wash part of the three-compartment sink. There was no standing water and Cook M held the blender parts while she poured soap directly on the dishes, scrubbed them with a steel wool pad, and rinsed them under the running water. Cook M then held the blender parts over the sanitization side of the three-compartment sink, which was empty and poured the sanitizer directly on the blender parts, then placed them on the tray, while she got some paper towels. Cook M then used the paper towels to dry the blender parts to start on the next pureed dish. Cook M stated she normally used paper towels to dry the dishes because it was faster. Cook M stated she was running behind. During an observation and interview on 02/28/2024 between 12:05 PM and 12:17 PM, Cook M was checking the temperatures of the lunch meal that was held on the steam table. The temperatures were as follows: 1. The chicken fried chicken patties were held at 125 degrees Fahrenheit. 2. The mechanical soft chicken fried chicken was held at 130 degrees Fahrenheit. 3. The pureed chicken fried chicken was held at 132 degrees Fahrenheit. 4. The pureed green beans and potatoes were held at 128 degrees Fahrenheit. 5. The mashed potatoes were held at 125 degrees Fahrenheit. Cook M stated the temperatures should have been between 140- and 160-degrees Fahrenheit. The DM was observing Cook M check the temperatures at the steamtable. The DM stated the temperatures on the steamtable should have been greater or equal to 165 degrees Fahrenheit. The DM stated if the temperatures on the steam table were below 165 degrees Fahrenheit, the facility policy was to reheat the food. During an observation on 02/28/2024 beginning at 12:23 PM, Cook M began serving the lunch meal, while the DM called out the diet consistency needed for the meal plate. Cook M nor the DM reheated the food prior to serving. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 02/28/2024 beginning at 1:21 PM, Cook M stated the process in the kitchen for checking temperatures was to check the temperature of the food as soon as it was finished cooking, and then just before the food was served on the steam table. Cook M stated she was made aware of what the temperatures should have been by reading it. Cook M stated if she was unsure what the temperature should have been, she was supposed to have asked the DM. Cook M stated she has not asked the DM what the temperatures should have been on the steam table. Cook M stated she knew the things on the steam table were below temperatures and she should have heated them up before she served. Cook M stated she did not have the time to reheat the food and serve the food on time. Cook M stated the steam table did not work properly to regulate the temperatures. Cook M stated she should not have thawed the meat in the sanitization sink. Cook M stated she did not normally do that but because the night staff did not take her meat out to the thaw, she needed to thaw it quickly for lunch. Cook M stated it was not the correct way to thaw the hamburger meat. Cook M stated the hamburger meat should have been in a container in the food preparation sink under cool running water. Cook M stated she was aware she did not properly use the three-compartment sink but was in a hurry. Cook M stated she was running behind and should have let the blender parts air dry. Cook M stated it was important to ensure food was served at the proper temperatures to ensure resident did not become sick. Cook M stated it was important to ensure meat was thawed correctly to prevent sickness from food-borne illness. Cook M stated it was important to ensure the three-compartment sink was properly used to ensure the equipment was sanitary and safe to prevent cross-contamination. During an interview on 03/02/2024 beginning at 2:23 PM, the DM stated the hard-shell eggs were not pasteurized, which she verified through the lending food company she was ordering from. The DM stated they were taken out of the building, and she would not be ordering them anymore. The DM stated she had been ordering the eggs from the time they had switched companies. The DM stated it was an honest mistake and she was not aware there were not pasteurized. The DM stated she assumed they were pasteurized. During an interview on 03/02/2024 beginning at 4:28 PM, the DM stated the steam table has had issues for years. The DM stated the steam table has had all kinds of repairs and still does not work sometimes. The DM stated she had no way to regulate the temperatures so she kept it as hot as she could and hoped for the best. The DM stated meat should not have been thawing in the sanitization side of the three-compartment sink. The DM stated she educated Cook M when she found out. The DM stated the meat should have been thawing in the preparation sink under cold running water. The DM stated she expected staff to ensure the three-compartment sink was utilized correctly. The DM stated all the sink sections should have had hot water. The DM stated the first sink was for washing, the second sink was for rinsing, and the third sink was for sanitization. The DM stated after the dishes were sanitized it should have been placed on the tray to air dry. The DM stated it was important to ensure food was kept and served at the appropriate temperatures because the residents nutrition was important, and it affected their health and behaviors. The DM stated it was important to ensure meat was thawed correctly to prevent bacteria from contaminating the meat. The DM stated it was also important to ensure food was served at appropriate temperatures because they were a highly susceptible age group, and it could have caused illness. The DM stated it was important to ensure the three-compartment sink was properly used to ensure dishes were sanitized to prevent contamination and food borne illness. The DM stated when the dietary department switched companies after the change of ownership, she was told the eggs ordered were pasteurized so she assumed they were pasteurized eggs. The DM stated when eggs were not pasteurized, could have held food borne illness causing bacteria that was dangerous for the elderly people who were eating sunny-side up or over easy eggs. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/02/2024 beginning at 5:04 PM, the Interim Administrator stated he expected the dietary staff to ensure food was served at the correct temperatures and cooked all the way through. The Interim Administrator stated hot food should have been hot and cold food should have been cold. The Interim Administrator stated he expected the dietary staff to ensure food was reheated per the facility policy. The Interim Administrator stated he expected meat to have been thawed correctly and to ensure eggs were ordered appropriately. The Interim Administrator stated he expected the dietary staff to ensure meals were served at appropriate temperatures and the three-compartment sink was utilized correctly to prevent food poisoning that could have made the residents sick. Record review of the Handling of Potential Hazardous Foods policy, undated, revealed When serving a tray line or buffet, keep .hot foods at least 140 degrees Fahrenheit .when preparing fried eggs (not pasteurized) . it is required to cook the yolk thoroughly despite possible decreased meal acceptance from residents in order to fully destroy any possible bacteria . Record review of the Daily Food Temperature Control policy, undated, revealed all hot foods shall be cooked and held for service at temperatures of 140 degrees Fahrenheit or above. Record review of the Food Safety policy, undated, revealed Potential hazardous food shall be maintained at:140 degrees or above . Record review of the Thawing Foods policy, undated, revealed foods may be thawed in the following manner .under portable running water of a temperature of 70 degrees or below, with sufficient velocity to agitate and float off loose food particles into the overflow, in a sealed package . Record review of the three-compartment sink manufactures website, titled How to Wash Dishes using a Triple sink, accessed on 03/02/2024, revealed Sink #1: press dispenser button to add the right amount of detergent for your water type and soil load .water temperature should be a tested 110 - 120 degrees Fahrenheit .Sink #3 spray or dip items into hot water until all traces of detergent and food are gone .Sink #3 soak in hot water, minimum temperature of 171 degrees Fahrenheit for 30 seconds .air drying is the only approved way of drying equipment and utensils .		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview, and record review, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to maintain the highest practicable well-being of each resident for 1 of 1 facility reviewed for administration. The facility administration failed to ensure adequate staff were available and aware of job functions to provide for residents needs when the facility's Administrator position experienced 4 changes within 6 months. The facility failed to ensure the DON was aware that she was the abuse coordinator in absence of the Administrator, and she did not report, investigate or prevent further incidents of abuse per the facility's policy. The facility administration failed to ensure adequate nursing staff were available to provide for residents needs which resulted in Resident #44's physical assault by Resident #41, Resident #130's, Resident #4's, and Resident #180's unwitnessed falls. The facility administration failed to ensure pharmaceutical services were provided as needed, which resulted in Resident #45's hospitalization on [DATE], Resident #127's Vesicare not being administered, and medications being administered 1-6 hours late to Resident #71, Resident #179, Resident #44, Resident #45, and Resident #57. The facility administration failed to ensure the secured unit was not staffed with only 1 direct care staff (CNA) at night, which resulted in staff not being able to prevent accidents or request emergent assistance and having to leave the secured unit unsupervised to seek assistance. The facility administration failed to ensure ADON E did not remain on a shift for over 24 hours on 02/23/2024-02/24/2024 due to excessive call ins. An Immediate Jeopardy (IJ) situation was identified on 02/28/2024 at 3:50 PM. The IJ template was provided to the facility on [DATE] at 4:19 PM. While the IJ was removed on 03/01/2024 at 5:10 PM, the facility remained out of compliance due to the facility's need to evaluate the effectiveness of the corrective systems. These deficient practices could place residents at risk for abuse, serious injury, serious harm, serious impairment, and death. Findings included: 1. Record review of a face sheet dated 2/27/2024 indicated Resident #44 was an [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia (memory loss), muscle weakness, reduced mobility, anxiety disorder. (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of a Significant Change MDS dated [DATE] indicated Resident #44 was sometimes understood and usually understands others. The MDS indicated Resident #44 was unable to complete her BIMS exam due to her cognition. The MDS indicated Resident #44 had inattention and disorganized thinking being continuously present. The MDS indicated Resident #44 had no behavioral symptoms but wandered 1-3 days during the assessment period. The MDS indicated Resident #44 required extensive assistance of two staff for transfers, and extensive assistance of one staff member for bed mobility, and locomotion on and off the unit. The MDS indicated Resident #44 had a history of falls with fractures within the last 6 months. Record review of the comprehensive care plan dated 12/13/2023 and updated on 1/07/2024 indicated Resident #44 was at risk to fall related to unsteady gait/balance, generalized weakness, and poor safety awareness. The care plan indicated Resident #44 was at risk to wander related to a history of attempts to leave the facility related to poor safety awareness and resides on the secured unit. Record review of a Weekly Skin assessment dated [DATE] and documented by LVN CCC, indicated Resident #44's skin was normal with no bruising. The note indicated Resident #44's had a surgical incision to the right hip with staples and steri-strips in place with no drainage and no signs of infection. Record review of a Fall Nurses Note dated 6/12/2023 and documented by LVN YY indicated Resident #44 had a fall with a bump on the right side of her head. Record review of a Weekly Skin assessment dated [DATE] documented by LVN DDD, indicated Resident #44's skin was normal with no bruising. Record review of a SBAR note dated 6/18/2024 documented by LVN YY indicated Resident #44 had swelling and pain to the right hip replacement. The note indicated Resident #44 was ordered a mild pain reliever and an x-ray to the right hip. Record review of a right hip x-ray dated 6/19/2023 indicated Resident #44's prosthetic right femoral head was in proper alignment. Resident #44's x-ray revealed there were no fractures or acute dislocation. The x-ray indicated Resident #44's prosthesis was properly situated without any loosening. The x-ray conclusion indicated the right hip arthroplasty was intact. Record review of a progress note dated 6/21/2023 at 6:15 a.m., LVN YY documented Resident #44 had a bruise to the inner thigh on the right leg measuring 17 centimeters x approximately 11 centimeters with pain. LVN YY noted she administered a mild pain reliever to Resident #44. Record review of an Event Nurses' note dated 6/21/2023 at 6:15 a.m., LVN YY documented a bruise was found to Resident #44's right inner thigh measuring 17 centimeters x approximately 11 centimeters. The note indicated Resident #44's bruise was blue/purple and painful. LVN YY documented Resident #44 could not provide a statement related to her cognitive impairment. LVN YY said previous factors included previous falls. Record review of an incident note dated 6/21/2023 documented by LVN YY indicated Resident #44 had a large purple bruise on her inner right thigh (front) measuring 17 centimeters x approximately 11 centimeters. LVNYY said Resident #44 was unable to state what had happened. LVN YY documented there were no predisposing environmental factors, and the predisposing physiological factor was Resident #44 had memory impairment. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Brentwood Terrace Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 Stillhouse Road Paris, TX 75460	
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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of a Weekly Skin assessment dated [DATE] indicated Resident #44 skin color was normal, temperature was normal, with a large purple bruise to the right inner thigh with a firm center with bruising to her knee. During an interview on 2/29/2024 at 11:42 a.m., LVN YY said she was notified of Resident #44's bruise by CNA K. LVN YY said she assessed and measured the bruising and notified the physician, family, DON, and Administrator (previous). LVN YY said she was unsure how Resident #44 sustained the bruise and unsure why no one else had seen the bruise. During an interview on 2/29/2024 at 3:22 p.m., CNA K said she had found the bruising to Resident #44's right leg and reported to LVN YY. CNA K said while she was providing incontinent care for Resident #44, she moved the pillow between Resident #44's legs when she found a large purple bruise. Record review of a Consultation note dated 6/21/2023 indicated the orthopedic physician documented he knew Resident #44. The physician said he had treated her femoral neck fracture a month previous. The physician wrote he had seen Resident #44 a week ago and the x-rays showed a well-fitted well-fixed bipolar hip. The physician wrote he had plans to surgically repair Resident #44's right hip by removing the prosthesis, wire her with cables then reimplant the prosthesis and then put a plate and screws with wires and screws around the periprosthetic fracture. Record review of the Consolidated Physician's orders dated February 2024 indicated Resident #44 was ordered Cephalexin 500 milligrams three times daily for a urinary tract infection. Record review of a Medication Administration Record dated February 2024 indicated Resident #44's Cephalexin was ordered for administration on 2/26/2024 at 8:00 p.m., the medication administration record indicated Resident #44 received her antibiotic therapy Cephalexin at 2:51 a.m. on 2/27/2024. Record review of the of an Event Nurses' note dated 2/25/2024 at 6:30 p.m., indicated LVN D documented she was called to Resident #55's room. LVN D documented Resident #44 was lying on the floor beside the closet door on the floor on her back with Resident #41 standing over her. LVN D documented Resident #55 had an abrasion to her right temple area with bruising to her right inner arm. LVN D documented Resident #44 was unable to state what had happened but Resident #55 said Resident #44 pushed Resident #44 against the closet door. The event note indicated LVN D sent Resident #44 to the local hospital. The note in #17 interventions in place prior to this fall was none of the above. Record review of a progress note dated 2/25/2024 at 7:30 p.m., LVN D wrote she was called to another resident room where she found Resident #44 was found on the floor bedside the closet door on her back with Resident #44 standing over her, and Resident #55 stated Resident #41 pushed Resident #44 against the closet door. Record review of a Fall-Risk assessment dated [DATE] documented by LVN D indicated Resident #44 had intermittent confusion, no falls in the past 3 months, was ambulatory, and was incontinent. LVN D documented Resident #44 had a balance problem while standing, balance problem while walking, decreased muscular coordination, and change in her gait pattern when walking through a doorway. (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of a hospital Emergency Department History of Present Illness indicated Resident #44 was sent to the local emergency roignom on [DATE] with the chief complaint as assault. The note written by the physician indicated Resident #44 assessment revealed a head contusion (bruise) and a hematoma (a collection of blood outside of the vessel). The note indicated in the review of systems Resident #44 had a headache. The physical examination documented indicated Resident #44 was moderately distressed, had ecchymosis (bruising caused by injury), swelling, and tenderness to the right side of her head. Record review of a CT Head without Intravenous Contrast dated 2/25/2024 indicated Resident #44's CT impression indicated she had a right parietal scalp hematoma (A scalp hematoma is a collection of blood (either flowing or clotted from ruptured blood vessels that will then collect in space and tissue between the skull and skin). During an interview on 2/29/2023 at 3:40 p.m., the DON said she was not the DON during the incident on 6/21/2023 with Resident #44 but she indicated she would have investigated and reported the bruising. During an interview on 03/01/2024 at 8:52 AM, Administrator ZZ (previous administrator) said she always did an investigation when something was reported to her but depending on her investigation if she reported. Administrator ZZ said if she had not reported the incident with Resident #44's bruising/hip fracture it had to be for a reason. Administrator ZZ said she did not remember the specifics off the top of her head, and she kept a soft file in the administrator's office with her investigations. Administrator ZZ said a bruise that was not correlated with an incident was considered an injury of unknown injury and should be reported within 2 hours of finding it or being notified. 2. Record review of a face sheet dated 3/2/2024 indicated Resident #41 was an [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia with behavioral disturbances, the need for continuous supervision, and high blood pressure. Record review of a Significant Change MDS dated [DATE] indicated Resident #41 was usually understood and sometimes understands. The MDS indicated Resident #41's cognition was severely impaired. The MDS indicated Resident #41 had no physical, or verbal behaviors exhibited. The MDS indicated Resident #41 wandered daily. Record review of the comprehensive care plan dated 8/08/2023 and revised on 9/08/2023 indicated Resident #41 was at risk for mood problems and received medications. The goal of the care plan indicated Resident #41 would have an improved mood state. The care plan interventions included administer medications and monitor and record mood to determine if problems seem to be related to external causes. Record review of a progress note dated 2/25/2024 at 6:00 p.m., LVN D documented she was called to a resident room by CNA A. LVN D documented Resident #41 was in Resident #55's room where she found Resident #44 on the floor beside the closet door. LVN D documented Resident #41 was standing over Resident #44. LVN D documented she asked Resident #41 and Resident #44 what had occurred, and neither could explain. LVN D documented Resident #55 said Resident #41 pushed Resident #55 against the closet door and she fell . LVN D documented Resident #41 was very uncooperative and had tried to hit CNA A and Resident #55. (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of an Event Nurses' note dated 2/25/2024 at 6:30 p.m., indicated LVN D documented Resident #41 was found in another resident room. LVN D documented Resident #41 had displayed physical, and resident to resident behaviors with another resident injured. The Event Nurses' note indicated LVN D moved Resident #41's room and initiated every 15-minute checks. Record review of a Every 15 Minute Check sheet indicated Resident #41 was placed on every 15-minute checks starting on 2/25/2024 at 6:30 p.m. The Every 15- minute checks at 0015 indicated LVN D documented at 12:15 a.m., Resident #44 was asleep. LVN D had only her initials beside the other every 15-minute checks starting at 12:30 a.m. - 5:45 a.m. on 12/26/2024 there was no remarks indicating anything in regarding Resident #41. During an interview on 2/26/2024 at 9:32 p.m., CNA A said she was alone on the secured unit gathering her supplies in the spa/communal shower room when she heard a loud scream. CNA A said she ran out of the spa room and ran toward the end of the hall where she believed the sound was heard from. CNA A said upon entering the room, Resident #44 was lying in the floor, Resident #55 said Resident #41 had thrown Resident #44 into the door. CNA A said Resident #41 was aggressive with her at the time and tried to swing at her. CNA A said she left Resident #55's room and ran the length of the secured unit, opened the door, and yelled for help. CNA A said she was alone on the secured unit and had no other recourse than to go for help. CNA A said LVN D was passing medications and another nurse responded to her call for help. During an interview on 2/26/2024 at 11:46 a.m., the DON said on 2/25/2024 CNA A heard a noise and responded to the noise. The DON said LVN D called and said Resident #41 was upset and wandering in other rooms. The DON said CNA A had said Resident #44 was on the floor. The DON said she was unsure of Resident #44 hitting her head although she had an abrasion to her head. The DON said Resident #44 was sent to the emergency room closer to midnight due to complaining her head was hurting. During an interview on 2/26/2024 at 11:51 a.m., LVN D said she was called to the unit on 2/25/2024 at 6:30 p. m. by CNA A. LVN D said Resident #44 was lying in the floor of Resident #55's room, with Resident #41 standing over Resident #44 around 6:30 p.m. on 2/25/2024. LVN D said Resident #55 said Resident #41 pushed Resident #44 against the closet and Resident #41 fell . LVN D said at the time of the incident Resident #44 had an abrasion to her right temple area and a bruise to her inner right arm. LVN D said Resident #41 was very uncooperative and attempted to hit others. LVN D said she was advised to place Resident #41 on every 15-minute checks by the DON. LVN D said although her documentation was not completed yet Resident #41 remained asleep. LVN D said CNA A had to leave Resident #44 to come for help. LVN D said she was not on the secured unit but was on hall 400 when the incident occurred. During an interview on 2/26/2024 at 12:22 p.m., CNA H said CNA A had always worked the secured unit alone. CNA H said when CNA A was in the room with other residents who would be watching the other residents, or who would go for help. CNA H said there was no one was on the unit to get help when CNA A needed help. During an interview on 2/26/2024 at 10:54 a.m., LVN F said Resident #44 was discharged to the hospital and Resident #41 was on every 15-minute checks for aggressive behaviors. LVN F said after she reviewed Resident #44's electronic medical record and said there was not a progress note, a SBAR (situation, background, assessment, recommendation) note, a transfer note, or an incident report. LVN F said the electronic medical record should have had those assessments completed. (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation and interview on 2/26/2024 at 12:42 p.m., Resident #55 was sitting at the dining table and was unable to recall the incident in his room last night with Resident #'s 41 and 44. 3. Record review of a face sheet dated 2/27/2024 indicated Resident #4 admitted on [DATE] and readmitted [DATE] with the diagnosis of diabetes, muscle weakness, lack of coordination, reduced mobility, repeated falls, dementia, and assistance with personal care. Record review of the comprehensive care plan dated 1/22/2024 and revised on 2/05/2024 indicated Resident #4 had an ADL self-care performance deficit. The goal of the care plan indicated Resident #4 would remain at her current level of function in transfers, and toileting. The care plan interventions included Resident #4 required one staff assistance with toileting. The comprehensive care plan indicated Resident #4 was at risk for falls related to weakness and impaired cognition. The goal of the care plan was Resident #4 would not sustain a serious injury. The care plan interventions included ensure Resident #4's call light was within reach, ensure don't fall call sign at the foot of the bed visible by Resident #4, and frequent visual checks while in bed. Record review of an Admission MDS dated [DATE] indicated Resident #4 was usually understood and understands others. The MDS indicated Resident #4's cognition was moderately impaired. The MDS in section GG indicated Resident #4 required partial to moderate assistance with toileting, bed to chair transfers, toileting transfers and to sit and stand. Record review of a Fall-Risk assessment dated [DATE] at midnight LVN D indicated Resident #4 had 1-2 falls in the past, required assistance with elimination, and took 3-4 medications which could increase the risk of falls. The fall risk assessment indicated Resident #4 was at high risk to fall. Record review of a fall incident report dated 2/24/2024 at midnight, LVN D indicated Resident #4 ambulated without assistance and was not wearing any shoes or socks. Record review of a progress note dated 2/24/2023 at midnight, LVN D documented Resident #4 was sitting in the hallway on her bottom with her legs straight in front of her. LVN D said Resident #4 said she had slipped down. LVN D documented Resident #4 was not wearing shoes or socks. LVN D documented Resident #4 complained of right foot pain. Record review of a fall incident report dated 2/26/2024 at 10:30 p.m., LVN C indicated no injuries were observed. The incident report was left blank. Record review of a Fall-Risk assessment dated [DATE] at 10:30 p.m., LVN C documented Resident #4 was at high risk to fall. LVN C documented Resident #4 was disoriented, had 3 or more falls in the past 3 months, required assistance with elimination, had problems with balance, and took 3-4 medications which could cause falls. Record review of a Fall Nurses Note dated 2/26/2024 at 10:46 a.m., LVN F documented Resident #4 had a fall without injury. LVN F documented fall interventions were the bed low, interval monitoring, neurological checks, frequent visual checks, encourage and educate use of the call light. Record review of a progress note dated 2/26/2024 at 11:30 p.m., LVN C indicated Resident #4 said she had fallen on the floor, and she had been pulling up her pants. (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 2/27/2024 at 8:48 a.m., LVN C said CNA K was in another resident's room providing care when she heard Resident #4 calling for help. LVN C said CNA K was alone, so she had to hurriedly finish in the room to be able to assist Resident #4. LVN C said Resident #4 was lying on the bathroom floor when CNA K was able to get to her. LVN C said the secured unit was understaffed to provide adequate supervision for Resident #4 and other residents. During an observation and interview on 2/27/2024 at 11:48 a.m., CNA H responded to the surveyor assisting Resident #4 with activating her call light for assistance to the bathroom. CNA H responded and assisted Resident #4 from her bed to the wheelchair, then from the wheelchair to the toilet. CNA H left Resident #4 alone on the toilet and went to get Resident #4's lunch tray. Upon returning to the room, Resident #4 was exiting the bathroom already in her wheelchair. CNA H said Resident #4 had a history of falls and was a fall risk. Record review of an incident report dated 2/27/2023 at 11:45 p.m., LVN C documented Resident #4 had a fall with no injuries noted. The incident report had no further documentation within. Record review of an Event Nurses' Note-Fall dated 2/27/2024 at 11:45 p.m., LVN C documented Resident #4 had an unwitnessed fall. LVN C documented Resident #4 was found on the floor, indicated Resident #4 said legs gave out, and Resident #4 attempted to self-toilet. LVN C documented in Nursing Description: Resident #4 indicated she got up to use the bathroom, failed to call for help, denied bumping her head, and was found sitting on the floor. 4. Record review of a face sheet dated 2/29/2024 indicated Resident #130 was a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia with behavioral disturbances, lack of coordination, and a need for assistance with personal care. Resident #130 resided on the secured unit. Record review of the Comprehensive Care Plan dated 9/07/2023 and revised on 12/09/2023 indicated Resident #130 was a high risk for falls related to wandering. The goal of the care plan was Resident #130 would be free of falls. The care plan interventions included to anticipate and met Resident #130's needs, ensure his call light was within reach, encourage the use of the call light, and have prompt response to the request for assistance, and ensure Resident #130 wore appropriate footwear. The comprehensive care plan failed to have interventions after the falls on 11/26/2023 and 11/27/2023. Record review of an incident report dated 11/26/2023 at 10:00 p.m., LVN C indicated Resident #130 was found by the CNA on the floor, with no signs of pain. The note indicated Resident #130 was limping on the left leg and was sent to the local emergency room at 10:35 p.m. via the ambulance. Record review of a fall risk assessment completed by LVN C on 11/26/2023 indicated Resident #130 was always disoriented. The assessment indicated Resident #130 had no previous falls, was ambulatory, continent, had balance problems, decreased muscular coordination, and gait pattern changes. Record review of a Medication Administration Record dated 11/01/2023 - 11/30/2023 indicated on 11/25/2023 Resident #130 was administered Ativan 0.5 milligrams for anxiety or agitation. The record also indicated Resident #130 received the Ativan 0.5 milligrams twice daily on 11/26/2023 and on the morning of 11/27/2023. (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of an Event Nurses-Note dated 11/26/2023 at 10:00 p.m., indicated Resident #130 had an unwitnessed fall in his room. LVN C documented Resident #130 was assisted up and was noted to be limping on the left leg. LVN C documented the physician was notified and Resident #130 was sent to the local hospital. The note indicated the interventions included interval monitoring (specify below) there was no documentation below. The note indicated in additional interventions there were interventions of a low bed and interval monitoring (again not specified). The note indicated Resident #130 was independent with bed mobility, toileting, and transferring. The note indicated Resident #130 had an unsteady gait, balance problem, and lack of mobility strength. The note indicated Resident #130 was wearing shoes or anti-slip socks. The note indicated Resident #130 had Ativan 0.5 milligrams twice daily started on 11/25/2024. Record review of an incident report dated 11/27/2023 at 5:30 p.m., indicated Resident #130 was found with his head lying against the closet door by LVN HHH. The note indicated Resident #130 had a bruise to his right shoulder and a skin tear to his left hand. The note indicated the conclusion was Resident #130 had an unwitnessed fall with injuries. The note indicated his bed was changed to a low bed. Record review of an Event Nurses-Note dated 11/27/2023 at 6:39 p.m., indicated Resident #130 was found by LVN HHH when she was passing dining trays. The note indicated Resident #130 was lying with his head against the closet door. The note indicated Resident #130 had a skin tear. The note indicated Resident #130 had a purple bruise to his right shoulder. The note indicated Resident #130 was in pain noted by his occasional moans or groans, and facial grimacing. The note indicated Resident #130's physical factors included previous fall, urinary tract infection, pain, and incontinence. The note indicated Resident #130 required 1 staff with bed mobility, toileting, transferring, and walking. The note indicated Resident #130 leaned forward. Record review of an e-Transfer Form dated 11/27/2023 at 6:00 p.m., indicated Resident #130 was transferred to the local hospital due to a fall by LVN HHH. Record review of a Fall-Risk assessment dated [DATE] at 6:47 p.m. indicated Resident #130 was disoriented, has fallen 3 or more falls in the past 3 months, ambulatory, and incontinent. The assessment indicated Resident #130 had balance problems while standing and walking. Record review of the History of Present Illness from the local hospital on 11/27/2023 indicated Resident #130 fell and was sent to the local emergency room . The note indicated Resident #130 had a right hip fracture. The note indicated Resident #130 was seen 24 hours prior to this visit related to multiple falls at the facility. Record review from the hospital orthopedist report dated 11/27/2023 indicated Resident #130 had fallen over the last couple of weeks at least 8-9 times. The orthopedist documented Resident #130 was in the emergency room the day before post a fall with negative x-rays at the time. The note indicated the CT results indicated a minimally impacted right femoral neck fracture. The note indicated the physician spoke to the family and the family wanted a non-operative treatment and return to the facility with palliative care. (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of hospital records dated 11/27/2023 indicated Resident #130 was admitted at 6:59 p.m. with the diagnosis of closed fracture of the right hip. The discharge records indicated Resident #130 was returned to the facility on hospice services. Resident #130's discharge orders included bedrest, non-weight bearing to the right leg, and pain management. Record review of the cat scan of the chest, abdomen, and pelvis dated 11/27/2023 indicated right femoral neck fracture. Record review of a progress note dated 11/29/2023 at 4:25 p.m., indicated the social worker documented Resident #130 returned from the hospital, admitted on a hospice service, and was made a do not resuscitate status. Record review of a physician's progress note dated 11/29/2023 indicated Resident #130 had a fall with a fracture to the right hip and he was being treated conservatively. Record review of an Incident Report dated 12/01/2023 at 3:30 p.m., completed by LVN YY indicated Resident #130 was observed sitting on the floor beside his bed with his back leaning on the mattress. The note indicated Resident #130's bed was in low position. The note indicated the predisposing physiological factors were confusion, incontinent, recent medication changes, and impaired memory. Record review of a progress note dated 12/02/2023 at 8:00 p.m., LVN D documented Resident #130 had a fall slipped off the bed. LVN D documented there were no injuries. LVN D documented she administered Tramadol 50 milligrams due to Resident #130 appeared in pain, and then he was assisted up to the recliner because he refused to rest in his bed. During an interview on 2/26/2024 at 11:51 p.m., LVN D said she worked the 6:00 p.m. - 6:00 a.m. shift as the nurse for the secured unit and Hall 400. LVN D said her job duties on this shift was to pass the assigned residents their medications, provide nursing care, and assist with nurse aide care as needed. LVN D said on this night she had Resident #44 was assaulted by Resident #41 in the room of Resident #55. LVN D said she had to stop the tasks she was completing to assess the situation, send Resident #44 to the local emergency room , place Resident #41 on 1:1 oversight, and then complete all the tasks this associated with this incident. LVN D said CNA A was alone in the unit when Resident #41 assaulted Resident #44 according to Resident #55's statement. LVN D said CNA A tried to separate Resident #41 and Resident #55 but Resident #41 was too aggressive. During an observation and interview on 2/26/2024 at 6:15 p.m., LVN D was at the nursing desk when she said she had a bit more to complete on the tasks from her shift before leaving. LVN D said she had been at the facility now 24 hours. (continued on next page)		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 2/27/2024 at 8:48 a.m., LVN C said she was not able to physically able to visualize Resident #41 but relied on the CNA to do 1:1 with Resident #41. LVN C said due to having only 2-3 CNAs on the 6:00 p.m. to 6:00 a.m. shift she was unable to complete her resident care tasks including administration of medications timely according to the orders. LVN C said she had many times informed the nursing management she would have to invoke Safe Harbor to ensure resident safety. LVN C said only when she would tell management she would invoke Safe Harbor would she get extra help to pass medications at least to the assigned Hall 400. LVN C said she had also notified the Medical Director of the nursing duties she was unable to complete timely. LVN C said in the secured unit the CNA was most often working alone and she would assist as she could. LVN C said CNA K was in a room with another resident when Resident #44 fell . During an interview on 2/27/2024 at 10:55 a.m., LVN C said she had not completed all the tasks from her shift regarding resident care but was told by nursing management she had to leave because she was scheduled for her next shift at 6:00 p.m. Record review of the Schedule Sheet dated 2/25/2024 indicated the census was 81 and the facility had scheduled: 6:00 a.m. - 6:00 p.m.: 2 student nurse aides, and 3 CNAs with one a no call no show status; 2 RNs and 1 LVN 6:00 p.m. - 6:00 a.m.: 2 CNAs and 1 student nurse aide who called off; and 1 RN and 1 LVN 6:00 a.m. - 2:00 p.m. 1 MA was scheduled 2:00 p.m. - 10:00 p.m. 1 CNA who called off. 10:00 p.m. - 6:00 a.m. 1 CNA Record review of the Employee Punch Report dated 2/25/2024 - 2/26/2024 indicated: LVN YY, RN U, LVN EEE, and LVN RRR worked 6:00 a.m. - 6:00 p.m. shift on 2/25/2024. LVN D and RN DD worked 6:00 p.m. -6:00 a.m. shift, on 2/25/2024. ADON E worked 7:47 p.m. - 11:11 p.m. on 2/25/2024. ADON WW worked 7:19 p.m. - 11:17 p.m. on 2/25/2024. CNA Y, CNA GGG, SNAs RR and PPP worked 6:00 a.m. - 6:00 p.m. shift on 2/25/2024. CNA SSS worked 6:00 p.m. - 6:00 a.m. shift on 2/25/2024. CNA H worked 5:00 a.m. - 5:00 p.m. shift on 2/25/2024. CNA K worked 10:00 p.m. - 6:00 p.m. shift on 2/25/2024. CNA A worked 6:00 p.m. - 9:00 p.m. shift on 2/25/2024. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Brentwood Terrace Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 Stillhouse Road Paris, TX 75460	
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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of a Daily Census form dated 2/26/2024 indicated on Hall 400 resided 24 residents and on the secured unit there were 15 residents. During an interview on 02/27/2024 at 8:28 AM, ADON WW stated she was at the facility working on 02/25/2024. ADON WW said she went to work at 5:23 AM and stayed until 1 PM then returned to the facility and worked from 7 PM to 11 PM. ADON WW sta		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable disease and infections for 1 of 3 residents (Resident #53) reviewed for infection control practices. The facility failed to ensure CNA G performed hand hygiene and glove changes while providing incontinent care to Resident #53. These failures could place residents at risk for urinary tract infections, cross contamination, and the spread of infections. Findings included: Record review of a face sheet dated 3/06/2024 indicated Resident #53 was an [AGE] year-old female who admitted on [DATE] with the diagnoses of dementia, need for assistance with personal care, and kidney disease. Record review of the Quarterly MDS dated [DATE] indicated Resident #53 was usually understood and usually understood others. The MDS indicated Resident #53's BIMS score was 2 indicating she had severe cognitive impairment. The MDS in section GG indicated Resident #53 required substantial/maximal assistance with toileting hygiene, and partial/moderate assistance for personal hygiene. The MDS indicated Resident #53 was always incontinent of bowel and bladder. Record review of the Comprehensive Care Plan dated 1/05/2023 indicated Resident #53 had a pressure ulcer to her sacrum and indicated the intervention of incontinent care after each episode and apply a moisture barrier. The comprehensive care plan provided failed to mention an ADL care deficit. Record review of a CNA Proficiency Audit dated 2/20/2024 indicated NA G was checked off in the skills area of perineal care by ADON E: female and passed satisfactory skill level. Record review of a Wound Evaluation and Management Summary dated 2/26/2024 indicated Resident #53 had a Stage 3 pressure wound (full thickness skin loss, involves damage or death of subcutaneous tissue that may extend down to, but not through, underlying tissues and muscles, and presents clinically as a deep crater, with or without undermining of adjacent tissues) to her sacrum (large triangular bone at the base of the spine). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 2/28/2024 at 11:37 a.m., ADON S and CNA G was prepared to administer wound care to Resident #53's sacral pressure injury when Resident #53 was rolled on to her left side and was found to have had a bowel movement. CNA G removed her gloves, exited the room, entered the spa room, obtained incontinent care items (wipes, gloves, and a brief) and returned to Resident #53's room. CNA G returned to the room, applied another pair of gloves, then taking some wipes she cleansed Resident #53's anal area with wiping twice, then CNA G raised to the dressing covering Resident #53's wound and used the wipes and cleansed again front to back, folded the wipe and cleansed from front to back again. CNA G then rolled the brief up towards Resident #53 as she was pulling the brief out from underneath Resident #53. With the same gloves on CNA G then pulled the clean brief from the plastic bag and held the brief until ADON S was ready to place brief on Resident #53. After ADON S placed brief underneath Resident #53, CNA G assisted Resident #53 to roll to apply the brief. Using the same gloves CNA G repositioned Resident #53, applied her sheet and blanket, and even held Resident #53's hand for a few moments. CNA G then removed her soiled gloves and placed them in the plastic bag. CNA G then walked over to Resident #53's roommate to answer a question and placed her hand on her shoulder without performing hand hygiene. CNA G exited Resident #53's room without hand hygiene. CNA G stated thought she did pretty good when asked how she believed she performed incontinent care. CNA G said she was not aware even though her gloves were not visibly soiled she had to change gloves and perform hand hygiene between clean and dirty. CNA G said she failed to perform incontinent care on Resident #53's peri area. During an interview on 2/28/2024 at 11:55 a.m., ADON S said CNA G should have not brought in a whole package of wipes into Resident #53's room to perform incontinent care. ADON S said CNA G failed to cleanse Resident #53's peri area, failed to change gloves, and complete hand hygiene. ADON S said the provision of incontinent care incorrectly could lead to urinary tract infections, skin conditions, and affects infection control practices. ADON S said the CNAs have been checked off and she expected the CNAs to provide incontinent care correctly. During an interview on 3/02/2024 at 2:15 p.m., LVN F said she expected the CNAs to perform hand hygiene and glove changes between each resident's care, between clean and dirty exposures, and between resident rooms. LVN F said good hand hygiene practices prevent infections. LVN F said nursing was responsible for ensuring staff were performing hand hygiene correctly. During an interview on 3/02/2024 at 3:02 p.m., the DON said she expected incontinent care to be performed correctly. The DON said the ADONs perform skills check offs with the CNAs to ensure incontinent care and hand hygiene were performed correctly. The DON said incontinent care was monitored by rounds, and thru proficiency check offs. The DON said proper hand hygiene and incontinent care should be provided to prevent infections. During an interview on 3/02/2024 at 4:00 p.m., the Administrator said he expected staff to follow the facility's infection control policy. The Administrator said he expected glove changes to occur between dirty and clean to prevent urinary tract infections. The Administrator said the nursing management was responsible for monitoring the competency check offs for hand hygiene and incontinent care. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/02/2024 at 4:39 p.m., the Regional Compliance Nurse said CNA G was nervous performing incontinent care and hand hygiene because she was able to perform skills check offs within the hour and pass the skills. The Regional Compliance Nurse said when hand hygiene and incontinent care was not provided accurately there was a risk for infection. The Regional Compliance Nurse said the nursing management was responsible for ensure these skills monitored. Record review of a CNA Proficiency Audit dated 2/20/2024 indicated NA G was checked off in the skills area of perineal care by ADON E: female and passed satisfactory skill level. Record review of an Infection Control Plan: Overview policy dated 3/2023 indicated: Infection Control: the facility will establish and maintain and Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection .Implement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on interview and record review, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy and providing written rationale, by the provider, when an antibiotic was used despite criteria, to determine the appropriate the use of an antibiotic for 1 of 2 residents and reviewed antibiotic use. (Resident #5) 1. The facility did not ensure Resident #5 was assessed using the established and accepted criteria to determine if her UTI met the criteria for antibiotic use. 2. The facility did not ensure an SBAR was performed to indicate a change of condition when Resident #5 was exhibiting signs and symptoms of a UTI. These failures could place residents receiving antibiotics at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased antibiotic-resistant infections. The findings included: Record review of the order summary report, dated 02/28/2024, revealed Resident #5 was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease. Record review of the quarterly MDS assessment, dated 01/11/2024, revealed Resident #5 had clear speech and was usually understood by others. The MDS revealed Resident #5 was usually able to understand others. The MDS revealed Resident #5 had a BIMS score of 8, which indicated moderately impaired cognition. The MDS revealed Resident #5 had no behaviors or refusal of care. The MDS revealed Resident #5 was always incontinent of bowel and bladder. The MDS revealed Resident #5 had a diagnosis of UTI during the last 30 days. The MDS revealed Resident #5 received antibiotics during the 7-day look-back period. Record review of Resident #5's comprehensive care plan, dated 03/02/2024, did not address her history of UTIs. Record review of the urinalysis with culture and sensitivity, received 02/08/2024, revealed Resident #5 had a high range of Escherichia coli (bacteria) in her urine. Record review of the assessments tab in the electronic charting system, accessed 03/02/2024 at 2:21 PM, revealed Resident #5 had a urinary tract infection note for 02/09/2024, 02/10/2024, 02/12/2024, and 02/13/2024. There were no notes for 02/08/2024, 02/11/2024, 02/14/2024, or 02/15/2024. Record review of the assessments tab in the electronic charting system, accessed 03/02/2024 at 2:26 PM, revealed Resident #5 had no SBAR assessment completed during the month of February 2024. Record review of the orders tab in the electronic charting system, accessed 03/02/2024 at 2:26 PM, revealed Resident #5 had an order, which started on 02/02/2024 and was completed on 02/15/2024, for nitrofurantoin 100 mg (antibiotic) twice daily for a UTI. (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the MAR, dated February 2024, revealed Resident #5 received antibiotics for a UTI on and between 02/08/2024 to 02/15/2024. Record review of the antibiotic log between September 2024 and February 2024, revealed Resident #5 had no antibiotic use logged in February 2024. During an interview on 03/02/2024 beginning at 1:54 PM, LVN W stated when a resident exhibited signs or symptoms of a UTI, she would have contacted the doctor for an order for a urinalysis with a culture and sensitivity as appropriate. LVN W stated some assessments and progress notes were completed if the results of the labs indicated the resident had a UTI. LVN W stated an SBAR, and urinary tract infection note would have been completed under the assessments tab. LVN W stated there was no assessment that she filled out to indicate whether residents met the criteria for antibiotic use. LVN W was unsure why Resident #5 did not have an SBAR completed when the doctor was contacted. LVN W stated the doctor would have been notified and new orders would have been implemented per the doctor's orders. LVN W stated the doctors would usually start the antibiotics prophylactically while waiting for the culture and sensitivity results, and then change the antibiotics if it was required. LVN W stated when the culture and sensitivity results were received, they would have been collaborated with the doctor, who would have decided to either continue the current antibiotic or to change the antibiotic mediation. During an interview on 03/02/2024 beginning at 2:03 PM, ADON E stated she recently received her Infection Control Preventionist certification. ADON E stated the protocol for residents who exhibited signs and symptoms of a UTI was to contact the doctor and obtain an order for a urinalysis with culture and sensitivity as indicated. ADON E stated the doctors would usually start the antibiotics prophylactically while waiting for the culture and sensitivity results, and then change the antibiotics if it was required. ADON E stated when the results for the labs were received the facility should have collaborated with the doctor to determine if continued antibiotic use was indicated or if the antibiotic needed to have been changed. ADON E stated an SBAR, change of condition report, and urinary infection assessment should have been completed. ADON E stated the urinary infection assessment should have been completed daily if the resident was on an antibiotic. ADON E stated the nurses on the floor were responsible for completing the assessments. ADON E stated antibiotics were monitored in the morning stand up meeting. ADON E stated the nursing management made sure all forms were filled out correctly in the electronic charting system and if any forms were missing the nurses would have been called to complete the documentation. ADON E stated the antibiotics were logged into a report and it was determined if the antibiotic met criteria. ADON E was unsure why Resident #5 did not have the required forms completed or why her antibiotic use was not logged into the antibiotic log. ADON E was unsure if Resident #5 met criteria for antibiotic use. ADON E stated it was important to ensure antibiotic stewardship policies were followed to protect the residents from unnecessary antibiotic use or super infections from inappropriate antibiotic use. During an interview on 03/02/2024 beginning at 3:33 PM, the Pharmacy Consultant stated her role in antibiotic stewardship for the facility was to run an antibiotic report from the facility and make dosing recommendations as needed. The Pharmacy Consultant stated she could not speak on Resident #5 unless she had the chart in front of her and she was unable to pull it up. The Pharmacy Consultant stated she was unable to answer any further questions. (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/02/2024, beginning at 4:51 PM, the DON stated her role in the antibiotic stewardship program was to ensure antibiotic orders were entered into the electronic charting system and to ensure the antibiotics met McGeer's criteria and were logged on the antibiotic logs. The DON stated the assessment to determine if antibiotics met McGeer's criteria were located in the electronic charting system under assessments and should have been completed. The DON stated and SBAR should have been completed as an infection was considered a change in condition. The DON stated the ADONs and herself were responsible for monitoring to ensure the appropriate forms were completed for antibiotic stewardship. The DON stated it was important to ensure antibiotic stewardship policies were implemented to help identify proper antibiotic use and to ensure antibiotics were not received unnecessarily. During an interview on 03/02/2024 beginning at 5:04 PM, the Interim Administrator stated his role in antibiotic stewardship was to ensure it was reviewed. The Interim Administrator stated he expected the antibiotic stewardship policies to be implemented to ensure residents were receiving what they needed. Record review of the Antimicrobial Stewardship policy, undated, revealed When facility staff suspects a resident has an infection, the nurse should perform and document a complete assessment of the resident using established and accepted assessment protocols to determine if the resident's status meets minimum criteria for initiated antibiotics .this facility uses the Loeb Minimum Criteria .when a nurse contacts a physician/prescriber to communicate a resident's change in condition and a suspected infection, the nurse should have the medical record available and should perform an SBAR assessment .the facility will track antibiotic usage for the facility using the infection/antibiotic log .		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 46928 Based on interview and record review, the facility failed to develop, implement, and maintain annually an effective training program for existing staff, consistent with their expected roles for 4 of 21 employees (LVN QQQ, LVN C, SW, and Housekeeping Supervisor) reviewed for required annual trainings. The facility failed to ensure LVN QQQ, LVN C, the SW, and the Housekeeping Supervisor received their restraint training annually. This failure could place residents at risk for the inappropriate use of restraints. Findings included: Record review of the employee files indicated the following staff had not completed their annual restraint training: *LVN QQQ (hire date 02/01/2023), *LVN C (hire date 02/01/2023), *the SW (hire date 02/01/2023), *the Housekeeping Supervisor (hire date 02/01/2023). During an interview on 03/02/2024 at 10:23 AM the Corporate HR Specialist said LVN QQQ, LVN C, the SW and the Housekeeping Supervisor had not completed the required annual restraint training. The Corporate HR Specialist said the last restraint training that LVN QQQ and LVN C was completed on 01/25/2023. The SW and the Housekeeping last restraint trainings were completed on 01/23/2023. The Corporate HR Specialist said LVN QQQ, LVN C, the SW, and the Housekeeping Supervisors should have completed their annual restraint training in February 2024 based on their hire date. The Corporate HR Specialist said it was the responsibility of the HR Coordinator to ensure the required annual trainings were completed. The HR Specialist said staff who do not complete the required annual restraint trainings, would not be knowledgeable of restraints. During an interview on 03/02/2024 at 10:47 AM, the HR Coordinator said she was unsure how the annual required trainings for LVN QQQ, LVN C, the SW and the Housekeeping Supervisor were missed. The HR Coordinator said there was a time constraint for the staff to complete the required trainings online. The HR Coordinator said she checked the trainings daily and ensured the staff who had not completed the trainings were discussed among management. The HR Coordinator said staff who did not complete the required trainings were in serviced and disciplinary action was initiated. (continued on next page)		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/02/2024 at 02:04 PM, the DON said she expected restraint training to be completed upon hire and annually. The DON said the HR Coordinator was responsible for ensuring the trainings were completed timely. The DON said staff who did not complete the restraint trainings as required would not have the knowledge about restraints. During an interview on 03/02/2024 at 02:22 PM, the Interim Administrator said he expected restraint training to be completed upon hire and annually. The Interim Administrator said by staff not completing the required training annually they would be unaware of what constituted a restraint. The Interim Administrator said the HR Coordinator was responsible for ensuring the required trainings were completed. The Interim Administrator said the trainings automatically triggered for completion on the online continuing education program. Record review of the facility's policy titled New Employee Orientation dated 2015, did not address the required annual required trainings for staff.		