STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676045	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Terrace Healthcare and Rehabilitation	2885 Stillhouse Road Paris, TX 75460

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interviews and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promotes maintenance or enhancement of his or her quality of life for 4 of 5 residents (Resident #5, Resident #7, Resident #10, and Resident #58) reviewed for resident rights. The facility failed to ensure CNA A treated Resident #5, Resident #7, Resident #10, and Resident #58 respectfully when she failed to speak to them while providing care. This failure could place residents at risk of embarrassment, feelings of worthlessness, decreased self-worth, loss of dignity, and a diminished quality of life. Findings included: 1. Record review of Resident #5's face sheet dated 01/08/2025 indicated Resident #5 was an [AGE] year-old female initially admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #5 was able to make herself understood and understood others. The MDS assessment indicated Resident #5 had a BIMS score of 13, which indicated her cognition was intact. The MDS assessment indicated Resident #5 required supervision or touching assistance with personal and toileting hygiene and lower body dressing, and partial to moderate assistance with showering/bathing self and putting on taking off footwear. Record review of Resident #5's care plan last reviewed 01/05/2025 indicated she had an impaired cognitive function that varies. Resident #5's care plan indicated interventions to use the resident's preferred name, identify yourself at each interaction, face the resident when speaking and make eye contact, reduce any distractions, the resident understands consistent, simple, directive sentences, provide the resident with necessary cues stop and return if agitated, and cue, reorient and supervise as needed. 2. Record review of Resident #7's face sheet dated 01/08/2025 indicated she was a [AGE] year-old female initially admitted to the facility on [DATE] with diagnoses which included dementia with other behavioral disturbance (deterioration of memory, language, and other thinking abilities). (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's Quarterly MDS assessment dated [DATE] indicated she was able to make herself understood and understood others. The MDS assessment indicated Resident #7 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #7 was independent with eating, oral hygiene, toileting hygiene, required set-up or clean-up assistance with dressing, and supervision or touching assistance with showering/bathing, putting on/taking off footwear, and personal hygiene. Record review of Resident #7's care plan last reviewed 12/17/2024 indicated she had a limited physical mobility related to poor balance to provide supportive care, and assistance with mobility as needed. 3. Record review of Resident #10's face sheet dated 01/08/2025 indicated she was an [AGE] year-old-female admitted to the facility on [DATE] with diagnoses which included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area). Record review of Resident #10's Quarterly MDS assessment dated [DATE] indicated she was able to make herself understood and understood others. The MDS assessment indicated Resident #10's BIMS was a 14, which indicated her cognition was intact. The MDS assessment indicated Resident #10 required partial/moderate assistance for toileting hygiene, showering/bathing self, dressing, and personal hygiene. Record review of Resident #10's care plan last reviewed 10/31/2024 indicated she had a behavior problem of excessive use of call light unknowingly at times without need due to numbness to left hand and tremors in right hand. Interventions included explain all procedures to her before starting and allow her to adjust to changes, assist her to develop more appropriate methods of coping and interacting, and anticipate and meet resident's needs. 4. Record review of Resident #58's face sheet dated 01/08/2025 indicated he was a [AGE] year-old male initially admitted to the facility on [DATE] with diagnoses which included atherosclerotic heart disease of native coronary artery without angina pectoris (buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow without chest pain). Record review of Resident #58's Comprehensive MDS assessment dated [DATE] indicated he was able to make himself understood and understood others. Resident #58's BIMS score was 13, which indicated his cognition was intact. The MDS assessment indicated Resident #58 required substantial to maximal assistance with toileting, dressing, showering/bathing self, and personal hygiene. Record review of Resident #58's care plan last reviewed 10/31/2024 indicated he had impaired cognitive function or impaired thought processes. Interventions included to use the resident's preferred name, identify yourself at each interaction, face the resident when speaking and make eye contact, reduce any distractions-turn off TV, radio, close door, the resident understands consistent, simple, directive sentences, provide the resident with necessary cues, stop and return if agitated. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a resident group meeting starting on 01/06/2025 at 11:04 AM, Resident #5, Resident #7, Resident #10, and Resident #58 said CNA A did not treat them with dignity and respect, and she was rude to them. Resident #58 said CNA A had been working every day without a day off and she was not a people person. Resident #58 said CNA A did not treat anyone with respect. Resident #58 said CNA A was usually the only one on his hall and I think she takes it out on us because she is the only one working that hall. Resident #58 said CNA A did not speak when she was providing care. Resident #58 said he had reported CNA A to the nurses 2-3 times before and they never do anything. Resident #7 said CNA A did not treat her respectfully and ignored her because CNA A did not speak to Resident #7 when Resident #7 spoke to CNA A. Resident #7 said one day CNA A was sitting at the nurses' station on the computer and Resident #7 asked her something and she did not respond. Resident #10 said CNA A was rude to her because she overheard CNA A refer to her as the white person, and CNA A did not speak to her while providing care. Resident #10 said she had not reported it because they won't do anything. Resident #5 said CNA A was rude to her because she did not speak to her while providing care. Resident #5, Resident #7, Resident #10, and Resident #58 said they were not afraid of CNA A, but they felt disrespected by CNA A. During an interview on 01/07/2025 at 1:16 PM, CNA A said she was coming up on one year for her employment at the facility. CNA A said she had not had any issues with Resident #5, Resident #7, Resident #10, or Resident #58. CNA A said when she provided care to the residents she went in their room and asked them what they needed and did it for them. CNA A said she explained to the residents what she was doing while providing care to them. CNA A said she had not ignored any residents, and when they spoke to her, she spoke back to them. CNA A said she had never refused to provide care to any residents. CNA A said she had not been working every day and worked per her rotation. CNA A said it was important to treat the residents with dignity and respect for good customer service, to do as they needed because it was her job to make sure they were okay. CNA A said if the residents were not treated with dignity and respect, they could feel neglected and abused, and it would affect them if they did not get their needs met. During an interview on 01/07/2025 at 9:26 PM, CNA B said she worked the night shift with CNA A. CNA B said Resident # 10 had told her CNA A would not speak back to Resident #10 when spoken to. CNA B said she had not reported Resident #10 telling her CNA A would not speak to her to anyone. CNA B said she told CNA A she might want to speak to Resident #10. CNA B said she had not heard CNA A refer to Resident #10 as the white lady. CNA B said no other residents reported any issues with CNA A. During an interview on 01/08/2025 at 12:14 PM, the DON said in the past, there was an incident between Resident #7 and CNA A. Resident #7 reported CNA A was rude to her because she would not talk while providing care. The DON said a customer service in-service was completed with CNA A. The DON said there were not other complaints about CNA A. The DON said she had not observed any issue with CNA A's care towards the residents. The DON said she expected the staff to treat the residents respectfully, talk to the residents while they were providing care, and let them know what they were doing. During an interview on 01/08/2025 at 12:48 PM, the Administrator said to his knowledge CNA A did not have any inappropriate behaviors towards residents. The Administrator said he expected for every resident to be treated with respect and customer service was a big deal. The Administrator said if residents were not treated with dignity and respect it could impact their emotional well-being. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Resident Grievance received 08/06/2024 indicated Resident #7 reported in resident council that the night aide (CNA A) was rude because she would not talk to her when she was providing care. Resolved date 08/06/2024. The DON was assigned to take action, and the corrective action taken to prevent recurrence was employee to receive counseling. Signed by the Administrator 08/06/2024. Record review of CNA A's employee file indicated an In-Service Training Topic Customer Service dated 08/06/2024 provided by the DON signed by multiple staff, including CNA A. Record review of the facility's policy titled, Resident Rights, revised 11/28/2016, The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident .The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care .The resident has a right to be treated with respect and dignity, including .The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents .

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 46892 Based on interview and record review, the facility failed to consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility and failed to demonstrate their response and rationale for such response for 6 of 6 confidential residents reviewed for resident council. The facility failed to ensure there was documentation of the facility's efforts to resolve concerns about call light response times collected at the resident council meetings on 07/15/2024, 08/22/2024, and 09/20/2024. This failure could place residents at risk of not having their concerns and grievances followed through and a diminished quality of life. Findings included: Record review of the Resident Advisory Council Minutes for 07/15/2024 indicated the call lights were not being answered timely. Record review of the Resident Advisory Council Minutes for 08/22/2024 indicated the call lights were not being answered timely. Record review of the Resident Advisory Council Minutes for 09/20/2024 indicated the call lights were not being answered timely. Record review of the grievances from July 2024-January 2025 did not indicate grievances to address the efforts to resolve the resident councils' concerns. During a confidential group interview with 6 residents on 01/06/2025 starting at 11:04 AM, the resident group said call lights were not answered timely. The resident group said they had mentioned it in the resident council meetings and to staff members and nobody had gotten back to them with any resolution. During an interview on 01/07/2025 at 7:17 PM, RN D said occasionally the residents complained about the call lights not being answered timely. RN D said he reported it to the ADONs and was not provided a resolution. RN D said he tried to help the CNAs the best he could. RN D said it was important for the call lights to be answered timely because it was the residents' home, and they should have their needs met in a timely manner. During an interview on 01/08/2025 at 10:22 AM, ADON E said none of the residents had reported to her the call lights not being answered timely. ADON E said none of the staff had reported to her the call lights were not being answered timely. During an interview on 01/08/2025 at 12:14 PM, the DON said the staff had not reported issues with answering the call lights timely. The DON said none of the residents had reported to her that the call lights were not answered timely. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/08/2025 at 12:48 PM, the Administrator said when there were grievances in resident council, they started off with staff education, and then they followed up at the next resident council meeting. The Administrator said after the resident council he completed grievances if there were multiple concerns. The Administrator said he would look for grievances completed for the resident council and provide them (none were provided upon exit of the facility). The Administrator said he was aware of the call lights not being answered timely and it was an ongoing issue. The Administrator said it was important to address the issues that the resident council voices to do the best to meet the residents' needs. Record review of the facility's policy titled, Grievances, revised 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. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. 1. The facility will notify residents on how to file a grievance orally, in writing, or anonymously with postings in prominent locations. 2. The grievance official of this facility is the administrator or their designee. 3. The grievance official will: o Oversee the grievance process o Receive and track grievances to their conclusion o Lead any necessary investigations by the facility o Maintain the confidentiality of all information associated with grievances o Issue written grievance decisions to the resident .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interview, and record review, the facility failed to ensure the right to formulate an advanced directive for 1 of 20 residents (Residents #9) reviewed for advanced directives. The facility did not ensure Resident #9's OOH-DNR included the physician's printed name. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: Record review of Resident #9's face sheet, dated 01/08/25, indicated Resident #9 was a [AGE] year-old female, originally admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of Resident #9's physician order summary report, dated 01/08/25, indicted an active physician's order for code status: DNR with an order date 05/28/19. Record review of Resident #9's quarterly MDS, dated [DATE], indicated Resident #9 sometimes made herself understood, understood others. Resident #9's BIMS score was a 3, which indicated her cognition was severely impaired. Record review of the comprehensive care plan, initiated 12/09/24, indicated Resident #9 had an order for DNR. The care plan interventions included all aspects of DNR will be explained to resident or responsible party, resident will be maintained at a level of comfort as ordered by the physician and social services to consult with resident and RP regarding their decision to continue DNR. Record review of Resident #9's OOH-DNR form dated 05/23/18 reflected the physician's printed name was missing. During an interview on 01/07/25 at 3:47 p.m., the Social Worker stated she was responsible for completing DNRs. The Social Worker stated she started working at the facility around May 2020. After reviewing Resident #9's electronic medical record, she stated Resident #9 OOH-DNR was missing the physician printed name. The Social Worker stated she monitored by random audits. The Social Worker stated she could not give a specific date on her last audit. The Social Worker stated she happened to miss the actual printed name was missing. The Social Worker stated it was important to ensure DNRs were completed to respect the resident wishes. During an interview on 01/08/25 at 12:43 p.m., the Administrator stated he expected DNRs to be filled out completely, including signatures. The Administrator stated the social worker was responsible for overseeing and monitoring the DNR. The Administrator stated it was important to ensure residents code status was up to date and DNRs completed to respect the resident preference. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Do Not Resuscitate Order revised 10/12/13 indicated . the facility will honor two types of Do Not Resuscitate orders: a physician's order for Do Not Resuscitate and the Texas Out-of-Hospital DNR Order

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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 #43) residents reviewed for care plans. The facility failed to update Resident #43's care plan after she no longer required a fall mat on last revision date 11/26/2024. This failure could place Resident # 43 at risk of not having their individualized needs met and a decreased quality of life. Findings Included: Record review of Resident # 43's face sheet dated 1/07/2025, revealed Resident # 43 was an [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnoses of dementia (memory loss), muscle weakness (decreased ability of muscles to generate force or power), reduced mobility (person has difficulty moving around or walking as they normally would), anxiety disorder (a mental health condition that causes excessive and uncontrollable feelings of fear or worry that can interfere with daily life). Record review of a comprehensive MDS dated [DATE] indicated Resident #43 was sometimes understood and usually understands others. The MDS indicated Resident #43 was unable to complete her BIMS exam due to her cognition. The MDS indicated Resident #43 had inattention and disorganized thinking being continuously present. The MDS indicated Resident #43 had no behavioral symptoms but wandering. The MDS indicated Resident #43 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. Record review of the comprehensive care plan dated 11/26/24 indicated Resident #43 was at a high risk for falls, related to confusion and poor safety awareness. The care plan interventions indicated Resident #43 fall mat to be placed at bed side. Record review of Resident # 43's order summary dated 01/07/2025, did not indicate she required a fall mat at bedside. During an observation on 01/06/2025 at 9:35 a.m., Resident #43 was sitting up in bed with no fall mat at the bedside. Resident # 43 was non-interview able. During an observation on 01/07/2025 at 8:30 a.m., Resident #43 was in bed with no fall mat at the bedside. Resident # 43 was non-interview able, surveyor attempted to contact family member. (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 01/07/2025 at 9:35 a.m., RN K stated MDS was responsible for updating the care plan. RN K stated if an incident occurred over the weekend, she would try to update the care plan. RN K stated Resident # 43 no longer needed a fall mat at bedside because she could not transfer or ambulate on her own. RN K stated Resident # 43 did not attempt to get out of the bed by herself. RN K stated it was important for the care plan to be updated so the nursing staff would be able to provide the appropriate care. During an interview on 01/08/2025 at 9:30 a.m., RN L stated the nursing staff usually updated the care plan with any change of condition and the MDS updated the care plan quarterly and performed annual assessments. RN L stated it was a group effort with the nursing staff to make sure the care plans were correct. RN L stated if Resident #43 had a change in condition and no longer required a fall mat the care plan should have been updated at that time. RN L stated residents are discussed in morning meeting and adjustments were made as needed to the care plan. RN L stated she did not know why Resident # 43's care plan was not updated. During an interview on 01/08/2025 at 9:45 p.m., the Administrator stated nursing staff was responsible for updating the care plan. The Administrator stated it was nursing responsibility to make sure residents care plan reflected Resident #43 no longer needed a fall mat at bedside. The Administrator stated any change in condition a resident had was discussed in the morning meeting and the change to the care plan should be done at that time. The Administrator stated he would monitor in morning meeting. 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on observations, interviews, and record review the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel for 2 of 20 residents (Resident #34 and Resident #59) reviewed for medications at their bedside. 1. The facility failed to ensure the nebulizer medication for Resident #34 was not left at the bedside on 01/05/2025 and 01/06/2025. 2. The facility did not ensure Resident #59's Lamisil (medication used to treat fungal infections of the skin), Cortizone-10 (medication used to treat swelling, itching and redness of the skin), and Flonase (medication used to relieve seasonal and year-round allergic and non-allergic nasal symptoms) were properly safe and secured. These failures could place residents at risk for misuse of medication and overdose, drug diversions, adverse reactions of medications, and not receiving the therapeutic benefit of medications. The findings included: 1. Record review of the face sheet, dated 01/07/2025, reflected Resident #34 was a [AGE] year-old male who initially admitted to the facility on [DATE] with a diagnosis of COPD (type of progressive lung disease characterized by chronic respiratory symptoms and airflow limitation). Record review of the quarterly MDS assessment, dated 11/21/2024, reflected Resident #34 had clear speech and was understood by others. The MDS reflected Resident #34 was able to understand others. The MDS reflected Resident #34 had a BIMS score of 12, which indicated moderately impaired cognition. The MDS reflected Resident #34 had an active diagnosis of COPD. Record review of the comprehensive care plan, revised 09/18/2023, reflected Resident #34 had a diagnosis of COPD. The interventions included: give aerosol or bronchodilators as ordered and monitor/document any side effects and effectiveness. Record review of the order summary report, dated 01/07/2025, reflected Resident #34 had an order, which started on 03/05/2024, for Ipratropium-Albuterol Inhalation Solution (nebulizer breathing treatment) 0.5-2. 5mg/3mL - 1 application inhale orally two times a day for wheeze/shortness of breath related to COPD. Record review of the MAR, dated January 2025, reflected Resident #34 received Ipratropium-Albuterol Inhalation Solution (nebulizer breathing treatment) twice daily. (continued on next page)

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	676045	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Terrace Healthcare and Rehabilitation	2885 Stillhouse Road Paris, TX 75460

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 01/05/2025 at 10:37 AM, the chamber of Resident #34's nebulizer mask was filled approximately half full of a clear liquid. Resident #34 stated the nurse had placed his breathing treatment medication into the chamber earlier in the morning, but he had not taken it yet. Resident #34 stated the nursing staff usually placed the medication into his nebulizer and left the medication at bedside for him to take when he was ready. During an observation and interview on 01/06/2025 at 8:16 AM, the chamber of Resident #34's nebulizer mask was filled approximately half full of a clear liquid. Resident #34 stated the nurse brought the medication to him this morning, but he had not taken it yet. During an interview on 01/08/2025 beginning at 10:05 AM, LVN F stated she normally administered Resident #34's breathing treatment. LVN F said the procedure for administering breathing treatments was to check the oxygen level and vital signs, set up the breathing treatment, and turn on the machine. LVN F stated she did not stay with Resident #34 because he took the treatment himself. LVN F stated Resident #34 could have turned the machine off if he was not ready to take it. LVN F stated on most days she checked to ensure Resident #34 completed the breathing treatment. LVN F stated she was unsure if she went back to check if Resident #34 had finished his treatment on 01/06/2025. LVN F stated the breathing treatment was considered medication. LVN F stated Resident #34 had not been assessed for self-administration of medication. LVN F stated it was important to ensure medication was administered and not left at the bedside to ensure no other residents took the medication and so the residents would have received the prescribed dosage of medication. During an interview on 01/08/2025 beginning at 10:20 AM, LVN G said she was responsible for administering Resident #34's breathing treatment. LVN G said the procedure for administering breathing treatments was to set up the breathing treatment, turn on the machine, and leave the room. LVN G said after she left the room, she set a timer on her watch to go back and check on Resident #34. LVN G said Resident #34 turned off the breathing machine at times after she left the room. LVN G said Resident #34 had not been assessed for self-administration of medication and was unable to self-administer his medications. LVN G said Resident #34 was unable to have medications left at the bedside. LVN G stated on 01/05/2025 she went back to check on Resident #34, but she did not check his breathing machine to ensure the medication had been taken. LVN G said it was important to ensure medication was administered and not left at the bedside to ensure resident safety and prevent exacerbation of COPD. During an interview on 01/08/2025 beginning at 12:29 PM, the DON stated nurses were responsible to ensure breathing treatments were administered, completed, and placed back into the bag. The DON stated Resident #34 turned his machine off at times, but the nurses should have made sure the breathing treatment was completed. The DON stated Resident #34 had not been assessed for self-administration of medication and his breathing treatment should not have been left at bedside. The DON stated she started in-service education with the nurses. The DON said it was important to ensure breathing treatments were completed and not left at the bedside to prevent COPD exacerbation or respiratory symptoms. 43047 2. Record review of Resident #59's face sheet, dated 01/08/25, reflected he was admitted to the facility on [DATE] with diagnoses which included Parkinson's (brain disorder that causes unintended or uncontrollable movements). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the order summary report dated 01/08/25 did not address the use of Lamisil, Cortizone-10, or Flonase. Record review of the quarterly MDS assessment, dated 12/06/24, indicated Resident #59 made himself understood and understood others. Resident BIMS score was 11, which indicated his cognition was moderately impaired. Record review of the comprehensive care plan, revised on 04/26/23, indicated Resident #59 has an ADL self-care performance deficit related to Parkinson's disease. The interventions included: personal hygiene as required: hair, shaving, oral care as needed, and required staff x1 for assistance with bathing and toileting. During an observation and interview on 01/05/25 at 10:48 a.m., Resident #59 was lying in bed when the state surveyor observed a tube labeled Lamisil and Cortizone-10 on his nightstand in a basket. The state surveyor also noted a nasal spray labeled Flonase in the basket. When asked what the medications were used for Resident #59 stated he had not used the Lamisil in a long time, and the Flonase was used for deodorant and could not remember what the Cortizone-10 was used for. Resident #59 stated a family member probably brought the medications to the facility. During an observation on 01/06/25 at 8:59 a.m., Resident #59 was sitting in his wheelchair when the state surveyor observed a tube labeled Lamisil and Cortizone-10 on his nightstand in a basket. During an observation and interview on 01/08/25 at 8:45 a.m., RN C stated Resident #59 had not been checked off for self-administration. RN C stated if a resident was able to self-administer an assessment must be completed and an order obtained prior to administration. RN C observed the Lamisil, Cortzione-10, and Flonase in the basket on Resident #59's nightstand. RN C removed the medications from Resident #59's room. RN C stated it was important medications were not at bedside for resident safety. During an interview on 01/08/25 at 12:05 p.m., the DON stated nurses were responsible for ensuring medications were stored appropriately. The DON stated before a resident could keep medications at bedside a self-administer assessment must be completed. The DON stated the MD must be notified and orders would be obtained. The DON stated she monitored by daily champion rounds to ensure compliance. The DON stated there had not been any issues in the past. The DON stated it was important to ensure medications were not left at bedside for resident safety. During an interview on 01/08/25 at 12:34 p.m., the Dietary Manager stated she was responsible for champion rounds for Resident #59. The Dietary Manager stated during her rounds this week she did not notice any medications in the basket. The Dietary Manager stated it was important to ensure medications were not left at bedside for resident safety. During an interview on 01/08/25 at 12:43 p.m., the Administrator stated he expected medications to be stored on the medication cart. The Administrator stated the nursing department was responsible for monitoring and overseeing that medications were not left out. The Administrator stated it was important to ensure medications were not left at bedside to prevent a medication error or misadministration. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's undated policy titled Storage of Medication indicated . Medications and biologicals are stored safely, securely, and properly following manufacturers recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . 6. Except for those requiring refrigeration, medications intended for internal use are stored in medication cart or other designated area .

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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 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on observation, interview, and record review, the facility failed to provide liquids consistent with the resident's needs, for 1 of 23 (Resident #9) residents reviewed for liquid inconsistency. The facility did not ensure staff served Resident #9 her iced tea during her lunch meal on 01/05/25. This failure could place residents at risk for dehydration and loss of interest in eating. Findings included: Record review of Resident #9's face sheet, dated 01/08/25, indicated Resident #9 was a [AGE] year-old female, originally admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life) and unspecified protein-calorie malnutrition (protein calorie deficiency). Record review of the order summary report dated 01/08/25 indicated Resident #9 had the following orders: *Regular diet ground meat texture, thin/regular consistency with an order start date of 03/31/23. Record review of Resident #9's quarterly MDS, dated [DATE], indicated Resident #9 sometimes made herself understood, understood others. Resident #9's BIMS score was a 3, which indicated her cognition was severely impaired. Resident #9 required setup or clean-up assistance with eating. Record review of the comprehensive care plan, revised 01/06/25, indicated Resident #9 was at risk for nutritional problem including weight loss and dehydration related to missing some teeth. The care plan interventions included maintain preferences, offer alternatives, provide between meal snacks, and provide, serve diet as ordered. Record review of Resident #9's meal ticket dated 01/05/25 indicated Resident #9 would receive iced tea for her beverage during her lunch meal. During an observation on 01/05/25 at 12:39 p.m., Resident #9 was served her lunch tray consisting of baked ham, turnip greens, lima beans, cornbread, and blackberry cobbler. Resident #9 did not receive here iced tea. During an observation and interview on 01/05/25 at 12:47 p.m., the state surveyor asked RN C to review Resident #9's meal ticket for any missing items. After reviewing the meal ticket RN C stated Resident #9 had not received her iced tea. RN C stated Resident #9 should have received a glass of iced tea when her tray was provided. RN C stated it was important for Resident #9 to receive her drink to prevent dehydration. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/08/25 at 12:05 p.m., the DON stated she expected Resident #9's drink to be served with her meal. The DON stated nursing staff should ensure a drink was given to the resident when the resident sat down. The DON stated prior to state surveyor intervention there was not a system in place to monitor because this issue had never happened. The DON stated it was important to ensure residents received their drinks with their meal for hydration purposes. During an interview on 01/08/25 at 12:43 p.m., the Administrator stated he expected drinks to be served with meals. The Administrator stated whoever was assisting in the dining room was responsible for ensuring residents received their drinks. The Administrator stated it was important to ensure drinks were given when the residents received their tray to prevent dehydration. Record review of the facility's policy titled Hydration revised 10/05/16 indicated . The facility provides each resident with sufficient fluid intake to maintain proper hydration and health. The resident will receive sufficient amounts of fluid based on assessed need to prevent dehydration and promote optimum physiological functions Staff should offer hydration, unless contraindicated at the following intervals: prior to, during, and following meals .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47612 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. The facility failed to ensure: 1. The microwave was clean and free of food debris. 2. The deep fryer was clean and free of food debris. 3. Three sheet pans were free from encrusted black colored grease buildup coating on the outside and the inside surface. These failures could place residents at risk for foodborne illness. Findings include: During an initial tour observation in the kitchen on 01/05/2025 at 10:20 a.m., there was brown flakey debris in the microwave, dark brown grease with brown flakey debris floating in the deep fryer, and three sheet pans with encrusted black colored grease buildup coating on the outside and the inside surface. During an interview on 01/05/2025 at 11:00 a.m., [NAME] H stated the microwave was used during breakfast and had not been cleaned out. [NAME] H stated the deep fryer was cleaned weekly on Thursdays. [NAME] H stated they had fried fish last Friday and had not had time to clean the deep fryer. [NAME] H stated the sheet pans had carbon build on them and needed to be replaced. [NAME] H stated it was important to keep appliances clean to prevent food born illness. During an interview on 01/06/2025 at 8:25 a.m., the Dietary Manager stated the microwave was to be wiped out after every use, the deeper fryer was cleaned weekly unless they had fried fish, then it was cleaned after frying fish. The Dietary Manager stated she knew the sheet pans had carbon buildup on them and she was trying to order new ones as she could to keep from going over budget. The Dietary Manager stated she would do an in-service on kitchen sanitation. The Dietary Manager stated it was important for the equipment in the kitchen to be clean to prevent the residents from getting sick. During an interview on 01/08/2025 at 9:45 a.m., the Administrator stated he expected equipment in the kitchen to be clean to prevent food borne illness. The Administrated stated the deep fryer should be cleaned weekly and the microwave cleaned after each use. The Administrated stated he would do daily observance to monitor the kitchen. Record review of the facility's undated policy Dietary Service Personnel Policy and Procedures, revealed work surfaces must be kept as neat and clean as possible during preparation and service. All work areas must be thoroughly cleaned and sanitized after use