STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676049	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Healthcare and Rehabilitation - Paris	520 SE 8th St 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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on interview and record review, the facility failed to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional for 2 of 4 residents (Resident #13 and Resident #28) reviewed for comprehensive assessments and timing. The facility did not ensure Resident #13's Annual MDS assessment was completed within 14 days of admission. The facility did not ensure Resident #28's Admission MDS assessment was completed within 14 days of admission. This failure could place residents at risk of not having their needs identified and met. Findings included: Record review of Resident #13's face sheet dated 11/18/24 indicated she was [AGE] years old and admitted to the facility on [DATE] with diagnoses which included diabetes (high blood sugar). Record review of Resident #13's comprehensive MDS assessment, with an ARD of 10/23/24, indicated in Section A0310 it was an Annual assessment (required by day 14). The MDS assessment for Resident #13 indicated in Section A1600 an entry date of 7/02/22. The MDS assessment in Section Z0500 was signed completed on 11/08/24, which indicated the MDS assessment for Resident #13 was completed 3 days late. Record review of Resident #28's face sheet dated 11/20/24 indicated he was [AGE] years old and admitted to the facility initially on 10/14/24 and readmitted on [DATE] with diagnoses which included vascular dementia (problems with reasoning, planning, judgement, memory, and other thought processes caused by brain damage from impaired blood flow to the brain). Record review of Resident #28's comprehensive MDS assessment, with an ARD of 10/18/24, indicated in Section A0310 it was an Admission assessment (required by day 14). The MDS assessment for Resident #28 indicated in Section A1600 an entry date of 10/14/24. The MDS assessment in Section Z0500 was signed completed on 11/03/24, which indicated the MDS assessment for Resident #28 was completed 3 days late. (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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/24 at 9:26 AM, the MDS Coordinator Resource Nurse said she took over the facility's MDS Coordinator duties on 10/22/24 after the regular MDS nurse left 10/18/24 on maternity leave. The MDS Coordinator Resource Nurse said there was no excuse on the assessments being completed/signed late. The MDS Coordinator Resource Nurse said the assessments were just part of the end of the month assessments that were due or past due when she assumed the building. The MDS Coordinator Resource Nurse said they did not have a policy related to MDS assessments, but they followed the RAI Manual as their guidelines. During an interview on 11/20/24 at 2:22 PM, the ADM said he would expect MDS assessments to be completed and signed timely per the facility's policies. Review of the RAI guidelines accessed on 11/25/24 at 10:42 AM, Minimum Data Set 3.0 Resident Assessment Instrument User's Manual v1.19.1, dated October 2024 revealed . for OBRA-required Comprehensive assessments, assessment completion is defined as completion of the CAA process in addition to the MDS items, meaning that the RN assessment coordinator has signed and dated both the MDS (item Z0500) and CAA(s) (item V0200B) completion attestations . since a Comprehensive assessment includes completion of both the MDS and the CAA process, the assessment timing requirements for a comprehensive assessment apply to both the completion of the MDS and the CAA process . the MDS completion date (item Z0500B) must be no later than day 14. This date may be earlier than or the same as the CAA(s) completion date, but not later than .

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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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on interview and record review, the facility failed to complete a resident assessment within the required time frame for 4 of 18 residents (Resident #9, Resident #16, Resident #26, and Resident #31) reviewed for quarterly assessments. The facility did not ensure Resident #9, Resident #16, Resident #26, and Resident #31's quarterly MDS assessments were completed within 14 days of the ARD. This failure placed residents at risk of not having their assessments completed timely which could result in not having their individually assessed needs met. Findings included: 1. Record review of Resident #9's face sheet dated 11/20/24 indicated she was [AGE] years old and admitted to the facility initially on 10/12/21 and readmitted on [DATE] with diagnoses which included syncope and collapse (fainting or passing out). Record review of Resident #9's MDS assessment, with an ARD of 10/23/24, indicated in Section A0310 it was a Quarterly assessment (required by day 14). The MDS assessment for Resident #9 indicated in Section A1600 an entry date of 2/27/24. The MDS assessment in Section Z0500 was signed completed on 11/08/24, which indicated the MDS assessment for Resident #9 was completed 3 days late. Record review of the CMS transmittal report dated 11/13/24, indicated Resident #9's quarterly assessment was due to be completed by 10/23/24. The MDS assessment was accepted with the CMS Warning Record, Assessment Completed Late . the assessment completion date was more than 14 days after the assessment reference date. 2. Record review of Resident #16's face sheet dated 11/20/24 indicated she was [AGE] years old and admitted to the facility on [DATE] with diagnoses which included Alzheimer's (progressive disease that destroys memory and other important mental functions). Record review of Resident #16's MDS assessment, with an ARD of 10/18/24, indicated in Section A0310 it was a Quarterly assessment (required by day 14). The MDS assessment for Resident #16 indicated in Section A1600 an entry date of 11/23/16. The MDS assessment in Section Z0500 was signed completed on 11/03/24, which indicated the MDS assessment for Resident #16 was completed 3 days late. Record review of the CMS transmittal report dated 11/06/24, indicated Resident #16's quarterly assessment was due to be completed by 10/18/24. The MDS assessment was accepted with the CMS Warning Record, Assessment Completed Late . the assessment completion date was more than 14 days after the assessment reference date. 3. Record review of Resident #26's face sheet dated 11/20/24 indicated he was [AGE] years old and admitted to the facility on initially 9/13/19 and readmitted [DATE] with diagnoses which included hypertension (high blood pressure). (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #26's MDS assessment, with an ARD of 10/16/24, indicated in Section A0310 it was a Quarterly assessment (required by day 14). The MDS assessment for Resident #26 indicated in Section A1600 an entry date of 1/06/24. The MDS assessment in Section Z0500 was signed completed on 11/03/24, which indicated the MDS assessment for Resident #26 was completed 5 days late. Record review of the CMS transmittal report dated 11/06/24, indicated Resident #26's quarterly assessment was due to be completed by 10/16/24. The MDS assessment was accepted with the CMS Warning Record, Assessment Completed Late . the assessment completion date was more than 14 days after the assessment reference date. 4. Record review of Resident #31's face sheet dated 11/20/24 indicated he was [AGE] years old and admitted to the facility on [DATE] with diagnoses which included diabetes (high blood sugar). Record review of Resident #31's MDS assessment, with an ARD of 10/17/24, indicated in Section A0310 it was a Quarterly assessment (required by day 14). The MDS assessment for Resident #31 indicated in Section A1600 an entry date of 8/19/19. The MDS assessment in Section Z0500 was signed completed on 11/03/24, which indicated the MDS assessment for Resident #31 was completed 4 days late. Record review of the CMS transmittal report dated 11/06/24, indicated Resident #31's quarterly assessment was due to be completed by 10/17/24. The MDS assessment was accepted with the CMS Warning Record, Assessment Completed Late . the assessment completion date was more than 14 days after the assessment reference date. During an interview on 11/20/24 at 9:26 AM, the MDS Coordinator Resource Nurse said she took over the facility's MDS Coordinator duties on 10/22/24 after the regular MDS nurse left 10/18/24 on maternity leave. The MDS Coordinator Resource Nurse said there was no excuse on the assessments being completed/signed late. The MDS Coordinator Resource Nurse said the assessments were just part of the end of the month assessments that were due or past due when she assumed the building. The MDS Coordinator Resource Nurse said they did not have a policy related to MDS assessments, but they followed the RAI Manual as their guidelines. During an interview on 11/20/24 2:22 PM, the ADM said he would expect MDS assessments to be completed and signed timely per the facility's policies. Review of the RAI guidelines accessed on 11/25/24 at 10:42 AM, Minimum Data Set 3.0 Resident Assessment Instrument User's Manual v1.19.1 dated October 2024 revealed . the Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type . the MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) .

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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 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** 44596 Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for 3 of 16 residents (Resident #173, Resident #16, and Resident #61) reviewed for ADLs. The facility failed to provide scheduled showers and/or bed baths to Resident #173, Resident #16, and Resident #61 at least 3 times per week. These failures could place residents at risk of not receiving services/care and decreased quality of life. Findings included: 1.Record review of Resident #173's undated face sheet revealed she was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of diabetes mellitus type II (condition that happens when the body cannot regulate the way sugar is used as fuel), COPD (a group of lung diseases that cause breathing problems over time), and stage III pressure ulcer to the sacrum (deep wound that involves several layers of skin extending to subcutaneous (fatty) tissue located at the where the spine and pelvis connect). Record review of Resident #173's quarterly MDS assessment dated [DATE] revealed a BIMS of 10 which indicated moderate cognitive impairment. Resident #173 required supervision for eating and maximal assistance for personal hygiene, bathing, and toileting. Resident #173 was coded to have (1) Stage III pressure ulcer and (2) unstageable pressure ulcers. Record review of Resident #173's care plan dated 09/26/2024 titled ADL self-care deficit revealed Resident #173 had a self-care deficit related to impaired mobility, generalized weakness, and monopoiesis of the left lower extremity. The intervention was listed as staff will physically assist resident with ADLs. Resident #173 had no care plans related to refusal of bathing. Record review of Resident #173's bathing documentation revealed the following days a scheduled bath was missed beginning 09/15/2024 and ending 11/19/2024. 09/17/2024 09/21/2024 09/24/2024 09/26/2024 09/28/2024 10/05/2024 (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/08/2024 10/10/2024 10/15/2024 10/17/2024 10/22/2024 11/05/2024 11/14/2024 During an interview and observation on 11/18/2024 at 11:00 a.m., Resident #173 had a strong smell of body odor, greasy hair that was slicked down to her head, and full thick moustache to her upper lip. Resident #173 stated she had a wash down in the bed the previous week, but the CNA had not shaved her in a couple of weeks. Resident #173 stated she liked to have her facial hair removed with each bath, but she was not getting 3 baths per week like she was supposed to. She stated she was supposed to get a bath on Tuesday, Thursday, and Saturday on the 2-10 shift but they were often too busy to get to all the bathing on the 2-10 shift. Resident #173 stated she could not remember the last time she had her head fully washed. She stated she refused a lot of things but never refused to be bathed because she knew she needed it for her skin to heal and she did not want to smell badly. She stated body odor was embarrassing and having facial hair was for men. During an interview on 11/19/2024 at 2:30 p.m., CNA J stated she gave Resident #173 a bed bath on Saturday 11/14/2024. She stated she had not shaved or washed Resident #173's hair when giving her a bed bath. She stated a bath should include personal hygiene like shaving and hair washing. She stated Resident #173 being bed bound made washing her hair difficult. She stated she had not known Resident #173 to refuse care. CNA J stated there were times it was difficult to give full baths or showers to all residents each shift, but if you had good time management it was not impossible. 2. Record review of Resident #16's undated face sheet revealed she was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of Alzheimer's disease, glaucoma (a group of eye diseases that can damage the optic nerve and lead to blindness), and depression (a common mental health condition that can impact thoughts, feelings, and behaviors). Record review of Resident #16's quarterly MDS assessment dated [DATE] revealed a BIMS of 15 which indicated no cognitive impairment. Resident #16 required maximal assist with bathing, personal hygiene and toileting. Resident #16 was not coded for refusal of care. Record review of Resident #16's care plan dated 09/08/2024 titled ADL self-care deficit revealed Resident #16 had a self-care deficit related to impaired mobility, limited range of motion, and blindness. The intervention was listed as staff will physically assist resident with ADLs. Resident #16 had no care plans related to refusal of bathing. Record review of Resident #16's bathing documentation revealed the following days a scheduled bath was missed beginning 09/01/2024 and ending 11/19/2024. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/02/2024 09/04/2024 09/06/2024 09/11/2024 09/13/2024 09/16/2024 09/23/2024 10/23/2024 10/25/2024 10/30/2024 11/08/2024 11/11/2024 11/13/2024 11/15/2024 During an interview on 11/16/2024 at 9:15 a.m., Resident #16 stated she was given a cold washcloth to wipe off today. She stated she wanted to have a bath more often than 3 days a week, but she understood everyone needed a turn. She stated her bath days were Monday, Wednesday, Friday, and she normally got a bath once or twice a week. She stated it was important for her to be clean to feel happy. During an interview on 11/19/2024 at 2:30 p.m., CNA J stated she gave Resident #16 her bath on the 2 p.m. to 10 p.m. shift. CNA J stated there were times it was difficult to give full baths or showers to all residents each shift, but if you had good time management it was not impossible . 3.Record review of Resident #61's undated face sheet revealed she was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of anxiety, Raynaud Syndrome (a condition that causes decreased blood flow to extremities and depression (a common mental health condition that can impact thoughts, feelings, and behaviors). Record review of Resident #61's quarterly MDS assessment dated [DATE] revealed a BIMS of 09 which indicated moderate cognitive impairment. Resident #61 required supervision for bathing, toileting, and personal hygiene. No refusal of care was documented on the MDS. (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 #61's care plan dated 09/08/2024 titled ADL self-care deficit revealed Resident #61 had a self-care deficit related to impaired mobility. No care plan for refusal of care was documented. Record review of Resident #61's bathing documentation revealed the following days a scheduled bath was missed beginning 09/01/2024 and ending 11/19/2024. 09/02/2024 09/11/2024 09/13/2024 09/16/2024 09/20/2024 09/25/2024 09/27/2024 09/30/2024 10/02/2024 10/04/2024 10/14/2024 10/21/2024 10/25/2024 10/28/2024 11/01/2024 11/06/2024 11/08/2024 11/13/2024 11/15/2024 (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 and observation at 11/16/2024 at 9:00 a.m., Resident #61 stated she had gotten a bath once a week for the last month. She stated she was unsure why the staff would not assist her with a bath she just required supervision and someone to wash her back. She stated she was incontinent at times, and she felt unclean without bathing at least every other day. She stated she wanted to stay in the room when she fears she smells like urine. She stated she had reported to the DON she was not getting her baths and she changed the days the baths were scheduled. She stated she was a Monday, Wednesday, Friday bath on the 6 a.m. to 2 p.m. shift. During an interview on 11/16/2024 at 11:00 a.m., CNA F stated Resident #61 was a resident that received her bath on Monday, Wednesday, and Friday. She stated she was supervision only and baths were important to Resident #61. She stated she had no problems getting all her baths completed on her assigned hallway. She stated Resident #61 had only refused once in the entire time she had been a resident that she recalled. During an interview on 11/20/2024 at 10:00 a.m., the DON stated she expected all residents to get their baths at least 3 days a week. She expected if a refusal occurred for the CNA to notify the nurse and the nurses to contact the family with each refusal. She stated Resident #173 only liked bed baths, Resident #16 had days when she did not want to be bothered and Resident #61 refused in the past. The DON stated she understood refusals were not documented in the chart and notifying the family was not charted either. The DON stated it was important for everyone to maintain hygiene for the residents over all wellbeing. During an interview on 11/20/2024 at 11:00 a.m., the ADM stated he expected all residents to get their baths as scheduled. He stated he expected all refusals to be documented and an attempt to be made to have the family intervene in their refusal. He stated it was crucial for the resident's psychological wellbeing to have good hygiene. Requested ADL policy on 11/19/2024 at 2:00 p.m. and 11/20/204 at 11:00 a.m. No ADL policy was provided prior to exit.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 44596 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents and injury from hot liquid spills for 1 of 6 resident's (Resident #173) reviewed for accident and supervision. Resident #173 sustained a thermal burn from spilling hot coffee on her leg, served by CNA A without obtaining the temperature of the liquid on 11/12/2024. The noncompliance was identified as past non-compliance (PNC). The Immediate Jeopardy (IJ) began on 11/12/2024 and ended on 11/14/2024. The facility had corrected the non-compliance before the survey began. This failure could place residents served hot liquids at risk for thermal burns if spilled. The findings included: Record review of Resident #173's undated face sheet revealed she was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of diabetes mellitus type II (condition that happens when the body cannot regulate the way sugar is used as fuel), COPD (a group of lung diseases that cause breathing problems over time), and stage III pressure ulcer to the sacrum (deep wound that involves several layers of skin extending to subcutaneous (fatty) tissue located at the where the spine and pelvis connect). Record review of Resident #173's quarterly MDS assessment dated [DATE] revealed a BIMS of 10 which indicated moderate cognitive impairment. Resident #173 required supervision for eating and maximal assistance for personal hygiene, bathing, and toileting. Resident #173 was coded to have (1) Stage III pressure ulcer and (2) unstageable pressure ulcers. Record review of Resident #173's care plan revealed a care plan dated 11/12/2024 titled Actual Impairment. Resident #173 had actual impairment to skin integrity of right medial thigh and right upper thigh related to a 2nd degree burn. Record review of Resident #173's hot liquid assessment dated [DATE] revealed she was able to manage hot liquids independently with no oversight. Record review of Resident #173's incident accident report dated 11/12/2024 at 2:24 p.m., revealed RN ADON B found burns to Resident #173's right upper thigh and medial thigh and around the back of the thigh down to the upper inner knee and upper calf. Open areas were noted to right medial thigh measuring 2cm X 2cm and right upper thigh 0.5 cm X 0.5 cm. Redness to top of thigh to the medial thigh down to the knee and upper calf area. The resident stated I spilled a cup of coffee on my leg this morning. It did not hurt, and it still does not hurt. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/19/2024 at 12:50 p.m., RN ADON B stated Resident #173 had (2) 2nd degree burns being treated daily since 11/12/2024 when she sustained the burns from a hot liquid spill. RN ADON B stated LVN ADON C was the person that investigated the incident and had the details of the occurrence. He stated Resident #173 had not reported the spilled coffee to anyone prior to his findings. During an interview on 11/19/2024 at 1:00 p.m., LVN ADON C stated Resident #173 had spilled a cup of hot coffee on herself on 11/12/2024 and sustained 2nd degree burns to her right thigh. She stated the coffee was served to Resident #173 by CNA A. She stated CNA A made the coffee in the employee breakroom and served it to Resident #173 without taking the temperature of the coffee prior to serving it. She stated it was the policy of the facility to not serve any liquids to residents above 140 degrees to prevent injuries like Resident #173's burns from occurring. She stated she immediately informed the MD and Administrator when RN ADON C informed her on 11/12/2024. She stated the MD/NP came to the facility that afternoon and an ad hoc QAPI meeting was held. She stated the MD, both ADONs, the ADM, dietary manager and social worker all attended the meeting. She stated she began to in-service all staff on not providing hot liquids or foods with hot liquids from anywhere other than the kitchen and not to heat items in the microwave for the residents. She stated she completed 100% of the staff by 8:00 p.m. on 11/12/2024. She stated she also began the hot liquid monitoring tool in which she chose 5 residents to interview about hot liquids and temp their liquids and foods with liquids prior to them eating daily for a week and then 2-3 times a week for 3 weeks. She stated she and the other administrative nurses completed hot liquid assessments and updated the care plans of the resident's that had changes to their dependence level. During an interview on 11/19/2024 at 1:45 p.m., CNA A stated she was the one that served Resident #173 coffee from the breakroom coffee pot. She stated she was just trying to make the resident happy. She stated when doing peri care for Resident #173 she mentioned wishing she had a cup of coffee. CNA A stated she went to the breakroom and brewed a fresh pot of coffee for her and brought her a cup. She stated Resident #173 drank and ate all her food in her bed, so she thought nothing of giving her a cup of coffee. She stated she was unaware she spilled the coffee until she was told when she was called and questioned about the incident by LVN ADON C. CNA A stated it never occurred to her that the temperature would be hot enough to burn the resident if she spilled it on herself. She stated she had been in serviced on not providing any hot liquid or food with liquid to the residents from anywhere but the kitchen and not to microwave anything and give it to the residents. During an interview on 11/19/2024 at 1:50 p.m., Resident #173 stated she asked for a cup of coffee during the night shift on 11/12/2024. She stated CNA A was nice enough to go and get her a cup of coffee and bring it back to her. She stated CNA A sat the coffee on her bedside table and left the room. Resident #173 stated she added sugar and creamer to the coffee and when she went to stir the coffee with a spoon the cup fell over and the coffee spilled onto her sheet and soaked through to her legs. She stated she was not aware of the burn because she had not felt it. She stated CNA A was not aware she was not supposed to have the kitchen test the temperature of the coffee before giving it to her. She stated she had asked for coffee in the past and drank it without any problems . The facility corrected the noncompliance on 11/14/2024 by the following: - Inservice 100% of staff about not serving hot liquids or food containing hot liquid that was not provided by the kitchen. Do not microwave food and serve to the resident. And all liquids or food with liquids served to the resident must be 140 degrees or below. -Completed 11/12/2024 8:00 p.m. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Healthcare and Rehabilitation - Paris	520 SE 8th St Paris, TX 75460

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Started hot liquid assessment tool 11/12/2024 to interview residents and monitor the temperature of the liquids served to 5 residents daily for week and then 5 residents 2-3 days a week for 3 weeks. - Monitoring remained in progress - QAPI meeting held to discuss hot liquid management for resident safety on 11/12/2024. - Completed 11/12/2024 - MD/NP evaluated Resident #173's burn and wrote treatment orders - Completed 11/12/2024 - Hot liquid assessments completed on all residents- Completed 11/14/2024 - Care plan updated on any resident that had a status change related to the hot liquid assessment- Completed 11/14/2024. Record review of a Quality Assurance (QA) Meeting Sign-in Sheet dated 11/12/2024 indicated the facility had an QA meeting addressing hot liquid management for resident safety. The QA Meeting Sign-in Sheet indicated the RN ADON B, LVN ADON C, ADM, MD/NP, dietary manger, housekeeping supervisor, floor nurses, and CNAs attended the meeting. Record review of the MD progress note dated 11/12/2024 revealed Resident #173 had been seen on 11/12/2024 at 4:00 p.m. and was noted to have spilled hot coffee on her thigh. Resident #173 had a large red patch with a few blistered areas. Most of the redness was now a 1st degree burn. A couple of the area are 2nd degree burns with no evidence of infection. Record review of the hot liquids assessment dated [DATE] completed by LVN ADON C for Resident #173 indicated she was to remain independent with hot liquids with no oversight required. Record review of the care plan titled actual skin impairment updated on 11/12/2024 by RN ADON B revealed Resident #173 had actual impairment to skin integrity of right medial thigh 2 cm x 2 cm and right upper thigh 0.5 cm x 0.5 cm related to a 2nd degree burn. It indicated the treatment for the burns was for each area to be cleansed daily, triple antibiotic ointment applied and covered with a silicone dressing. Record review of the treatment administration record (TAR) for Resident #173 dated 11/12/2024 to 11/19/2024 indicated daily treatments were completed to the right medial thigh and right upper thigh burns. Record review of the hot liquid monitoring tool dated 11/12/2024 revealed monitoring of 5 residents from 11/12/2024 to 11/18/2024. The residents were asked if they were served hot liquids after 8 p.m. when the kitchen was closed, if the temperature of the liquids consumed the prior meal was too hot, and temperatures were recorded for hot liquids and soups. All staff interviewed (RN ADON B, LVN D, LVN E, CNA F, LVN H, CNA I, CNA J, LVN K, Laundry L, Therapist M, and Housekeeper N) on 11/19/2024 verbalized understanding of not providing hot liquids or food with hot liquid to the resident that was not prepared in the kitchen and not to microwave any food and give it to the resident without the kitchen testing the temperature first. They all verbalized 140 degrees as the maximum temperature of food and liquids served to a resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/19/2024 at 4:30 p.m., the DON stated the facility did not have a hot liquid policy. They only policy the facility had was a kitchen policy that no liquid be served greater than 140 degrees to the residents. She stated the facility did not have an accidents and hazards policy either. She stated she was on vacation when the incident with Resident #173 occurred, and she was not aware of the incident until she returned on 11/16/2024. She stated it was her expectation for all staff to go through the kitchen for service of food and liquids because the kitchen staff was trained to handle foods at temperatures safe for consumption by the residents. She stated she was unaware night shift was making coffee for Resident #173 in the breakroom, but the coffee pot had been removed from the breakroom. During an interview on 11/20/2024 at 1:00 p.m., the ADM stated he was torn by the incident that occurred with Resident #173. He stated CNA A was making sure the resident's rights were protected by allowing her coffee when the kitchen was closed, but it was an unsafe choice because the resident had a fluke accident with the coffee. He stated he expected all liquids to come from the kitchen and be the appropriate temperature prior to being served to the residents to prevent accidents such as this from occurring. The ADM stated there was no policy on accidents and hazards related to hot liquids spills caused by nursing staff. The ADM stated all liquids served to the residents should be 140 degrees or less to prevent burns. The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on 11/12/2024 and ended on 11/14/2024. The facility corrected the noncompliance before the survey began.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications (is a medication used: In excessive doses (including duplicate therapy); or For excessive duration; or Without adequate monitoring; or Without adequate indication for its use; or In the presence of adverse consequences which indicate the dose should be reduced or discontinued) for 1 of 6 residents (Resident #66) reviewed for unnecessary medications in that: The facility failed to ensure Resident #66 had documented diagnoses for the use of Humulin R (Regular insulin, also known as neutral insulin and soluble insulin, is a type of short-acting medical insulin. It is used to treat type 1 diabetes, type 2 diabetes, gestational diabetes, and complications of diabetes such as diabetic ketoacidosis and hyperosmolar hyperglycemic states). This failure could place residents at risk for adverse drug reactions (unintended, harmful events attributed to the use of medicines) and receiving unnecessary medications. Findings include: Record review of Resident #66's face sheet dated 11/19/24 indicated Resident #66 was a 76-years-old male admitted on [DATE] with diagnoses including malignant neoplasm of colon(a cancerous growth in the colon or rectum), unspecified, hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), and unspecified protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function). Resident #66 face sheet did not reflect diagnoses of diabetes mellitus. Record review of Resident #66's quarterly MDS assessment dated [DATE] indicated Resident #66 was understood and understood others. Resident #66 had clear speech, adequate hearing, and adequate vision. Resident #66 had a BIMS score of 15 which indicated intact cognition. Resident #66''s MDS assessment did not reflect diagnoses of diabetes mellitus. Record review of Resident #66''s care plan dated 10/17/24 indicated Resident #66 had diabetes mellitus. Diabetes medication as ordered by doctor. Monitor and document for side effects and effectives. Monitor and document report to MD PRN signs and symptoms of hypoglycemia: sweating, tremor, increased heartrate (Tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait. Record review of Resident #66's consolidated physician order active as of 11/12/24 indicated : * Humulin R Injection Solution (Insulin Regular) (Human)) Inject as per sliding scale: if 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	units; 401+ = 12 units Call MD, subcutaneously in the morning for diabetes mellitus. Ordered date 11/12/24 . Record review of Resident #66's hospital history and physical dated 10/08/2024 did not reflect diagnoses of diabetes mellitus. During an interview on 11/19/24 at 1:25 P.M., the DON was asked why Resident #66 did not have a diagnosis for diabetes mellitus and he took Humulin R insulin. The DON said Resident #66 came from the hospital with the insulin orders. She said the MD said he did not know why Resident #66 did not have a diagnosis for diabetes mellitus from the hospital. During an interview on 11/19/24 at 2:57 P.M., the MD said he glanced over hospital orders for new residents. He said he reviewed and glanced over hospital records when residents came from the hospital. The MD was asked why a diagnosis for diabetes mellitus was not in Resident #66's medical history. He said the hospital should had sent Resident #66 to the facility with a diagnosis of diabetes mellitus, because they sent him back on Humulin R insulin and Glucerna for tube feeding, which implied he had a diagnosis of diabetes mellitus. He said Resident #66 should have had the diagnosis for diabetes mellitus before he came to the facility. The MD said the records did not show Resident #66 had a diagnosis of diabetes mellitus, but the hospital was treating him as a diabetic. During an interview on 11/20/24 at 8:16 A.M., ADON B said everyone that was a nurse would be responsible for putting in a new resident's diagnosis and new orders, but most of the time the charge nurse or the admission nurse put that information in the system. He said ADON C or himself normally checked orders and diagnosis behind the charge nurse or admission nurse. He said the MDS nurse normally put in the diagnosis code. He said ADON C or himself normally checked the resident's orders to make sure the resident has a diagnosis for a medication. During an interview on 11/20/24 at 8:44 A.M., RN Q said the charge nurse was responsible for putting in the orders for a new or returning residents that came from the hospital. She said the MDS nurse normally put the diagnosis in the system. During an interview on 11/20/24 at 9:05 A.M., LVN S said we as nurses a responsible for putting in orders for a new or returning resident when they return from the hospital during an admission. LVN S said the charge nurses do admissions on the weekend, because the facility has an admission nurse during the week. She said when she put orders in, she put the medication and what it was for, but she did not know how to add a diagnosis. During an interview on 11/20/24 at 10:18 A.M., MDS R nurse said the facility had an admission nurse that put in the new admission orders and knew how to link the diagnosis with the orders. She said typically the admission nurse checks the diagnosis and put in the diagnosis when he put in the orders. She said normally one of the ADON's checked behind the admission nurse. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 10:24 A.M., ADON C said usually the residents has a diagnosis for diabetes mellitus if they have been diagnosed with it when they leave the hospital. She said she guess when looked at the diagnosis he should have had a diagnosis for diabetes mellitus. She said she usually the ADON's checked orders and diagnosis behind the admission nurse or charge nurses to make sure the orders are in the system and the admission was complete. She said the resident not having a diagnosis for diabetes mellitus was a rare incident, because he came from the hospital on insulin and glucerna . During an interview on 11/20/24 at 10:36 A.M., the DON said the MDS put in the resident's diagnosis. She said the admission nurse, charge nurse or any available nurse were responsible for putting the orders in the system. She said the ADON's were responsible for checking the any orders placed in the system. She said the ADON's does not check for the diagnosis; the MDS nurse checked the diagnosis . During an interview on 11/20/24 at 11:24 A.M., ADM said the DON was the overseer of all medications and orders. He said it was not just one person responsibility to check medication orders and diagnosis. He said all resident's diagnosis should be in the system because we need to know what we were treating the resident for. Record review of a facility's Administration of Medications revised date 07/2017 indicated .medications must be given in accordance with the resident's service plan .

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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** 44596 Based on interviews and record reviews, the facility failed to ensure a gradual dose reduction was attempted for 3 of 6 residents (Resident #1, Resident #13, and Resident # 37) reviewed for unnecessary medications/ gradual dose reduction in that: 1. The facility failed to ensure a gradual dose reduction (GDR) was attempted or document contraindication for a gradual dose reduction for Resident #1's ordered Risperdal (antipsychotic medication used to treat certain disorders by changing how the brain uses neurotransmitters) 4mg orally twice daily ordered 04/17/2024. 2. The facility failed to ensure a GDR was attempted or document contraindication for a GDR for Resident #13's Risperdal/risperidone 0.5 mg by mouth two times daily ordered on 3/09/23. 3. The facility failed to ensure Resident #37's Haldol and Risperidone (antipsychotic medications that treats several types of mental health conditions, including schizophrenia and bipolar disorder) medication had a specific, appropriate diagnosis for use. 4. The facility failed to ensure Resident # 37's PRN (as needed) Ativan (a medication used for anxiety) was discontinued or reviewed by a physician to extend usage after 14 days. These failures could place residents at risk for possible psychotropic medication side effects, adverse consequences, decreased quality of life and dependence on unnecessary medications. Findings included: 1. Review of the resident face sheet revealed, Resident #1 was a [AGE] year-old female that admitted on [DATE] with the diagnoses of Tourette's Syndrome (a neurological condition that causes people to have sudden repetitive and uncontrolled movements and sounds), dementia, and cerebral infarction (stroke). Review of the quarterly MDS assessment dated [DATE] indicated Resident #1 had a BIMS (brief interview of mental status) of 00, which indicated a severe cognitive impairment. The MDS revealed Resident #1 had short- and long-term memory impairment. The MDS revealed Resident #1 required limited assistance with ADLs. No hallucinations, delusions, behavior, rejection of care or wandering was noted on the MDS. Resident #1 received antipsychotic medication 7 days out of 7 days. Review of physician consolidated orders dated November 2024 for Resident #1 revealed an order for Risperdal 4 mg orally twice daily ordered 04/17/2024. Record review of the consultant pharmacist recommendations for January 2024 to November 2024, revealed no GDR for Resident #1's Risperdal 4mg twice daily medication with original order date of 04/17/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/2024 at 2:00 p.m., the DON stated there was no GDR for Risperdal for Resident #1. She stated she left it up to the pharmacist to know when each resident was due for a GDR and understand that CMS guidelines for the dose reduction. She stated their policy was to follow CMS guidelines. 2. Record review of Resident #13's face sheet dated 11/18/24 revealed she was [AGE] years old and admitted to the facility on [DATE]. Resident #13 had diagnoses of paranoid personality disorder (mental health condition marked by a pattern of distrust and suspicion of others without adequate reason to be suspicious), anxiety (feelings of worry, excessive fear, and anxiousness), dementia (loss of memory, language, problem-solving and other thinking abilities interfering with daily life), and depression (persistent feeling of sadness). Record review of Resident #13's annual MDS dated [DATE] revealed she had a BIMS of 15, which indicated she was cognitively intact. The MDS did not indicate Resident #13 had any behaviors. The MDS indicated Resident #13 received an antipsychotic medication. Record review of Resident #13's Order Summary Report dated 11/19/24 revealed an order for Risperdal (Risperidone) 0.5 mg by mouth two times daily related to Paranoid Personality Disorder with a start date of 3/09/23. Record review of Resident #13's care plan initiated on date 11/04/21 revealed she used Psychotropic medications related Personality disorder with an intervention to consult with pharmacy, Medical Doctor to consider dosage reduction when clinically appropriate. Record review of Resident #13's MAR dated 11/01/24-11/30/24 revealed she had an order for Risperdal (Risperidone) 0.5 mg give one tablet by mouth two times daily related to Paranoid Personality Disorder with a start date of 3/09/23. Record review of a letter from the Consultant Pharmacist dated 11/19/24 indicated . Resident #13 received risperidone for paranoid personality disorder/schizophrenia . two years ago in November 2022, she brought to Medical Doctor's attention that the risperidone may be contributing to Resident #13's restless leg syndrome and suggested a dose decrease in her risperidone even though that would typically not be recommended schizophrenic patient . he however, did not believe it to be contributing and instructed us to continue with the risperidone . in 2023, I followed up as seen in attached from them to clarify diagnosis and it was for paranoia not dementia behaviors and as such it would be detrimental to have a dose decrease . Record review of the facility's Consultant Pharmacist's Medication Regimen Review: Listing of Residents Reviewed with No Recommendations from January 2024 through October 2024, indicated the following was a list of residents which were reviewed during the consultant pharmacist's visit, but did not require any recommendations .Resident #13. During an interview on 11/19/24 at 11:28 AM, the DON said Resident #13 had a failed GDR and she provided documentation of a Note to Attending Physician/Prescriber dated 11/30/22 the physician disagreed with the recommendation to decrease Risperdal without any explanation or reason signed and dated 12/2/22. The DON also provided a nursing note dated 2/14/23 where new orders were received to discontinue Risperdal per physician and on 3/9/23 new orders were received to restart Risperdal 0.5 mg twice daily. The DON said no further GDRs had been attempted. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Record review of a face sheet dated 11/18/14 revealed Resident #37 was an [AGE] year-old male and was admitted to the facility initially on 06/04/20 and readmitted on [DATE] with diagnoses including vascular dementia (a type of dementia that occurs when blood vessels in the brain are damaged, reducing the flow of oxygen and nutrients to the brain) without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, depressive disorders, and stroke. Record review of Resident #37's quarterly MDS assessment dated [DATE] revealed he was understood and understood others. Resident #37 had a BIMS score of 14 which indicated no cognitive impairment. The MDS revealed there was no evidence of an acute change in mental status. The MDS indicated Resident #37 had diagnoses including non-Alzheimer's dementia, anxiety disorder and depression. The MDS indicated Resident #37 was receiving antipsychotic medications. Record review of Resident #37's care plan last updated 11/12/24 revealed he was receiving psychotropic medications related to behavior management. There was an intervention to administer medications as ordered and to monitor for sided effects and effectiveness. Record review of Resident #37's physician Order Summary Report dated 11/18/24 revealed an order for Ativan oral tablet 1 milligram, give 1 milligram by mouth every 4 hours as needed for anxiety. The start date for the Ativan was 10/24/24 and there was no end date. The Order Summary Report revealed an order for Risperidone tablet 0.5 milligrams, give 1 tablet by mouth two times a day for altered mental status with a start date of 11/12/24. Record review of Resident #37's MAR dated 10/01/24 - 10/31/24 revealed Resident #37 was ordered Ativan Oral tablet 1 milligrams, give 1 milligram by mouth every 4 hours with an order date of 10/24/24. Resident #37 was administered Ativan on 10/27/24, 10/28/24, and 10/29/24. The MAR revealed Resident #37 was ordered to receive Haldol Injection Solution 5 milligrams per milliliter, inject 5 milligrams intramuscularly one time only for delusions with an order date of 10/24/24. The medication was administered to Resident #37 on 10/24/24. Record review of Resident #37's MAR dated 11/01/24 - 11/18/24 revealed Resident #37 was ordered Ativan Oral tablet 1 milligrams, give 1 milligram by mouth every 4 hours with an order date of 10/24/24. Resident #37 was administered Ativan on 11/01/24, 11/04/24, 11/12/24, and 11/14/24. The MAR revealed Resident #37 was ordered to receive Risperidone Tablet 0.5 milligrams by mouth two times a day for altered mental status with a start date of 11/12/24. The medication was administered on 11/12/24 - 11/18/24. The MAR revealed Resident #37 was ordered to receive Haldol Injection Solution 5 milligrams per milliliter, inject 5 milligrams intramuscularly one time only for altered mental status and agitation. The MAR indicated Resident #37 received the injection on 11/12/24 in the left upper arm. Record review of a psychiatric Visit Note dated 11/12/24 revealed Resident #37 had current medication of Ativan 1 milligram every 4 hours as needed and Risperidone 0.5 milligrams two times a day. The note revealed the Ativan was for anxiety and the Risperidone was for Altered Mental Status. There were diagnoses of Vascular dementia, moderate, with anxiety and Vascular dementia, moderate, with psychotic disturbance. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a psychiatric Visit Note dated 11/19/24 revealed Resident #37 had current medication of Ativan 1 milligram every 4 hours as needed and Risperidone 0.5 milligrams two times a day. The note revealed the Ativan was for anxiety and the Risperidone was for Altered Mental Status for continuing behaviors. There were diagnoses of Vascular dementia, moderate, with anxiety and Vascular dementia, moderate, with psychotic disturbance. During an interview on 11/19/24 at 2:54 p.m., the DON said Resident #37 said God was telling him he needed to leave the facility. She said he had an issue last week (the week of 11/12/24) where he thought he was God. She said he was trying to fight the nurse. She said he was given a one-time dose of Haldol. She said appropriate diagnoses for the use of anti-psychotic medications was Tourette's, Huntington's Disease, and Schizophrenia. She said Resident #37 did not have any of those diagnoses. She said they do plan to take him off the Risperidone and were just hoping his symptoms were acute. During an interview on 11/19/24 at 3:40 p.m., the attending Physician said Resident #37 was now under the care of senior psychiatric services. He said they were following the recommendations of the psychiatric services. He said at first, he thought the behavioral symptoms were related to a urinary tract infection, but he no longer thought so. He said the symptoms were totally unrelated. He said appropriate diagnoses for the use of an antipsychotic medication was any acute psychosis, Tourette's, Schizophrenia, and Bipolar. During an interview on 11/20/24 at 9:50 a.m., the DON said the Ativan should have had a 14 day stop date. She said she would have expected the Ativan to have a 14 day stop date or the doctor to have put in a routine order. She said if there not being a stop date it could cause a resident to receive an unnecessary medication. She said altered mental status was not an approved diagnosis for anti-psychotics. She said she did not know how a resident receiving an anti-psychotic without an appropriate could negatively affect a resident. During an interview on 11/20/24 at 10:59 a.m., the RPH O said she reviews each resident's medications. She said Altered Mental Status was not appropriate diagnosis for the use of anti-psychotic medication. She said Tourette's, Huntington's Disease, and Schizophrenia were the appropriate diagnoses for use of anti-psychotic medications. She said residents were not supposed to be on PRN (as needed) medications for more than 14 days. She said over 14 days she would have alerted the facility. She said residents taking unnecessary anti-psychotic medications could have adverse effects such as falls. During an interview on 11/20/2024 at 1:15 p.m., RPH O stated she was unaware she had to make recommendations on residents that had a diagnosis of schizophrenia, Huntington's, or Tourette's. She stated she reviewed them but since she did not feel a change needed to be made, she made no documentation and no recommendations. She stated she made no recommendations for Resident #1 because she had Tourette's and she felt she needed the medication. She stated no recommendations were made for Resident #13 because she had an appropriate diagnosis. She stated any resident on PRN antianxiety medications needed the order renewed every 14 days. She stated not doing so could lead to the use of unnecessary medications. (continued on next page)

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	676049	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Healthcare and Rehabilitation - Paris	520 SE 8th St Paris, TX 75460

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled Psychoactive Medications dated 07/2024 indicated . Residents who use psychotropic medications shall be evaluated for gradual dose reduction unless clinically contraindicated, in an effort to discontinue these drugs . residents do not receive psychotropic drugs pursuant to an as needed PRN order unless medication was necessary to treat a diagnosed specific condition that was documented in the clinical record . PRN orders for psychotropic drugs were limited to 14 days . 46062 44128

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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** 48958 Based on observations, interviews, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 1 of 18 residents (Resident #40) reviewed for infection control practices. The facility failed to ensure LVN T performed hand hygiene after blood sugar was taken from a resident. LVN T entered Resident #40's room and did not perform hand hygiene prior to obtaining Resident #40's blood sugar and gave insulin on 11/19/24. These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections. Findings included: 1. Record review of Resident #40's face sheet, dated 11/19/24, indicated she was an [AGE] year-old female was admitted to the facility on [DATE]. Her diagnoses included diabetes Mellitus with hyperglycemia (elevated blood sugar, is a type 2 diabetes that can result in complications affecting various organs and increased risk of heart disease), acute on chronic diastolic (congestive) heart failure and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) unspecified. Record review of Resident #40's quarterly MDS assessment, dated 08/18/24, indicated she had an incomplete BIMS score, but was understood by others and made others understand. Diabetes mellitus was addressed on the MDS. Record review of Resident #40's care plan, dated 04/17/24, indicated she had diabetes mellitus on medications for diabetic management. Interventions: diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Fasting serum blood sugar as ordered by doctor. Monitor/document/report to MD PRN signs and symptoms of hypoglycemia: sweating, tremor, increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait. Monitor/document/report to MD PRN for sign and symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdomen pain, Kussmaul breathing, acetone breath (smells fruity), stupor, coma. Record review of Resident #40's orders indicated: Humulin R Injection Solution (Insulin Regular (Human)) Inject as per sliding scale: if 0 - 150 = none;151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401+= 12 units Call Physician, subcutaneously before meals for diabetes, dated 11/08/2024. Insulin Glargine Solution 100 UNIT/ML Inject 16 units subcutaneously in the morning for diabetes. Record review of LVN T'S competency for Orientation and annual skills checklist for licensed nurses dated 5/1/24. (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 on 11/19/24 at 7:03 A.M., LVN T left one resident's room without washing or sanitizing her hands, then entered Resident #40's room and took her blood sugar and administered her insulin, then sanitized her hands afterwards. During an interview on 11/19/24 at 1:28 P.M., LVN T said when she went from one resident to another resident she should gel in and gel out. She said she have did both hand washing and using hand sanitizer between residents, but hand washing should always be best choice. She said she felt uncomfortable answering the question, should she have had washed your hands before taking Resident #40's blood sugar and giving her insulin? She said improper hand hygiene can cause the spread of germs such as Covid. She said proper hand hygiene keeps infection control down along with PPE. During an interview on 11/19/24 at 2:51 P.M., LVN U said when a nurse checks one residents blood sugar before checking another resident's blood sugar hand hygiene should be performed, because that is a bodily fluid. She said improper hand hygiene can cause infection. She said she educated the nurses on hand hygiene all the time. During an interview on 11/20/24 at 8:16 A.M., ADON B said when a nurse goes from one resident's room to another resident's room to do a blood sugar and to give insulin, the nurse should wash their hands or at least sanitizer. He said improper hand hygiene can cause infections and cross contamination. During an interview on 11/20/24 at 8:44 A.M., RN Q said when a nurse goes from one resident's room to another resident's room after performed a resident's blood sugar and giving insulins; the nurses should have washed their hands. She when nurse does not wash their hands this could cause infection issues for the residents. During an interview on 11/20/24 at 9:05 A.M., LVN S said when a nurse obtained a blood sugar from one resident, then goes to another resident's room they should wash their hand. LVN S said a negative effect of improper hand hygiene could be infection. During an interview on 11/20/24 at 10:24 A.M., ADON C said when a nurse checked a resident's blood sugar, then goes to another resident's room to check their blood sugar and given insulin; the nurse should wash her hands. She said infections are the negative effects on the resident when proper hygiene was not performed. During an interview on 11/20/24 at 10:36 A.M., the DON said when a nurse took another resident's blood sugar, then goes to another resident's room to take their blood sugar and give insulin; the resident is at risk for infection. She said nurses should wash their hands before and after care of a resident. During an interview on 11/20/24 at 11:00 A.M., the ADM said he expected the nurses to perform hand hygiene before and after care of a resident. He said infection control issues occurred with improper hand hygiene. He said he all staff would be in-serviced on hand hygiene. Record review of the facility's Hand Hygiene policy, last revised 10/2022, stated: .It's the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. 2. Use an alcohol- based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. before and after direct contact with residents . c. before preparing or handling medications . i. after contact with resident's intact skin . j. after contact with blood or bodily fluids . Record review of the facility's Infection Control Policy/ Procedure for Glucometer, Cleaning and Decontamination, last revised 12/2009, stated: It is the policy of this facility to follow recommendation form the CDC. The CDC states the HBV can survive for at least one week in dried blood on environmental surfaces or on contaminated instruments. The following recommendations provide the guidance for cleaning and decontamination of glucometers that may be contaminated with blood and body fluids . Record review of the facility's Infection Control policy, last revised 12/2023, stated: The infection prevention and control program was a facility wide effort involving all disciplines and individual and is an integral part of the quality assurance and decreased the risk of infection to residents and personnel performance improvement program . The program will be carried out by the facility infection preventionist. It was the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards .3.The facility personnel will conduct themselves and provide care in a way that minimizes the spread of infection . b. facility personnel will wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice .

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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** 44128 Based on interview and record review, the facility failed to maintain an antibiotic stewardship program that included a system to monitor antibiotic use, for 1 (Resident #37) of 18 residents reviewed for antibiotic use. The facility failed to conduct appropriate monitoring of antibiotic use for Resident #37 by not including the resident in the Tracking and Trending Log when he was treated for a urinary tract infection. These failures could place residents receiving antibiotics at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased antibiotic-resistant infections. Findings included: Record review of Resident #37's face sheet dated 11/18/24 revealed he was [AGE] years old and admitted to the facility initially on 06/04/20 and readmitted on [DATE] with diagnoses including vascular dementia (a type of dementia that occurs when blood vessels in the brain are damaged, reducing the flow of oxygen and nutrients to the brain), functional urinary incontinence, and stroke. Record review of Resident #37's quarterly MDS assessment dated [DATE] revealed he was understood and understood others. Resident #37 had a BIMS score of 14 which indicated no cognitive impairment. The MDS did not reveal Resident #37 had a urinary tract infection in the last 30 days. The MDS revealed Resident #37 was taking an antibiotic. Record review of Resident #37's care plan last updated 11/12/24 revealed he had a urinary tract infection with an intervention to give antibiotic therapy as ordered and to monitor/document for side effects and effectiveness. Record review of a Hospital History & Physical dated 10/23/24 revealed Resident #37 was admitted to the hospital minimally positive urinalysis (urinary tract infection) and antibiotics were started. Record review of hospital records dated 10/24/24 revealed Resident #37 was discharged on the hospital on 10/24/24 and to start taking Ciprofloxacin HCl (an antibiotic commonly used for urinary tract infections), 500 milligrams, twice a day. Record review of consolidated physician's orders for Resident #37 revealed an order for Cipro Oral Tablet 500 milligrams, give 500 milligrams twice a day. The order had a start date of 10/24/24 and an end date of 10/29/24. Record review of a MAR dated 10/01/24 - 10/31/24 for Resident #37 revealed an order for Cipro Oral Tablet 500 milligrams, give 500 milligrams two times a day for infection for 5 days. The medication was administered to Resident #37 beginning 10/24/24 and ending on 10/29/24. (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 an Infection Surveillance form dated 10/31/24 revealed Resident #31 had been diagnosed with a urinary tract infection. Resident #37 had started a treatment of Cipro 500 milligrams, twice a day for 5 days beginning 10/24/24. Record review of Tracking and Trending for antibiotic use for October 2024 revealed Resident #37 was not monitored concerning his use of antibiotics. During an interview on 11/20/24 at 9:03 a.m., ADON C said she was the Infection Preventionist. She said once the antibiotic was written she checks the orders. She said she then completed an infection control evaluation assessment to see if the resident met criteria. She said if the resident did not meet criteria, she contacted the doctor to make sure they wanted the resident to stay on the antibiotic. She said then each resident was then color coded on the tracking and trending map. She said if she saw a trend, she then initiated in-services for staff. She said residents that were diagnosed in the hospital were included in this process. She said Resident #37 should have been included. She said anyone with a urinary tract infection or was on an antibiotic should have been included. She said someone not being included on tracking and trending would make it inaccurate. She said the tracking and trending log not being correct would cause monitoring information incorrect and appropriate in-services might not be completed. She said depending on what the infection was it could potentially cause the spread of infection. She said she was not sure why she had not added Resident #37 to the tracking and trending log. During an interview on 11/20/24 at 9:50 a.m., the DON said she would have expected Resident #37 to have been monitored for antibiotic stewardship. She said the resident not being included could affect the tracking and trending to see if there was a problem with urinary tract infections in his setting. During an interview on 11/20/24 at 1:20 p.m., the Administrator said he would have expected the Infection Preventionist to have monitored Resident #37 for the use of antibiotics. He said he expected staff to follow the rules. He said you must monitor the residents so that you can see the results antibiotic use. Record review of an Antibiotic Stewardship facility policy last revised on 12/2023 indicated, .It is the policy of this facility to implement an Antibiotic Stewardship Program (ASP) that is incorporated in the overall Infection Prevention and Control Program which will promote appropriate use of antibiotics while optimizing the treatments of infections, at the same time reducing the possible adverse events associated with antibiotic use. This policy has the potential to limit antibiotic resistance in the post-acute care setting, while improving treatment efficacy and resident safety, and reducing treatment-related costs. This policy will include basic elements about antibiotic resistance and opportunities for improvement .The team will .track measure of outcome surveillance related to antibiotic use .incorporate monitoring of antibiotic use .