STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676059	A. Building B. Wing	02/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Westchase	11910 Richmond Ave Houston, TX 77082

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48923 Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 21 (Resident #44) residents for dignity. -RT A pushed Resident #44 into the dining room with his catheter bag strapped onto his leg which had urine in it and was exposed with no privacy cover. This failure could put residents at risk of psychosocial distress from failure to protect their dignity. Findings included: Record review of Resident #44's face sheet last captured 02/20/2025 revealed a [AGE] year-old male originally admitted on [DATE] and most recently admitted on [DATE]. His medical diagnoses included cognitive communication deficit, muscle wasting and atrophy (decrease in muscle function), Type 2 Diabetes Mellitus, and Alzheimer's Disease. Record review of Resident #44's Quarterly MDS dated [DATE] revealed a BIMS (assessment for resident's cognition) score of 00, indicating severe cognitive impairment. Resident #44 required partial assistance with eating, oral hygiene and upper body dressing and required total assistance with toileting, showering or bathing self, lower body dressing and putting on and taking off footwear. Record review of Resident #44's care plan last revised on 02/06/2025 revealed Resident #44 was care-planned for attempts pulling the FC (foley catheter) tubing out secondary to poor decision making and will place foley bag on top of the bed even after being educated on having the bag needed to lower than bladder, with interventions including: monitoring behaviors and documenting number of episodes and reminding and educating resident on importance of keeping the foley catheter tubing locked. Observation on 02/18/2025 at 12:25pm, Resident #44 was wheeled into the dining room by RT A with the resident's exposed foley bag strapped to his left leg with some urine noted in the bag. Resident #44 was wearing shorts at the time. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with ADON on 02/18/2025 at 12:25pm, she said that the foley bag being exposed was an issue with dignity and that she would not want people to know she had one. She said she would not have brought Resident #44 to the dining room without covering up the bag or have the resident wear long pants, which is why the Activities Director brought out a blanket to cover his waist down. Interview with RT A on 02/20/2025 at 9:30am, he said that the catheter bag needed to be covered and having it exposed affects a resident's dignity and privacy. RT A said he was coming down the hall and saw Resident #44 was coming from the gym, and when RT A saw his catheter bag exposed, he asked a staff member why his catheter bag was not covered. RT A then saw another resident about to fall in the hall so RT A left Resident #44 near the door of the resident's room to assist the other resident. When RT A came back to Resident #44's room, Resident #44 pointed to the dining room, so RT A wheeled him there and forgot to check on if the catheter bag was covered. He stated being trained on resident privacy and dignity . Record review of the facility's policy on urinary leg draining bags last revised October 2010 read in part, General Guidelines .4. Maintain privacy of drainage bag under resident clothing.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32422 Based on Record review and interview, the facility failed to transmit encoded, accurate, and complete MDS data to the CMS System within 14 days after a facility completes the resident's assessment for 2 out of 3 residents, (CR #96 and CR #97) reviewed for MDS transmission. -The facility failed to transmit a completed Discharge MDS assessment for CR #96 within 14 days of completion. -The facility failed to transmit a completed Discharge MDS assessment for CR #97 within 14 days of completion. These failures could place residents at-risk of not having their assessment completed and submitted timely, which could result in denial of services and or payment for services. Findings included: Record review of CR #96's Admission Record revealed a [AGE] year-old male. CR #96 had an admitted [DATE] and discharge date of [DATE]. CR #96 diagnoses included acute on chronic systolic (congestive) heart failure (refers to a sudden worsening of symptoms in a patient who already has a chronic condition of systolic heart failure, meaning their heart muscle is weakened and cannot pump blood effectively, causing congestion in the body due to fluid buildup) and other abnormalities of gait (any unusual or irregular patterns of walking or movement that aren't categorized as a specific, well-defined gait abnormality). Record review of CR # 96's Discharge MDS assessment dated [DATE] revealed the assessment was not transmitted to CMS. Record review of CR #96's Discharge plan of care dated [DATE] revealed that CR #96 was discharged home with home health, PT, OT, and transition to home. CR #97 Record review of CR #97's Admission Record revealed a [AGE] year old male. CR #97 had an admitted 10/ , d+[DATE] and discharge date of [DATE]. CR #97 diagnoses included Traumatic subdural hemorrhage with loss of consciousness status unknown (means a bleeding collection of blood within the brain's outer layer (subdural space) caused by a head injury, where the medical team cannot determine whether the patient lost consciousness following the injury due to a lack of information or the patient's condition at the time of assessment; essentially, it indicates a head injury with a potential brain bleed where the level of consciousness is not definitively known) and Epilepsy (A group of disorders marked by problems in the normal functioning of the brain. These problems can produce seizures, unusual body movements, a loss of consciousness or changes in consciousness, as well as mental problems or problems with the senses). (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of CR # 97's Discharge MDS assessment dated [DATE] revealed the assessment was not transmitted to CMS. Record review of CR #97's Discharge Summary dated [DATE] read Note Text: Resident discharged home with his personal belongings. Discharge instructions and he verbalized understanding. Picked up by family member and resident ambulated on his own out of facility to personal car. An interview on [DATE] at 9:37 am with the MDS Coordinator she said that the Discharge MDS assessments for CR #96 and CR #97 should have been transmitted to CMS within 14 days and they were not. She said the facility uses the RAI Manual. She said there would be no harm to the resident, but the negative outcome would be that the facility would not be in compliance. She said the facility also has another staff member to help with MDS assessments when needed, the facility transmits assessments weekly, the MDS assessments that were not transmitted were missed. During an interview on [DATE] at 1:46 pm, with the Administrator she said that the expectation would be that the MDS assessments were transmitted based on policy. She said the negative outcome would be that the facility would not be in compliance with the regulations. An interview on [DATE] at 9:27 am with RN W, she said she has completed and transmitted CMS assessments at other facilities and has been placed to assist with assessments currently but has never had to assist because they prior MDS Coordinator and the current MDS Coordinator have never needed her assistance. She said that the RAI Manual was used as the facility policy for assessments. Record review of the CMS's RAI Version 3.0 Manual, Chapter 5: Submission and Correction of The MDS Assessment revised ,d+[DATE] revealed:5.1 Transmitting MDS data- All Medicare and/or Medicaid-certified nursing facilities or agents of those facilities must transmit required MDS data records to CMS. 5.2 Timeliness Criteria- completion timing. For all other comprehensive MDS assessments, Annual assessment updates. the completion may be no later than 14 days from the ARD. Upon a resident's entry, discharge to community, discharge to another facility or discharge deceased , a subset of items but be completed within 7 days of the Event Date.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36918 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain nutrition, grooming and personal and oral hygiene for 1 of 5 residents (Resident #31) reviewed for ADLs. The facility failed to ensure Resident #31was provided personal grooming (facial hair on the chin and under the chin) by facility staff. This failure could place residents at risk for not receiving the assistance needed for daily care and services Findings included: Record review of Resident #31's sheet dated 02/19/25 revealed a [AGE] year-old female was initially admitted to the facility on ,d+[DATE]//21 and readmitted on [DATE]. Resident #31 had diagnoses included: chronic kidney disease (a condition where kidneys are damaged and cannot filter blood properly), diabetes mellitus (body do not produce enough insulin or use it properly) and heart failure (heart cannot pump enough blood to meet the body's needs). Record review of Resident #31's Quarterly MDS assessment dated [DATE] revealed Resident BIMS was 09 which indicated moderately impaired cognition. Resident #31 required extensive assistance with ADL with one staff assistant. Further review revealed the resident was incontinent of bowel and she had an indwelling catheter. Record review of Resident # 31's care plan revision on 11/20/24 revealed Resident #31 had ADL self-care performance deficit related to confusion, and impaired balance. Interventions: personal hygiene read the resident requires assistance of 1 staff participation with personal hygiene and oral care. During an observation on 02/18/25 at 9:50 a.m., Resident #31 had a facial hair on and under on her chin, and under her chain was black and white hair. During an interview on 02/18/25 at 9:50 a.m., Resident #31 said she wanted her facial hair shaved, and she had told the aides to shave her, but the aides did not, and she could not remember the aide's names. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/18/24 at 12:58 p.m., CNA C said she saw Resident #31 had facial hair on her chin and under her chin but did not shave Resident #31 because her shower days were during the evening shift. CNA C said the aides are responsible for shaving Resident #31, and she should be shaved on shower days and as needed. CNA C said Resident #31 shower days are on Tuesday, Thursday, and Saturday during the evening shift. CNA C said if Resident #31 wanted to be shaved and she was not shaved, Resident #31 may feel bad. CNA C said she had skills, such as check-off and in-service on ADL, which included shaving. CNA C said her training included asking the resident if the resident needed shaving whenever the resident had facial hair, and CNA C did not respond when she was asked why she did not ask Resident #31 if she needed to be shaved. CNA C said the nurses monitored the aide when the nurse made rounds. During an interview on 02/19/25 at 8:04 a.m., the IP said Resident #31 showers are scheduled three times a week and are on Tuesday, Thursday, and Saturday. The IP said Resident #31 should be shaved by the aide on shower days and as needed. The IP said Resident #31 should not have to ask to be shaved because it was part of the ADL care. The IP stated that unless the resident did not wish to be shaved, it was part of Resident #31's right to refuse care. The IP said Resident #31 would not feel very good because ladies want to look nice. The IP said the aides were responsible for shaving Resident #31, and the charge nurses monitored the aides. The IP said the nurse managers monitored the nurses during rounding. The IP said the aides had skills -check off, but she was unsure if it included shaving. The IP said the aides should check off on the POC if the aide shaved a resident. During an observation on 02/19/25 at 9:00 a.m., Resident #31 still had facial hair on her chin and under her chain. Resident #31 said she was not showered by the aide yesterday, and she thinks the aide showered two days ago, but the aide did not shave her. Resident #31 said CNA E did not ask if she needed to be shaved today. During an interview on 02/19/25 at 10::11 a.m., LVN S said when he made rounds yesterday (02/18/25) and today (2/19/25), he did not notice any facial on Resident #31chin. LVN S said the aides are supposed to shave Resident #31 on shower days and PRN. LVN S said none of the aides had told him that Resident #31 refused to shave. LVN S said Resident #31 would be depressed because female residents do not want facial hair. LVN S said CNA E did not tell him today (02/19/25) that Resident #31 refused to shave. During an interview on 02/19/25 at 10:53 a.m., the DON said the aide should ask the resident if the resident needed shaving, and Resident #31 wanted her daughter to shave her. The DON said the facility had no documentation of Resident #31 refusing to be shaved or wanting her daughter to shave her. The DON said Resident #31 would feel bad if she wanted her facial hair shaved, but the staff did not. The DON said she had never heard Resident #31 refuse to shave. During an interview on 01/20/25 at 12:04 p.m., FM #1 said she did not tell the facility that Resident #31 preferred for her to pluk or shave her. FM #1 said she lives out of state, and she even told the facility for staff to pluck or shave Resident #31, and she would pay for the services. FM #1 said Resident #31 had not told her she wanted her to be the person to shave her. Record review of the facility policy on shaving dated 2001MED - PASS, Inc. Revised December 2007 read in part . the purpose of this procedure is to promote cleanliness and to provide skin care .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** 36918 Based on interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as possible and that each resident received adequate supervision and assistance devices to prevent accidents for 1 out of 23 residents (CR #1) reviewed for adequate supervision. -CR #1 left the faciity on [DATE] on pass and did not return. The facility did not know where he was and did not make attempts to locate CR#1. This deficiency exposed residents living in the facility to potential harm, injury or death due to not being adequately monitored. An Immediate Jeopardy (IJ) was identified on 02/21/2025. The IJ template was provided to the facility on [DATE] at 11:13am. While the IJ was removed on 02/21/2025 at 1:40pm with the Administrator, DON, and Regional VP of Operations. While the IJ was lowered, the facility remained out of compliance at a scope of isolation and a severity of harm with potential for more than the minimal harm that is not an immediate jeopardy because all staff had not been trained on adequate supervision when residents leave the facility and elopement protocols. Findings: Record review of CR #1's face sheet dated 02/20/25 revealed a [AGE] year-old male was admitted to the facility on ,d+[DATE]//24. CR #1 had diagnoses included: cerebral infraction (stroke), traumatic subdural hemorrhage (bleeding that happens between the brain and the skull), hemiplegia and hemiparesis affecting right dominant side (paralysis on one side of the body, and weakness on one side of the body), Raynaud's Syndrome without gangrene (decreased blood flow to the fingers), acute metabolic acidosis (collection of conditions that often occur together and increased risk of diabetes, stroke and heart disease), and pigmentary glaucoma (right eye, severe stage) (pigments flakes from the iris and blocks the eyes drainage system). Record review of CR #1's admission MDS assessment dated [DATE] revealed CR #1 BIMS was 15 which indicated intact cognition. CR #1 required touching to limited assistance with ADL with one staff assistant. Further review revealed the resident was incontinent of bowel and bladder. Record review of CR #1's care plan revision on 02/06/25 revealed CR #1 had ADL self-care performance deficit, requires assistance. Interventions: ensure frequently used items are within reach. Further review revealed CR#1 had the potential for S/S of complications of cardiac problem related to coronary artery disease. Intervention: document and report to MD for S/S of fatigue, muscle weakness, nausea, and vomiting. CR#1 has cerebral vascular accident. Intervention: observe/document/report MD for neurological deficits: level of consciousness, dizziness, and weakness. CR #1 was on anticoagulant therapy (when residents take blood thinners for treatment of heart diseases) related to cerebral infraction. Intervention: observe/document/report to MD S/S of anticoagulant complications: sudden severe headaches, bruising, SOB, sudden changes in mental status. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of CR #1's AMA documentation was dated 01/16/25 at 6:00 a.m. and signed by the Physician. Record review of CR #1's on-pass sign-out sheet revealed CR #1 signed out on 01/16/25 and did not sign back in. Record review of CR #1 progress note dated 01/16/25 by LVN QQ read CR #1 out on pass this a.m., in stable condition. Record review of the hospital record dated 01/16/25 revealed CR # 1 was admitted to the hospital at 8:28 p. m., with admitting diagnosis code: Stroke. The records stated that he was at home watching TV and woke up with some vomiting which was unusual for him and unable to move his right hand and had some numbness. He then took himself to the hospital. Interview on 2/19/2025 at 5:20pm with the Administrator and the DON, the Administrator said CR #1 was his own RP. When he left no one at the facility was able to contact him. CR#1 went out on pass often. The Administrator said she did not know if the Ombudsman was informed that CR#1 left the facility. The DON said CR#1 was medically stable when he left the faciity on [DATE]. Record review of the facility's incident/accident log from September 2024 to February 2025 revealed CR#1 was not listed as having any incidents or accidents. Interview on 2/20/2025 at 2:33pm with MA B stated she worked all shifts. She stated observed CR#1 leaving theh facility with his backpack on 1/16/2025 around 9:30 am to 10:00 am and did not know if CR#1 had told someone he was leaving. MA B said CR#1 did not complain about any health conditions at the time. She did not know if CR#1 was coming back or not, but CR#1 left frequently, and she figured he would come back. MA B said resident would tell their nurse who has the logbook and residents would sign out and sign in when they arrive back to the facility. CR#1 would stay out for not long, and he would run a couple of errands and come back. MA B did not know if CR#1 came back that particular day or not, and when the resident did not return, the DON asked staff if anyone saw him leave so MA B told her she saw CR#1 exit the facility with his backpack. MA B did write a statement on what she saw. She worked until 5pm the next day, and remembered the facility was looking for CR#1 before that time. The DON called the code, asked staff to look down the hall for CR#1 and also searched his room, activities room, and staff conducted a perimeter search outside the facility. MA B said she did not get an update on what happened to CR#1 after he left. CR#1 was quiet, reserved and kept to himself and he did not have a roommate while he was at the facility. MA B said CR#1 was oriented times three (he was oriented to himself, place and time). MA B said residents who leave would get assessed by a nurse before they left and after they come back. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 2/20/2025 at 3:09pm, LVN QQ stated he worked 6a-2pm and he said he was on duty on 01/16/2025 when CR#1 left. He was not sure when CR#1 signed out. LVN QQ saw CR#1 come up to the front desk that day but LVN QQ was not paying close attention to him. CR#1 would say he was grown and that he didn't like when staff asked him where he went. To LVN QQ's knowledge, CR#1 never left the facility without signing out. LVN QQ did not look for CR#1 because he would always come back the next shift. The facility had a sign out book sitting on the counter and each resident had their own sheet. CR#1 knew how to access his own sheet because the book is in alphabetical order. The last time LVN QQ saw CR#1, he left in a stable condition. LVN QQ would visually look at residents before they left, and to him CR#1 was walking and LVN QQ didn't see anything going on that was concerning. LVN QQ could not remember much as he was working down the hall. LVN QQ found out CR#1 did not return to the facility the next day. Interview on 2/20/2025 at 4:10pm, LVN B stated she worked on 2p-10p shift. She said the facility tells residents nurses need to know where they're going so nurses can account for residents. Nurses talked to residents to make sure they're fine before leaving. Nurses are to conduct assessments before and after residents come back to make sure they're fine, if they have any pain, and how their outing was. She said CR#1 was alert and oriented times four. CR#1 knew the binder/book and several occasions LVN B told him to let people know when he was leaving. LVN B got a report that day that he left. He would leave as early as 6am and come back between 7:00 pm to 8:00 pm. When it was 9:00pm that day, LVN B sent a message to the DON to let her know CR#1 did not come back yet. LVN B called the phone number on CR#1's facesheet but it was not active, and she documented the call attempt. She heard the DON came to the facility that night but she left at 11:00 pm before the DON came. LVN B did not do any other documentation for CR#1, and on her rounds she did not see him either and that was unusual to her. When LVN B returned to work the next day, she knew the DON reached out to CR#1's physician but did not know what else the DON did as part of management duties. LVN B knew CR#1 still did not come back the next day. Interview on 2/20/2025 at 4:25pm with the DON, she said when the facility had a brand new resident, they educate them on on-pass protocols and initiate a new sing out sheet. Residents were taught to sign in, sign out and always let staff know they are going out. The binder was accessible to residents. For alert residents they could sign themselves out and let a nurse know verbally that they were leaving. The DON said for residents on skilled, they needed to be back by midnight and if not insurance would not pay. Before residents left on-pass, the facility would make sure they received therapy. For CR#1's case, the nurse called the DON and she made attempts to contact him that night and the next morning. The DON had progress notes documenting the attempts. The DON said she did not call the police because CR#1 was awake, alert and he left the facility every day and it was nothing new. She did not recall consulting with corporate if this incident was reportable or not. The DON did not worry because CR#1 left in a stable condition while at the facility. She said a visual assessment consisted of visually making sure the resident was stable, capable, alert and did not have shortness of breath. She said she found out CR#1's status of being in the hospital on 02/20/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with MD A on 2/20/2025 at 4:57pm, he was CR#1's primary physician. He said the facility notified him that CR#1 left on 1/16/2025 and he was told on 1/17/2025 that CR#1 did not return. MD A said he and the facility waited a full day to see if they could find the resident and conducted a search. He said the facility did everything they could. The facility informed him on 1/16/2025 at night that CR#1 left and when MD A came on 1/17/2025 for rounds he signed the AMA paperwork. MD A said he signed the AMA paperwork because CR#1 left and did not come back, and that's what MD A said the protocol was and that's what had done. CR#1 would go to appointments, but this time was different. The facility told MD A that they tried to look for the resident. The MD said he was trying to get CR#1 a long-term care bed. CR#1 had a lot of co-morbidities, and he was a very sick resident so that's why he needed to be at a facility like this one. CR#1 had agreed to be a LTC resident. MD A said CR#1 could make some decisions on his own and that cognitive impairment was not too bad. The facility still had not found CR#1 the next day. The Administrator was at the facility on 1/17/2025 and MD A and they both did the AMA paperwork. The facility did mention to him that CR#1 was found, and he did not receive any other updates. The nurses told MD A that CR#1 went out that day without telling anyone which was normal for CR#1. MD A said he was worried about CR#1 and told the facility to keep looking out for CR#1 and get in touch with emergency services and any of CR#1's contacts since that was the usual protocol. If CR#1 was found through emergency services, they would have notified the facility. If MD A knew the resident went to the hospital, he would have gone there to check on him, or the hospital would communicate with the facility about the resident, and MD A would find out about the resident's condition through the facility. (continued on next page)

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	676059	A. Building B. Wing	02/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Westchase	11910 Richmond Ave Houston, TX 77082

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with the Administrator on 02/20/2025 at 5:20pm, she said that the facility would see if residents were able to come and go on-pass based on cognition and also if residents were their own RP. The facility would also involve a resident's emergency contact, especially if residents left and came back with someone listed in their records. CR#1's physician was aware he would leave and come back. it was not uncommon for CR#1 to sign out and leave the facility. The facility required residents going out on-pass to sign in and out of the facility and nurses are to make sure residents were alert and make note of resident status. Nurses would assess the resident to make sure they were stable, but the Administrator did not know if nurses checked resident vitals. In her point of view, residents can leave on-pass if they are able to self-direct their own care and that residents' physicians would know if they were able to take care of themselves. it was not uncommon for CR#1 to sign out and leave the facility. was high-functioning with a BIMS score of 15 (he was cognitively intact) and would leave with his FM and took public transportation from what she understood. The Administrator said nurses assessed residents throughout the day so not assessing when residents left on-pass would not be harmful to residents. MA A saw CR#1 leave with his backpack and LVN QQ said CR#1 left when he came to the facility on his shift at 6a-2p. She said nurses are expected to come to the facility 15 minutes before the start of their shift. The Administrator said the facility called his phone number in his clinicals, but it did not work. The phone number for his family member also did not work. The Administrator called the rehab facility CR#1 was at from 1/23/2025 to 2/12/2025 and they had the same phone number she had. If a resident signed out and did not come back, the facility would make an attempt to reach the person to get a timeline, but his number was not work at the time and the facility documented attempts to reach him. The police were not notified. The facility did not note the resident to be missing, since he was daily directing his own care. The facility did not suspect the resident was in danger or missing based off of his habits. The Administrator said CR#1 told someone he was not feeling well, packed his bags and left the facility, telling someone he was going to the hospital. According to hospital records the Administrator received on 2/20/2025, the resident stated he was at home watching TV when he went to the hospital. On a number of occasions, CR#1 said he would go back to his prior arrangement. The resident met with someone who was helping him go to a group home and the Administrator said she would look for the documentation. She reported CR#1 leaving to the corporate side and to CR#1's physician. No one in corporate said CR#1 leaving was reportable to her knowledge. After CR#1's physician was notified, CR#1 was given AMA and the physician did not give any orders to continue to look for the resident given CR#1's health status, cognitive status and his habits. Record review of the facility's policy on Signing Residents Out last revised August 2006, the policy read in part, 1. Each resident leaving the premises (excluding transfers/discharges) must sign out . 3. Staff observing a resident leaving the premises and having doubts about the resident being properly signed out, should notify their supervisor at once .6. Inquiries concerning the signing out of residents should be referred to the Director of Nursing Services or to the Administrator. Record review of the facility's policy on Discharging the Resident without a Physician's Approval revised October 2012, the policy read in part, This was determined to be an IJ on 02/21/2025 at 11:13am. The DON was notified. The Administrator and DON were provided with the IJ template on 02/21/2025 at 1:19pm and a Plan of Removal was requested. The following plan of removal was accepted on 02/21/2025 at 4:12pm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Plan of Removal [Facility Name] Plan of Removal F689 2/21/2025 [Facility Name] submits the following Plan of Removal for the alleged failure to ensure residents remain free from accidents and hazards. What corrective actions have been implemented for the identified residents? CR#1 is no longer a resident at the time of this plan of removal. No corrective action possible to be taken for CR#1. How were other residents at risk to be affected by this deficient practice identified? An audit of all residents who go out on pass within the last 30 days was conducted by the DON on 2/21/25 to ensure that adequate supervision and follow-up was completed for these residents. At the time of the audit, it was noted that there are fifteen residents who routinely go out on pass and no additional supervision or follow-up was required. These residents were verified to be in-house by the DON on 2/21/25. All residents who leave out on pass have the potential to be affected by this alleged deficient practice. All residents who reside in the facility have the right to go out on pass and physician orders are not required to do so. What does the facility need to change immediately to keep residents safe and ensure it does not happen again? CR#1 is no longer a resident of the facility as of 2/21/25. All nursing staff, including CNAs, CMAs and nurses to be in-serviced by DON/Designee on ensuring adequate supervision for residents who leave out on pass and do not return. Additionally, they will be in-serviced on reviewing care plan interventions specific to residents going out on pass. This will be completed by 2/21/25. This includes notifying the administrator, DON and appropriate law enforcement agencies when a resident does not return from being out on pass. What corrective actions were taken? 1. The following actions were initiated immediately on 2/21/25. a. On 2/21/25 an audit was completed by DON (Director of Nursing) to ascertain all residents who go out on pass to ensure that their care plans reflected as such. The facility PPS nurse received this list from the DON and will update and revise all resident care plans for those who go out on pass. This will be completed by end of business 2/21/2025. b. DON and Administrator were educated on 2/21/25 by RVP (Regional [NAME] President of Operations) and CSD (Regional Clinical Services Director) on ensuring adequate supervision and follow up for residents who leave out on pass and do not return. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	c. Newly hired nurses and CNAs to be in-serviced during orientation by DON/Designee on proper procedure for residents who leave out on pass and do not return. d. In-services conducted by DON with nursing staff (CNAs, LVNs, RNs, CMAs) on 2/21/2025 regarding residents signing out on pass, reviewing and completion of the resident sign out book, and what to do if they do not return from being out on pass. This would include notifying the Administrator, MD and DON, attempting to contact the resident or RP, searching the premises, and (if resident is unable to be contacted or located) notifying local law enforcement and APS. In-services for all nursing staff to be completed by end of day 2/21/2025. e. Nursing staff will not be allowed to provide direct care until completion of in-services regarding residents signing out on pass, what to do if residents do not return from being out on pass and following care plan interventions. f. The facility chief nursing officer reviewed and revised the facility sign-out policy on 2/21/25 to reflect actions needed when a resident does not return from being out on pass. g. All residents who reside in the facility have the right to go out on pass and physician orders are not required to do so. h. Facility social worker/designee to audit and correct all active resident charts to verify contact information is up to date for the resident and/or RP. This will be completed by end of day 2/22/25. How will the system be monitored to ensure compliance? Nursing staff will review residents sign out book during shift change to identify any residents who are out on pass. If a resident is out on pass greater than eight hours the nursing staff will attempt to contact the resident or RP to ascertain their whereabouts and wellbeing. If unable to reach the resident or RP the nursing staff will notify the DON, MD, and appropriate law enforcement agencies. DON/Designee will review resident sign out book as part of the morning meeting process to ensure residents and staff are following the facility out on pass policy. Quality Assurance An impromptu Quality Assurance and Performance Improvement review of the plan of removal was completed on 2/21/22 with the Medical Director. The Medical Director has reviewed and agrees with this plan. Monitoring/Observations/Interviews/Record Reviews Record review of the IJ plan binder: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-The facility's policy for signing residents out last revised 02/21/2025, read in part, If a resident who has signed out has not returned the same day, then the staff will notify the DON and/or the Administrator. Facility staff will attempt to contact the resident/responsible party to determine whether the resident will be returning to the facility on another date. If the resident or responsible party cannot be reached, then the DON and/or the Administrator will initiate an immediate search of the premises. If the resident is not found during this search, then the DON/Administrator will notify local law enforcement/APS. -QAPI Signature page dated 2/21/25 related to CR#1's discharge 1/16/25, Administrator and Medical Director signed along with facility department heads. In-service sheet dated 2/21/2025 regarding team update on resident safety. -List of 25 residents highlighted with history of OPT (going out on past) in past 30 days, care plans were updated to include focus area of going out on pass with interventions which included ensuring resident has facility information, ensuring resident signs the out on pass book and notify when resident returns, and staff will verify resident has returned at the end of their shift monitoring if there is any change in condition, initiated 02/21/2025. -1 to 1 in-service record dated 02/21/2025, topic included residents leaving AMA versus residents out on pass, policy education and review. It read in part, out on pass isn't considered AMA if they don't return. A search must be performed as they are a missing resident. If they want to leave, they must fill out AMA paperwork or if refused to sign must make intentions known otherwise if any resident who leaves will be treated as a missing resident regardless of his or her BIMS. The in-service was completed by the Regional Nurse and Regional VP of Operations -In-service for nursing staff dated 02/21/2025 from 9:30am to 9:50 am completed by the Administrator which covered the Signing Resident Out policy last revised August 2006. This included sign-in, sign-out procedure, out on pass procedure including residents exiting the building must sign out and if staff recognized a resident had not returned that it be reported to Administrator. -In-service for nursing staff dated 02/21/2025 at 10:00 am completed by the DON, which covered residents who have gone out in the past and have not returned to the facility is considered missing residents. -In-service for staff dated 02/21/2025 at 3:40pm and ongoing, which covered checking resident care plans and interventions for those who go out on pass, residents signing out for a pass, nursing documentation being completed, ensuring residents return in stable condition, and reporting a resident not returning within eight hours to management. -Blank sign out sheet with the following columns: date, resident out on pass (yes or no), shift 6-2, shift 2-10, shift 10-6, and DON/Admin initial. -Complete census of residents dated 02/21/2025 at 6:49pm with a note, As of 7:30pm 2/21/25, all phone numbers verified and/or corrected and signed by the Administrator. Residents were marked as being their own RP or marked as updated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-Signing Residents Out policy last revised 02/21/2025 read in part, If a resident who has signed out has not returned the same day, then the staff will notify the DON and/or the Administrator. Facility staff will attempt to contact the resident/responsible party to determine whether the resident will be returning to the facility on another date. If the resident or RP cannot be reached, then the DON and/or the Administrator will initiate an immediate search of the premises. If the resident is not found during this search, then the DON/Administrator will notify local law enforcement/APS . Interview with the DON on 2/22/2025 at 9:20am, she said she did an audit for 23 residents and will update their care plan. Interview with RN W on 2/22/2025 at 9:27am, she said she received education on when a resident wanted to go out, she would check their condition and if they're able to make a healthy decision, check their physical condition, check who their RP was, check on transportation, if they needed skilled care during their time on-pass, if they required medication before leaving, check that the resident's contact information is current and let them know to call if they needed the facility's help. She was also educated on checking vital signs, documenting how long they will stay outside, educate the family about conditions to look out for, and see if the nursing supervisor approved resident's on-pass. If residents did not return according to the provided timeline, she would call their phone number to see if they were okay and tell her supervisor about the situation. Residents have the right to go and the facility should make sure they were safe. She said no residents had left the building on-pass on 2/21/2025 that she was aware of. Interview with CNA C on 2/22/2025 at 11:36am, she worked 6:00 am to 2:00pm. She was in-serviced on making sure residents told a nurse and signed out before leaving. If staff see residents leaving out the door to call them and verify they followed the protocols. CNA C said staff have to know who residents are leaving with, and if staff have not seen residents return for eight hours, to let a nurse know and they will call the resident to find out how they are. Interview with CNA B on 2/22/2025 at 11:42am, she worked 6:00 am to 2:00 pm and 2:00pm to 10:00pm. She received inservices on confirming with residents who were leaving on why they are going out, if they signed out yet and making sure they check with nurses at the facility. Interview with LVN C on 2/22/2024 at 11:54am, he said he worked 10:00 pm to 6:00 am shift. He was inserviced on making sure residents leaving are competent and finding out who is responsible for them. Nurses are to make sure residents come back, and if they do not staff will initiate a search by calling the resident's RP. If staff are unable to get hold of the person, to notify the DON and Administrator. Leaving is not considered AMA. Nurses document procedures such as going out on pass and documenting the resident's current status, who they are leaving with, how they are before leaving, where they are going and when they are coming back to the facility. Nurses document in the resident's medical records and a physical sheet for residents on each hall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with the DON on 2/22/2025 at 12:02pm, she in-serviced staff on what to do when residents go out on pass, including checking the resident's care plan, filling out the sign out form and documenting on-pass residents in each nurse's log and to check that before each shift to know which residents are coming back on that shift. Nurses are to help residents sign out, ask where they're going and document in residents' progress notes, make sure phone numbers are working, add vital signs and making sure residents want any medication for pain before leaving. If residents do not appear well, nursing staff are to report to the DON so that the resident and/or family members can be educated to make sure residents stay staff. If residents haven't returned, staff are to call the resident. If they have not returned and if they don't answer, report to management (Unit manager, Administrator, Social Worker, DON). If a resident is unable to be found, the facility will search the area. If the resident is unable to be found, the facility will call hospitals and police after 24 hours. The DON said that going forward, the facility will visit the resident's address on file if they do not return to the facility after being out on-pass. The DON said that CR#1 was going out every day and never had any problems with health. He did have medical conditions but no severe changes in conditions while at the facility. The DON said management estimated that CR#1 was able to take care of himself. The DON was notified 01/16/2025 around 9:00 pm through text and she called CR#1 at home and he did not answer. She also called early in the morning the next day. The DON said if residents are not located, they could be on the street in hot or cold weather. The DON will monitor the effectiveness of implemented procedures by reviewing resident sign-out logs for each hall at the end of the day for 30 days. The DON will continue to educate and in-service staff on what to do when residents are leaving a facility and what staff do if they have not returned. Interview with the AD on 02/22/2025 at 12:15pm, she was in-serviced on resident rights, asking residents where they are going if they leave the building. Staff should also check to make sure residents told their nurse and that the nurses are aware of residents leaving on-pass. If she noticed residents have not returned she would report it right away to the DON and Administrator. She would also assist with locating residents. Interview with CNA F on 2/22/2025 at 12:25pm, she said she worked 10:00 pm to 6: 00 am and sometimes helped with 6:00 am to 2:00 pm shift. CNA F said she was in- serviced on asking residents leaving the building where they are going, if they signed out, if they spoke to their nurse, and when they're coming back. She would notify her nurse if the resident has not returned. She would communicate concerns with the nurse on residents out on-pass. She had in-services on resident rights in the past. Interview with the Receptionist on 2/22/2025 at 12:29pm, she said she was in-serviced on stopping residents leaving and making sure they were signed out or direct them to the nurse's station. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with the Administrator on 2/22/2025 at 12:38pm, she said she was in-serviced by the Regional VP of Operations on 2/21/2025. She conducted in-services for department managers, coordinators and direct care staff about the new sign-in and sign-out policy and what needed to be done if residents leave, including redirecting them to nurse's station to sign in the log book, educating nurses on confirming a resident's RP, having contact information of the resident or family member, making sure residents return and reporting immediately to her or the DON if residents do not return. The Administrator said staff are to conduct follow-ups by calling the resident's RP and confirming an expected time to come back. If staff cannot get a response, they are to search the facility and premises and get law enforcement involved and calling the location resident said they were going. The Administrator said CR#1 signed out and the follow-up did not take place at the time. She was informed on 01/16/2025 late in the evening. She said CR#1 was not considered missing due to him frequently leaving the facility on-pass, but if a resident was noted to be missing and had not come back when they said they would, the facility would conduct a search and notify law enforcement. The Administrator said based off the conditions of CR#1 at the time and his habits, the facility felt he left the facility of his own choosing and was not in immediate danger. She discussed CR#1 with the DON, notified the doctor who gave us the discharge directives which was the AMA paperwork. The Administrator will monitor the implemented procedures with continuing to follow the sign-in and sign-out log and shift reports which they were already doing. She will also monitor the new separate logs for each hall in which nurses will review before starting the shift. Staff are expected to send a message to the DON and the Administrator for the time being when residents go out so they can make sure residents return. The monitoring period will be 90 days, and binders are to be reviewed at morning meetings, with the weekend RN supervisor monitoring to ensure protocols are being done. Interview with the BOM on 2/22/2025 at 12:50pm, she said she was in-serviced on letting the DON and Administrator know when she sees a resident leaving the facility. She said she will call the resident o [TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #31) reviewed for incontinent care. The facility failed to ensure CNA C did not place foley bag on Resident #31's bed during foley care. The facility failed to ensure CNA C properly cleaned Resident #31during incontinent care. This failure could place residents at risk for pain, infection, injury, and hospitalization . Findings included: Record review of Resident #31's sheet dated 02/19/25 revealed a [AGE] year-old female was initially admitted to the facility on ,d+[DATE]//21 and readmitted on [DATE]. Resident #31 had diagnoses included: chronic kidney disease (a condition where kidneys are damaged and cannot filter blood properly), diabetes mellitus (body do not produce enough insulin or use it properly) and heart failure (heart cannot pump enough blood to meet the body's needs). Record review of Resident #31's Quarterly MDS assessment dated [DATE] revealed Resident BIMS was 09 which indicated moderately impaired cognition. Resident #31 required extensive assistance with ADL with one staff assistant. Further review revealed the resident was incontinent of bowel and she had an indwelling catheter. Record review of Resident # 31's care plan initiated on 12/20/23 revealed Resident #31 had Indwelling Catheter dx: neurogenic bladder Interventions: Position catheter bag and tubing below the level of the bladder. Check for incontinence during rounds, wash, rinse, dry perineum and change clothing PRN after incontinence episodes. Record review of Resident #31's order summary report for February 2025 read in part . FC: Foley catheter 16 FR 10 cc bulb to bedside drainage, diagnosis: neurogenic bladder ordered date 02/27/24 . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/18/25 at 9:54 a.m., CNA C placed Resident #31's Foley bag on the bed while she provided incontinence and Foley care for Resident #31. The IP was in Resident #31's room, and she observed the care with the surveyor. Resident #31's foley bag was on the bed from 9:54 a.m. to 10:10 a.m. until the IP told CNA C to put the foley bag down below Resident # 31's bladder. CNA C wiped Resident #31's peri area during the incontinent and foley care. Still, she did not separate the labia (fleshy folds of skin that make up the external female genitalia), and she also did not separate the buttocks when she cleaned the bowel movement. When CNA C wiped the foley catheter French towards the body, instead of wiping away from the body, she did not anchor the foley French close to the insertion site to prevent the foley French from pulling when she cleaned the catheter French. The IP asked CNA C if she had finished cleaning Resident #31 and she said yes. Then the IP asked CNA C to separate Resident #31 buttocks and clean it again. When CNA C separated Resident #31's buttocks, she cleaned in between the buttocks and the anal three times, and there was bowel movement on the wipes. Then CNA C separated Resident #31's labia, revealing the area was red. When CNA C wiped the inside of the labia area, Resident #31 shouted, OUCH, and there was bowel movement and a tinge of red streaks when she wiped Resident #31 three more times. During an interview on 02/18/25 at 1:03 p.m., CNA C said she left the Foley bag on top of the bed when she provided Foley and incontinent care for Resident #31 until the IP told her to place the bag below Resident #31 bladder, and she hung the foley bag on the rail of the bed. CNA C said she had in-service on Foley care and was told to have the Foley bag below the bladder so the urine would flow down. CAN C said she placed the bag on the bed, which was on the same level as the bladder and the urine would flow back and could cause infection (UTI) for Resident #31. During an interview on 02/18/25 at 1:03 p.m., CNA C said she should have separated Resident #31 labia and buttocks to clean Resident #31 properly. CNA C said when the IP told her to clean Resident #31, she did it three more times, and there was a bowel movement on the wipes. She said if she did not clean Resident #31 well, she could have all kinds of infections. CNA C did not state what types of infection. CNA C said she had an in-service on Foley care and incontinent care, and the trainer said to use soap and water and clean the area until it is clean. During an interview on 02/19/25 at 8:13 a.m., the IP Said CNA C should not have placed the foley bag on the bed because the urine would backflow into Resident #31, and it could cause infection such as UTI. The IP said the nursing staff was responsible for ensuring the Foley bag was placed below the bladder. The IP said CNA C should have separated the labia and cleaned the area and the buttocks properly. The IP said when she asked CNA C to clean the buttocks and peri area after she said she was done cleaning Resident #31. The IP said CNA C cleaned out bowel movement residue both from the peri area and the rectum three more times, and the wipes had bowel movements. During an interview on 02/19/25 at 10::08 a.m., LVN S said CNA C should place Resident #31 foley bag at the foot of the bed or on the rail below the resident's bladder for the urine to flow through gravity. LVN S said the urine would flow back into Resident #31 bladder because CNA C placed the Foley on the bed at the same level as the bladder, and it could cause infection (UTI). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/19/25 at 10:36 a.m., the DON said she expected CNA C to follow facility protocol on Foley care, and the IP would train CNA C before she started working on the floor, and she was trained. The DON said the Foley bag should not be above or at the same bladder level. The DON said the IP educated the aides not to put the Foley bag on the bed because the urine would flow back to the resident, and it would cause UTI. The DON said the staffing coordinator, the IP, and herself monitored the nurse during rounding, and the nurse monitored the aides. The DON said if CNA C did not separate the labia area and if she did not appropriately clean, Resident #31 could get an infection. The DON said CNA C should anchor the tubing clean in a circular motion and wipe away from the resident, not towards the resident, to prevent UTI. During an interview on 02/19/25 at 3:03 p.m., the Administrator said CNA C should not have placed the foley bag on the same level of the bladder because the urine would flow back into Resident #31 bladder and Resident #31 could have an infection. The Administrator said CNA C should clean Resident #31's peri and rectum areas properly to prevent infection and skin breakdown. Record review of the facility's policy on Peri Care dated 2001 MED - PASS, Inc. Revised October 2010 read in part . the purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition .steps in the procedure #9b(1) separate labia and wash area downward from front to back . note: if the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review, the facility failed to provide care and services to prevent complications for 1 of 3 residents reviewed with gastrostomy tubes. (g-tubes) (Resident #76) CNA F did not inform the nurse to turn off Resident #76's gastrostomy tube feeding prior to providing care. CNA F lowered the head of Resident #76's bed to a flat position for incontinent care while the g-tube feeding continued to infuse. This failure could place residents with g- tubes at risk for complications, aspiration, and pneumonia. Findings included: Record review of Resident #76's sheet dated 02/19/25 revealed a [AGE] year-old female was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #76 had diagnoses included: PEG tube (a feeding tube placed into the stomach), diabetes mellitus (body do not produce enough insulin or use it properly) and hypertension (blood vessels have persistently raised pressure). Record review of Resident #76's Quarterly MDS assessment dated ,d+[DATE] revealed Resident BIMS was 06 which indicated severely impaired cognition. Resident #76 required extensive assistance with ADL with one staff assistant. Further review revealed the resident PEG tube. Record review of Resident # 76's care plan initiated on 06/24/24revealed Resident #76 had requires tube feeding related to dysphagia. Intervention: keep HOB elevated 45 degrees during and thirty minutes after tube feed. Observe side effects of feed intolerance/ aspiration: diarrhea, N/V, increased cough, Record review of Resident #76's physician for February 2025 read in part . GT: head of bed elevated at 30 to 45 degrees except to allow for ADL care ordered date 06/07/24 . GT: flush GT with H2O at 38 ML/HR for 22 hours VIA pump QD . GT: give Jevity 1.5 at 60CC/HR for 22 hours ordered date 01/08/25 . During an observation on 02/19/25 at 9:30 a.m., it was revealed Resident #76 was lying on the bed with the head of the bed flat while G tube feeding was infusing. CNA F continued to provide incontinent care, and when he finished giving care, he still left Resident #76 head of flat. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 02/19/25 at 9:49 a.m., LVN S said he observed Resident #76's head of the bed was flat, and the feeding was running. LVN S said Resident # 76 feeding should not be running while CNA F was providing incontinent care. LVN S said the head of the bed should not be flat because of aspiration, and if Resident #76 starts to aspirate and the resident was not found on time, that could be fatal for Resident#76. LVN S said CNA F should have told the nurse he was about to provide incontinent care so the nurse would turn off the G tube. After CNA F had provided the incontinent care for Resident #76, CNA F would tell the nurse, and the nurse would come and turn the feeding pulp on and make sure Resident #76's head of the bed was not flat. LVN S said the head of the bed should be between 35 and 40 degrees. LVN S said the charge nurse monitored the aides, but he did not know how the aides missed calling him. LVN S said the unit managers monitored the nurses during rounding. During an interview on 02/19/25 at 11:01 a.m., the DON said Resident #76's feeding should be placed on hold by the nurse while CNA F provided care for the resident. The DON said the feeding should be on hold to prevent Resident #76 from vomiting and abdominal pain. The DON said the facility has a standing order and protocol for residents on G tube, which is that the head of the bed should be elevated while the feeding is running and pulsed during care so the head of the bed can be lowered. The DON said CNA F was trained to tell the nurse to come to turn off the plump and to turn it back on aftercare. During an interview on 02/19/25 at 1:02 p.m., CNA F said the feeding was not stopped when he provided care for Resident #76 because he forgot about it. CNA F said the head of the bed was down, and he did not know what could happen to Resident #76 with the head of the bed down while the feeding was going on. CNA F said he had training on how to work with a resident with a G tube, and he did not remember what could happen to Resident #76, and the nurse monitored the aides during rounding. Record review of the facility undated training for staff on handling patients with PEG tubes during ADL care read in part .important steps before starting ADL care: 1. if a CAN is caring for a resident with a peg tube, they must call the nurse to pause the feeding before starting activities of daily living. This is particularly important if the care involves position changes, turning the patient, . that could increase the risk of aspiration. Reasons to pause feeding during ADL care .1. aspiration risk . repositioning the patient while they are being fed can lead to reflux and increase the risk of aspiration . resume feeding only once the patient is returned to a safe, upright position .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care and services, including oxygen administration was provided such care, consistent with professional standards of practice for 1 of 3 residents (Resident #81) reviewed for respiratory therapy in that: The facility failed to ensure Resident #81's oxygen was set according to physician orders. This failure could place residents at risk of respiratory distress. The findings were: Record review of Resident #81's face sheet dated 02/19/25 revealed a [AGE] years- old female was admitted to the facility on [DATE]. Resident #66 had diagnoses included: cerebral infraction (brain injury occurs when blood flow to the brain is blocked), hypertension (when blood against the walls of arteries is consistently too high), heart failure (heart cannot pump enough blood to meet the body's needs) and aphasia(language disorder that affects communication). Record review of Resident #81 admission MDS assessment dated [DATE] revealed Resident #81 had a BIMS of 00 out of 15 indicated severely impaired cognition. further review revealed Resident #81 was on oxygen therapy. Record review of Resident #81 care plan dated 02/03//25 revealed Resident#81 had potential for respiratory distress related to CVA, HX of TIA, CHF on oxygen therapy. Intervention: give nebulizer treatment and oxygen therapy as ordered. oxygen settings: 02 via nasal cannula @ 3L continuously. Record review of Resident#81's physician's order dated February 2025 read in part . O2: O2 at 3L/minute via nc continuously every shift stated 01/31//25 . During an observation on 02/18/25 at 10:31 a.m., revealed Resident #81 oxygen concentrator was set on 3. 5L During an observation on 02/18/25 at 10:32 a.m., CNA C said the setting on the oxygen concentrator was between 3 and 4 L. During an observation and interview on 02/18/25 at 10:37 a.m., LVN S said the setting on the oxygen was 3. 5 L. LVN S said he did not know how many liters of oxygen Resident #81 should be on. LVN S Resident #81 was moved to this hall yesterday (02/17/24). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/19/25 at 7:56 a.m., the IP said if the doctor's order said 2 to 3 L, Resident #81's should be set according to the order. The IP said it should not be above the order because Resident #81 could have COPD, and it would not be safe for the resident because it could do more harm than good. The IP said the charge nurses are responsible for making sure the setting on the concentrator was set according to the order. The IP said the nurse managers also check the sets on the oxygen concentrator when they make rounds. The IP said the nurse managers monitored the nurses, and the nurses had skills checks off, and it included oxygen administration. During an interview on 02/19/25 at 10::03 a.m., LVN S said Resident #81 setting on the oxygen concentrator should be set at what the physician ordered. LVN S said he did not get a report from the outgoing nurse and did not know why the concentrator was set at 3. 5 L. LVN S said the resident would have some adverse effects, but he could not verbalize what effect. During an interview on 02/19/25 at 10:27 a.m., the DON said LVN S or any other nurse did not tell her Resident #81 was having any respiratory issues, and they increased the O2 setting on the concentrator. The DON said the facility follows the physician's order. The DON said if Resident #81 was given more oxygen than ordered, the CO2 would increase, and Resident #81 would be more confused than usual. The DON said the charge nurse on the floor was responsible for monitoring the oxygen setting. The DON said the unit managers and the DON monitor the nurses during rounding. She said the nurses had a skills check-off, which included oxygen administration before working with residents with oxygen. Oxygen policy as requested from the administrator and DON on 02/19/25 at 4:29 p.m., through email and the policy was not provided upon exit.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation and interview the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for and 3 (shared medication cart between Hall 100 and 400, 200 and 300) of 6 medication carts reviewed for medication storage. - The facility failed to ensure the 200,300, shared 100 and 400 hall medication carts did not contain eyedrops, ointment, and nasal spray that were opened but not labeled with the resident's name and not dated. This failure could place residents at risk of adverse medication reactions and infections. Findings Include: During observation on 02/19/25 at 2:50 PM, the following medications were found in the medication carts for 200 hall with LVN AA: Serevent Diskus (Salmeterol Xinafoate inhalation powder) open and not dated Trelegy Ellipta 200 mcg inhalation power open and not dated Nystatin & Triamcinolone Acetonide 60gms open and not dated Diclofenac Sodium topical gel 1% (NSAID) arthritis pain reliever open and not dated Interview with LVN AA on 2/19/25 at 2:50 PM, LVN AA asked the surveyor if she could date the medication because she was not sure when it was open. She said the reason for dating the medications was for the medication not to be used after 30 days for it to be effective. During observation on 02/19/25 at 3:05 PM, the following medications were found in the medication carts for 300 hall with LVN BB: Refresh Optive Mega -3 with 4 vials open and not dated Refresh Optive Mega -3 with 2 vials open and not dated Refresh Optive Mega -3 with 2 vials open and not dated Interview with LVN BB on 2/19/25 at 3:05 PM, LVN BB said she checks the medication cart for 300 halls daily for expired medications. LVN BB said eyedrops when medication open should be dated, to help the nurses know when to discard it after 30 days. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 02/19/25 at 3:30 PM, the following medications were found in the medication carts shared between 100 and 400 hall with MA A. 1. Fluticasone USP 50 mcg nasal spray open and not dated 2. Fluticasone USP 50 mcg nasal spray open and not dated 3. Fluticasone USP 50 mcg nasal spray open and not dated 4. Fluticasone USP 50 mcg nasal spray open and not dated 5. Fluticasone USP 50 mcg nasal spray open and not dated 6. Fluticasone USP 50 mcg nasal spray open and not dated 7 Fluticasone USP 50 mcg nasal spray open and not dated 8. Fluticasone USP 50 mcg nasal spray open and not dated 9. Fluticasone USP 50 mcg nasal spray open and not dated 10. Allergy Nasal Spray open and not dated 11. Refresh Plus lubricant eye-30 single vial Interview with MA A on 02/19/25 at 3:30PM regarding medication not dated she said the resident gets it in the morning and not dating could cause harm to the resident because it will not be effective and she would showing the medication to the DON. In an interview with DON 2/19/25 at 4:00 PM, she said was not sure if they were supposed to labeled above medications when opened and the pharmacist was in the facility on 2/18/25 and said everything was fine. DON said they were going to look into their policy. Record review of the facility policy of storage of medications revised April 2007 :Policy Statement : The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy interpretation and implementation did not address the labelling and dating of medications when opened. According to the United [NAME] health trust, recommendations were that drops and ointments are used within one month (https://www.ghc.nhs.uk/wp-content/uploads/CHST-Expiry-Dates-of-Medication.pdf).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview 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 3 of 4 residents (Resident #31, Residents #41 and Resident #76) reviewed for infection control practices. - The facility failed to ensure CNA C followed proper infection control and hand hygiene for Resident #31 during Foley and incontinent care. - CNA AA did not utilize appropriate hand hygiene during Foley catheter care for Resident #41 - CNA AA did not utilize appropriate hand hygiene during incontinent for Resident #41 - The facility failed to ensure CNA F Donned proper PPE while providing incontinent care for Resident # 76 who was in enhanced barrier precaution isolation. These failures could place residents at risk of infection or a decline in health. The findings include: Resident #31 Record review of Resident #31's sheet dated 02/19/25 revealed a [AGE] year-old female was initially admitted to the facility on ,d+[DATE]//21 and readmitted on [DATE]. Resident #31 had diagnoses included: chronic kidney disease (a condition where kidneys are damaged and cannot filter blood properly), diabetes mellitus (body do not produce enough insulin or use it properly) and heart failure (heart cannot pump enough blood to meet the body's needs). Record review of Resident #31's Quarterly MDS assessment dated [DATE] revealed Resident BIMS was 09 which indicated moderately impaired cognition. Resident #31 required extensive assistance with ADL(activity of daily living) with one staff assistant. Further review revealed the resident was incontinent of bowel and she had an indwelling catheter. Record review of Resident # 31's care plan initiated on 12/20/23 revealed Resident #31 had Indwelling Catheter dx: neurogenic bladder(lack of bladder control) Interventions: Position catheter bag and tubing below the level of the bladder. Check for incontinence during rounds, wash, rinse, dry perineum(patch od sensitive skin between virginal opening and anus) and change clothing PRN after incontinence episodes. Record review of Resident #31's order summary report for February 2025 read in part . FC: Foley catheter 16 FR 10 cc bulb to bedside drainage, diagnosis: neurogenic bladder ordered date 02/27/24 . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 01/18/25 at 9:54 a.m., when CNA C was providing Foley and incontinent care for Resident #31, CNA C placed a clear plastic bag on the clean field, and it was touching the clean incontinent brief and wipe packet. CNA C placed the used wipes, which had bowel movements, and used incontinent briefs, which also had bowel movements, in the clear plastic bag. CNA C changed dirty gloves with bowel movements three times without sanitizing or washing her hands. When CNA C was about to DON(putting on gloves)the fourth gloves, the IP told her to go and wash her hands. During an interview on 02/18/25 at 12:54 p.m., CNA C said she should not have placed the thrash bag on the clean field and had the soil linen and wipes in the bag because of cross-contamination. CNA C said she forgot to wash her hands after she changed gloves three times, which had a bowel movement. CNA C said the IP told her to wash her hands when she was about to [NAME] the fourth glove without washing or sanitizing her hands. CNA C said it was an infection control issue because she did not wash her hands. CNA C said she had been in service on infection control and was educated to wash or sanitize her hands when she changed gloves to prevent cross-contamination. She stated the nurses monitored the aides when the nurses made rounds. During an interview on 02/19/25 at 8:20 a.m., the IP said CNA C should not have placed a trash bag on a clean field on a bedside table with clean supplies for incontinent care to prevent cross-contamination. The IP said CNA C changed dirty gloves three times without washing or sanitizing her hands, and on the fourth change, she told CNA C to go and wash her hands because of cross-contamination. During an interview on 02/19/25 at 10:49 a.m., the DON said CNA C should sanitize her hands after removing dirty gloves. The DON said CNA C should have sanitized her hands when she changed the used gloves to prevent cross-contamination. The DON said CNA C should not place her trash on the clean field to avoid cross-contamination. The DON said the IP had in-service on hand washing with the nursing staff, the nurses monitored the aides during rounding, and the nurse managers monitored the nurses. During an Interview on 02/19/25 at 3:04 p.m., the Administrator said that CNA C placed the dirty line bag on the clean field and did not wash her hands when she changed the dirty gloves during foley and incontinent care was an infection control issue, which was cross-contamination. Resident #41 Record review of Resident #41's face sheet, dated 02/19/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #41 had diagnoses which included: metabolic encephalopathy (a brain condition that occurs due to an imbalance of chemicals in the blood) acute cystitis with hematuria (a bladder infection that causes blood in the urine), essential (primary) hypertension, (high blood pressure) hyperlipidemia(high levels of fat in the blood), Parkinson's disease with dyskinesia movements(a condition where a person with Parkinson's disease experiences involuntary muscle movement) and Foley catheter (soft, plastic or rubber tube that is inserted into the bladder to drain the urine). Record review of Resident's #41 admission MDS assessment, dated 01/18/2025, reflected the BIMS score was 10, which indicated the resident's cognition was moderately impaired. Resident #41 had an indwelling catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #41's care plan, date 01/30/25, reflected the resident was at risk of urinary tract infections. Interventions included for caregiver teaching to include good hygiene practices, wipe, and cleanse from front to back and clean peri area well after bowel movement in order to help prevent bacteria in urinary tract. Record review of physician's order dated 1/14/25 Order Summary: FC: Foley Catheter 16FR 10cc bulb to bedside drainage, Foley catheter care Q shift and PRN : Diagnosis: urinary obstruction. Observation on 02/19/25 8:49 AM Resident#41 was lying in bed, HOB at 35-degree, resident was lying on the right side with F/C hanging on the left of the bed frame not secured. Incontinent care performed by CNA AA and CNA BB assisting. CNA AA entered Resident #41's room with enhanced precaution and washed hands (don gown and gloves). CNA AA cranked resident #41's bed to the position of comfort, without changing the gloves, she used the same gloved hands removed resident's cover sheet, then positioned resident on his back, open up Resident #41's brief, the indwelling catheter tubing was under resident draw sheet with Resident #41, lying on it in the bed. Resident #41 had 200 yellow urine in the drainage bag and large BM. Using the wet wipes CNA AA cleaned the groin several times and cleaned F/C straight down twice not in a circular motion, then repositioned to his right side, using the same gloves got the wipes and cleaned the buttock with large, bowel movement several times. C.NA AA then changed gloves without washing hands or using hand sanitizers, before donning a clean gloves, she then touched resident #41's call light to call for the treatment nurse for the soiled dressing to the sacral area. At 2/19/25 at 9:06 AM treatment LVN QQ came in to change the treatment. Interview with CNA BB on 2/19/25 at 9:25AM, about the F/C and incontinent care, she said CNA AA did not washed her hands after changing gloves, and she did not cleaned the F/C in a circular motion and F/C was not secured and it should be positioned on the same side Resident #41 was lying to avoid pulling. C.NA BB said she had in-services for incontinent and F/C training last month. Interview with CNA AA on 2/19/25 at 9:27 AM, about the incontinent and Foley catheter care, she thinks she did not do a good job, she said she was very nervous, and she forgot to changed her gloves and not changing gloves can cause cross contamination and infection. CNA AA had been working in the facility for 10 months and she had training for 6 weeks for incontinent and indwelling catheter care. Interview with the LVN QQ on 2/20/25 at 9:52 AM, LVN QQ been here a year in December 2024, 6-2p M-F, on 200 Hall which he worked has 2 residents with Foley catheter. CNAs and I monitor the Foley catheter. LVN QQ said he check the catheter when entered the facility, he said he checked on Resident #41l yesterday, I don't recall checking on the catheter today during multiple visits. LVN QQ said he was checking to make sure its flowing, making sure any sediment, blood in urine or if it's kinked up. It should have a stat lock to hold it. I don't know what it's called, could be safe lock. We lock it to hold it in place, stable, to prevent yanking, stretching, and causing trauma to the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676059	A. Building B. Wing	02/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Westchase	11910 Richmond Ave Houston, TX 77082

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If the urine isn't flowing and can be blocked. LVN QQ said he check it a couple of times a day, in the morning and see what the amount residents have in their bag and empty it. I will check it later in the afternoon. When I go in and out I do check on the bag. LVN QQ said he had in-services on catheter care, he doesn't remember when. Resident #41 does not have a history of UTI. Lack of Foley care can cause obstruction. In the continued interview, he was asked who was responsible for checking indwelling catheter was secured and monitoring it. LVN QQ said he was responsible and he checks it every so often and did not say when last the indwelling catheter was checked. During an interview on 2/20/25 at 5:25 PM, the DON revealed staff should be utilizing appropriate hand hygiene practices to prevent an infection. The DON revealed it was necessary to sanitize or wash the hands between glove changes. The DON stated she would conduct in-services now on peri care and infection control. Resident #76 Record review of Resident #76's sheet dated 02/19/25 revealed a [AGE] year-old female was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #76 had diagnoses included: PEG tube (a feeding tube placed into the stomach), diabetes mellitus (body do not produce enough insulin or use it properly) and hypertension (blood vessels have persistently raised pressure). Record review of Resident #76's Quarterly MDS assessment dated ,d+[DATE] revealed Resident BIMS was 06 which indicated severely impaired cognition. Resident #76 required extensive assistance with ADL with one staff assistant. Further review revealed the resident had a PEG tube. Record review of Resident # 76's care plan initiated on 06/24/24revealed Resident #76 had requires tube feeding related to dysphagia. Intervention: keep HOB elevated 45 degrees during and thirty minutes after tube feed. Observe side effects of feed intolerance/ aspiration: diarrhea, N/V, increased cough, Record review of Resident #76's physician for February 2025 read in part . GT: head of bed elevated at 30 to 45 degrees except to allow for ADL care ordered date 06/07/24 . GT: flush GT with H2O at 38 ML/HR for 22 hours VIA pump QD . GT: give Jevity 1.5 at 60CC/HR for 22 hours ordered date 01/08/25 . During an observation on 02/19/25 at 9:54 a.m. revealed CNA F was providing incontinent care for Resident #76, who was in the EBP room, and he did not wear a protective gown. During an interview on 02/19/25 at 9:57 a.m., LVN S said CNA F should have worn the protective gown while he provided incontinent care for Resident #76 because she was on EBP. LVN S said he observed CNA F providing incontinent care without a gown, and that was when he gave CNA F a gown and told him to stop and don the gown. LVN S said the rationale for wearing a gown was to prevent cross-contamination because Resident #76 had a G tube and wound. LVN S said the nurse monitors the aides while the nurse managers monitor the nurses. LVN S said he had in service on infection control, including PPE. (continued on next page)

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	676059	A. Building B. Wing	02/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/19/25 at 10:58 a.m., the DON said CNA F should have worn the gown while providing care for Resident # 76 in isolation to prevent cross-contamination. During an interview on 02/19/25 at 11:59 a.m., CNA F said he should have worn the gown while providing incontinent care for Resident #76 because she was in on enhanced barrier precaution and to prevent cross-contamination. CNA F said he had infection control training, including PPE. CNA F said the charge nurse monitored the aides during rounding. During an interview on 02/19/25 at 3:04 p.m., the Administrator said CNA F should have worn the disposable gown while he provided care for Resident #76 on enhanced barrier precautions to prevent cross-contamination. Record review of the facility undated in service on the importance of following up on ABP policy read in part . enhanced barrier precaution are essential to prevent the spread of infectious disease among staff and patients any patient placed on enhanced barrier precautions should be cared for in a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and multi drug resistance organism infection. when providing a daily living activities care for the patients, staff members must wear gowns . Goals . provide proper personal protective equipment as needed . Record review of facility hand washing/hand hygiene dated 2001 MED - PASS, Inc. Revised August 2015 read in part . the facility considers hand washing the primary means to prevent the spread of infections . policy implementation #7b . before and after direct contact with resident . #7m . after removing gloves .#9 . the use of gloves does not replace hand washing . 36918