STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676060	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambrosio Guillen Texas State Veterans Home	9650 Kenworthy St El Paso, TX 79924

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 51012 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, recognizing each resident's individuality for 7 of 15 residents reviewed for residents' rights, in that: -In the memory care unit, facility failed to serve 7 of 15 residents their meals at the same time as their tablemates, causing them to watch their tablemates eat while they waited up to 30 minutes for their meal. This failure could affect residents' self-esteem and dignity. The findings include: During an Observation on 1/27/25 at 11:30 AM, residents were observed sitting in dining area located in the memory care unit. The first meal cart containing the resident's lunch trays arrived at the memory care unit at 12:19 PM. The second meal cart containing the resident's lunch trays is observed to arrive to the unit at 12:27 PM. There are 2 of 4 residents observed in the first table not served while the other residents in table are eating their meal with 50% of meal observed eaten. The third meal cart containing the resident's lunch tray is observed to arrive to the unit at 12:41 PM. The fourth meal cart containing the resident's lunch tray arrived at 12:46 PM. At 12:47 PM, a second table observed with 1 of 4 residents ate his meal at 100% while the 3 of 4 at same table have not yet been served. At 12:48 PM, observation of the third table with 1 of 3 residents was eating meal with more than 25% of meal consumed, and the 2 of 3 residents at the same table were not served. During an interview with DON on 1/30/25 at 3:24 PM, she stated the nursing team needs to check the meal carts and observe who is in the dining room. She stated, The CNA's or the nurse hands the kitchen staff the tickets of the residents who are present in the dining room, so they are served at the same time. DON states The concern with the residents not eating at the same time is unfair to stare at someone else eating while they are not. The DON also stated, It shouldn't happen. The DON stated the nursing staff is responsible for notifying the kitchen for any pending trays, so all residents are served at the same time at the same table. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/25 at 04:24 PM with Pharmacy Nurse LN she states there is a seating chart for the dining room in the memory care unit that is updated with admissions, discharges, need for assistance, or preference. She states that residents unfortunately come back and forth from the dining area when waiting for their meal. She states the responsibility to ensure residents are all served at the same time at the same table is whoever is passing the trays such as nursing staff. Pharmacy Nurse LN states that the nursing staff also get assistance from the administrative staff to pass trays, so they are also responsible if they assist. During an interview with Interim CDM on 1/30/25 at 4:43 PM, he states the CNA's or nurses are responsible for ensuring that residents at the same table should be served and eat at the same time. He states nursing staff and kitchen staff work together to ensure residents are served their meals together. He states the risks of residents not being served at the same time include a personal attack or the resident may feel singled out. He denies having concerns regarding residents in the dining room not being served at the same time being reported to him . Record Review of the facility's policy named Resident Rights dated February 2020 read in part: The resident has the right to be treated with respect and dignity, including: The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854 Based on observation, interview and record review the facility failed to ensure residents were provided services with reasonable accommodation of needs and preferences for 1 of 13 residents (Resident #24). Resident call lights were not kept within reach for 1 resident (Resident #24). This failure placed residents at risk of having needs unmet when they are unable to contact staff. Findings included: Record review of Resident #24's face sheet dated 01/29/25 revealed Resident #24 was admitted on [DATE] to the facility. Record review of Resident #24's History and physical dated 05/08/24 revealed an [AGE] year-old female diagnosed with generalized muscle weakness, unspecified abnormalities of gait and mobility, lack of coordination and failure to thrive. Record review of Resident #24's quarterly MDS dated [DATE] revealed an [AGE] year-old female diagnosed with coronary artery disease (a type of heart disease involving the reduction of blood flow to the cardiac muscle), hypertension, renal insufficiency (a condition in which the kidneys are damaged and cannot effectively filter waste products from the blood), obstructive uropathy a condition where urine flow is blocked somewhere along the urinary tract), and generalized muscle weakness . Resident #24's cognition of understanding was a score of 12 indicating the resident was cognitively intact. Record review of Resident #24's care plan reviewed on 11/29/24 revealed she was at risk for injuries related to falls and indicated that the call light was to be within reach when she was in bed. In an observation on 01/27/25 at 10:17 AM, Resident# 24 was laying on her bed at this time. Her call light cord was tangled in between the drawers of her nightstand and the call light was laying on the floor. When she was asked if she would be able to reach for her call light if she needed help, she replied she would not be able to, and said she would have to wait until a staff member walked by her room to call for help. In an interview on 01/29/2025 at 1:29 PM with CNA A, she stated that she had been trained that resident call lights must remain within their reach at all times. CNA A explained that if a call light was on the floor, it posed a significant fall risk for residents. She emphasized that some residents lack the ability to bend over or walk independently, and if their call light was out of reach, they might attempt to retrieve it themselves, leading to a potential fall and injury. CNA A said all staff were responsible for making sure the residents had their call light within reach . (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/29/2025 at 1:38 PM with CNA B, she stated she had received training on proper call light placement. She was instructed to place the device within the resident's reach by clipping it to their bed sheets or clothing. She emphasized that call lights on the floor were not considered accessible, posing a fall risk if residents attempted to retrieve them. CNA B stated that inaccessible call lights could delay assistance for immobile residents, potentially creating an emergency. In an interview on 01/30/2025 at 9:06 AM RN C stated that checks and rounds were made every two hours to ensure residents had their call lights within reach. RN C indicated that if a resident did not have their call light accessible, the potential outcome was that they would not receive necessary assistance and would be unable to call for help. RN C said that all staff were responsible for checking for call light placement when they conduct rounds and that it was stated in the facility's policy that it had to be placed within the residents' reach. In an interview on 1/30/25 at 11:25 AM with the Activities Director, she stated the call light needed to be within reach of the resident and staff had to check that the call light was not wrapped on bed rails or anywhere else. She said the facility needed to test that the call light system was in working order. The Activities Director stated if a call light was on the floor and not within reach, accidents could happen, and residents could be at risk of not receiving help such as staying soiled for a long period of time or not receiving assistance with oxygen. In an interview on 1/30/2025 at 2:15 PM with LVN D, stated the call light needed to be within the residents reach at all times so the resident could have access to it. LVN D said if the resident was in bed, the call light needed to be clipped to the bed sheets. LVN D said there was a potential outcome for the resident to try to reach for it to request assistance and the resident could have fallen and injured themselves. In an interview on 01/30/25 03:36 PM with the DON she said the policy for call lights stated they needed to be within reach of the residents. DON said it was every staff's responsibility to check that the call lights were within reach. The DON said the call light for Resident #24 was not within reach. The DON said the potential outcome could be the resident not being able to reach a staff member to get assistance for their medical need in a timely manner. In an interview on 01/31/2025 at 8:35 AM with the Administrator, he stated the call light needs to be placed within reach of the residents. The administrator stated the potential outcome could be that the resident was not able to ask for assistance if the call light was not within reach . Record review of the facility's policy titled Call Light System dated October 2019 read in part: The facility will be equipped with a functioning call light at each resident's bedside, toilet, and bathing areas to allow residents to call for assistance. Call lights will directly relate to a staff member or centralized location to ensure an appropriate response.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 49854 Based on interview and record review, the facility failed to ensure residents were made aware of the grievance process for 5 of 12 Residents who were reviewed for their knowledge of the facility's grievance procedures and grievance resolutions during resident council meeting. The facility did not ensure residents or staff were aware of the facility's formalized grievance process. This deficient practice could place the residents at risk for decreased quality of life and feelings of hopelessness. Findings include: A confidential interview with the Resident Council Group revealed the residents did not know how to file a grievance with the facility or who was responsible for receiving, reviewing and attempting to resolve grievances voiced by the residents. Five residents who were in attendance stated they had not been explained the process on how to file a grievance during their admission. Record review of the Resident Council Minutes dated from August 2024 to January 2025 demonstrated they had not discussed grievances Policies and Procedures or resident rights for 6 months. During a confidential interview conducted on 01/29/2025, at a resident's room at 1:20 PM, both residents stated they had not been informed about the grievance filing process. They explained that while they would typically discuss any concerns with facility staff, they lacked specific instructions on how to formally file a grievance or whom to submit it to. During a confidential interview conducted on 01/29/2025 at 1:32 PM at a resident's room, the resident stated that he had not received instructions on how to file a grievance or where to obtain the necessary forms. He further indicated that this information was not discussed with him during his admission process. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/30/25 at 11:25 AM with the Activities Director, she stated the residents met once a month and usually on the first Wednesday of the month. In November they met twice because the administrator wanted the residents to meet the new administration and to discuss the issues with mealtimes. Also, to discuss who were the department heads, who they were and their roles. The Activities Director said she had been present in most of their meetings with the residents' permission and she took notes of their grievances and then passed them on to the social worker. The Activities Director said she knew there was a policy for the facility to follow up and close grievances within five days and after that, the facility needed to follow up with the result of the investigation of any grievances and let the residents know the result. She stated that every month it was discussed with the residents their rights and she provided copies to those in attendance. The Activities Director reviewed the resident council minutes with the surveyor, and they revealed there was no discussion recorded on how to file a grievance in their minutes. She stated she failed to note it in the concerns or recommendations. She stated she was not sure who would be responsible for letting the residents know about their rights and how to file a grievance upon admission. In an interview on 1/30/2025 at 12:21 PM with the Social Worker, he stated the admissions coordinator gives the residents a copy of the resident's rights upon their admission and during their care plan meeting process. He said as an IDT they discussed their rights and made sure for them to understand them. The Social Worker said he had reviewed with the residents how to file a grievance. He stated he had assisted residents who had grievances, but he did not have records of it. The Social Worker said that a way to improve and make sure the residents knew who to contact and how to file a grievance was by educating and discussing with the residents the process instead of the facility personnel doing it for them. In an interview on 1/30/2025 at 2:15 PM with LVN D, she stated the residents were constantly reminded that they had the right to file a complaint or grievance and that she had offered assistance in the past to file a grievance for a resident but said she did not know how the facility ensured the residents knew how to do it on their own. LVN D said it would be good for the facility to implement a procedure to make sure the residents could file grievances on their own instead of staff doing it for them. In an interview on 1/30/25 at 2:44 PM with the Director of Admissions, she said the admission packet included the residents' rights. During the admission process, she said she talked to the residents and family members about their rights in the facility. The Director of Admissions said the facility offered their services to the family to assist them to file a grievance and they explained the facility would try to help them resolve any issue they had. The Director of Admissions stated she did not know how the facility made sure the resident knew and understood the process to file a grievance or how to fill out a form and said whenever a resident or family member had come to her with a grievance, she would refer them to the social worker so the facility could help resolve any issue they might have. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/30/25 03:36 PM with the DON , she stated the residents were informed through admissions, social service assessment and by the nursing team about their rights The DON said it was the responsibility of all departments to provide reminders and education to the residents about their rights and on how to file a grievance, and administration would be responsible for educating the family members how to file a grievance. The DON said the potential outcome for a resident not knowing how to file a grievance is that their concerns would not be addressed or corrected and for the facility potentially not being able to meet the residents' needs and not doing their due diligence to address their concerns. The DON said she recognized there was room for improvement on how the residents had to be educated on how to file grievances, so their concerns were met in a prompt and effective manner. In an interview on 01/31/2025 at 8:35 AM with the Administrator, he stated he did not know who was mentioned in the policy who was responsible for addressing how to file a complaint in the facility. The Administrator said there were multiple people involved in admitting a resident. He stated that he believed the facility had a robust system for the residents to voice their concerns but stated he did understand the importance for residents to know how to file a grievance on their own and anonymously, and who to contact when they needed to voice a formal complaint. The Administrator said the possible outcome for residents not knowing how to file a grievance was they might not get assistance with whichever issue they were having . Record Review of the facility's policy named Resident Rights dated February 2020 read in part: The resident and/or resident representative will be notified individually or through postings in a prominent location of the right to file grievances orally, meaning spoken, or in writing. The contact information of independent entities with whom a grievance may be filed is posted in the facility and provided in the admission packet.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49854 Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice for 2 (Resident #68 and Resident #142) of 2 residents observed for oxygen management. -Resident #68 utilized oxygen in his room and did not have an oxygen sign posted outside of the room. -Resident #142 utilized oxygen in her room and did not have an oxygen sign posted outside of the room. These failures could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support and decline in health and at risk of fire hazards by not posting oxygen signs outside the residents' rooms. Findings include: Resident #68 Record review of Resident #68's face sheet dated 01/31/25 revealed Resident #68 was admitted on [DATE] to the facility. Record review of Resident #68's History and physical dated 08/27/24 revealed an [AGE] year-old male diagnosed with unspecified dementia with unspecified severity, pulmonary embolism (a blockage in one of the pulmonary arteries in your lungs), major depressive disorder, heart failure and asthma. Record review of Resident #68's quarterly MDS dated [DATE] revealed an [AGE] year-old male diagnosed with anxiety disorder, depression, asthma, pulmonary disease (a condition that affects the lungs and other parts of the respiratory system) and unspecified dementia . His BIMS score was a 9 reflecting he was moderately impaired. Record review of Resident #68's care plan reviewed on 11/29/24 indicated oxygen therapy and use of oxygen with an order of continuous and humidified when on concentrator. Resident# 142 Record review of Resident #142's face sheet dated 01/29/25 revealed Resident #142 was admitted on [DATE] to the facility. Record review of Resident #142's History and physical dated 10/07/24 revealed an [AGE] year-old female diagnosed with psychotic disturbance, anxiety, seizures, depressive disorders, insomnia, and muscle wasting and atrophy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #142's quarterly MDS dated [DATE] revealed an [AGE] year-old female diagnosed with Non-Alzheimer's Dementia, seizure disorder or epilepsy, malnutrition, anxiety disorder, and depression . Her BIMS score was 3 reflecting she was severely impaired. Record review of Resident #142's care plan reviewed on 01/23/25 did not indicate an oxygen therapy or initial revision for updated oxygen therapy use for Resident #142. During observation on 01/27/25 at 09:47 AM Resident#142 was asleep in bed. The bed was positioned to the lowest position and fall mats were observed to both sides of her bed. There was an oxygen concentrator in the room next to her bed and there was no oxygen sign posted outside of her room. In an interview on 01/27/25 at 11:19 AM with LVN E, she stated the facility's policy stated the residents needed to have oxygen signs posted at the entrance of their room. LVN E said Resident# 142 needed an oxygen sign posted outside their room and that she would check on the order. LVN E stated the potential outcome for not having an oxygen sign posted could result in Resident# 142 not being checked for her oxygen levels by staff and there was a potential for fire hazards as well. During observation on 01/28/25 at 2:40 PM in Resident #68 room, there was an oxygen concentrator inside the room next to his bed and there was no oxygen sign posted. In an interview on 01/29/2025 at 1:22 PM with CNA F, she said an oxygen sign had to be posted outside of a Resident# 68's door if there was an oxygen concentrator in the room. CNA F said the potential risk for not having an oxygen sign posted outside the room was that a resident could go out of oxygen and staff would not be able to check on them or if a resident opened the oxygen tank the room could fill with oxygen making it a fire hazard, especially with this Resident #68 because he was a smoker. In an interview on 01/29/2025 at 1:29 PM with CNA A, she stated she had received training on the proper posting of oxygen signs by watching training videos. CNA A explained that residents with oxygen concentrators in their rooms must have an oxygen sign displayed outside their door. This sign serves as a warning to other residents and visitors not to smoke in the room, which could pose a significant fire hazard. CNA A said the absence of an oxygen sign could result in the resident not being checked regularly for oxygen levels, potentially leading to a situation where the resident runs out of oxygen. CNA A said all staff were responsible for making sure oxygen signs were posted outside of the residents' room if they had a concentrator in their room. In an interview on 01/29/2025 at 1:38 PM with CNA B, stated that she had received training requiring the posting of oxygen signs outside resident rooms equipped with oxygen concentrators. She explained that the absence of such signs could lead to unchecked oxygen levels in residents, potentially causing health issues. CNA B highlighted the fire hazard posed by the presence of oxygen in the room, particularly if other residents, unaware of the oxygen, entered with lighters, pipes, or electronic cigarettes. CNA B stated this could endanger both the residents and the facility staff and visitors. In an interview on 01/30/2025 at 9:06 AM with the RN Supervisor, stated that, per policy, an oxygen sign should have been posted outside a resident's room if they had an oxygen concentrator. She explained that the absence of such a sign could have presented a potential fire hazard. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/30/25 at 11:25 AM with the Activities Director she stated that the residents who have oxygen in their room need to have an oxygen sign posted outside their door as a warning sign for fire hazards. The Activities Director said if there were no oxygen signs there was a potential outcome of not checking oxygen for residents. She stated there could also be potential fire hazard. In an interview on 01/30/2025 at 2:15 PM with LVN D, she stated that if there was an oxygen concentrator inside a resident's room, an oxygen sign must be posted outside of their room. LVN D said the potential outcome of not having an oxygen sign posted outside of a resident room could pose a risk of a fire hazard. In an interview on 01/30/25 at 03:36 PM with the DON, she said the oxygen sign was meant to alert everyone in the vicinity to take precaution and to let them know there was oxygen in use. The DON said whenever a concentrator was inside of a room, an oxygen sign needed to be posted outside the resident's room. The DON stated the potential outcome could be a safety hazard, increased the risk for an accident or incident by a resident being left unchecked for oxygen levels. The DON said there were potential fire hazards as well. In an interview on 01/31/2025 at 8:35 AM with the Administrator, he stated if there was oxygen being administered in a resident's room, it was required that an oxygen sign was posted outside of their room to alert staff to check for the residents' oxygen level. The Administrator said if there was a spark near an oxygen concentrator, there could be a fire hazard . Record review of the facility's Oxygen Administration Policy dated February 2015 under infection control and standard precautions read in part: Place a non-smoking sign outside the residence room.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51010 Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #26) of 4 reviewed for medication administration; 4 (Halls 400-800) of 7medication carts reviewed for controlled substances; 1 of 2 medication room reviewed for storage of medications. 1. -The facility failed to ensure Licensed Staff H signed the Controlled Drugs-Audit Record form after counting and verifying that all controlled substances in the medication cart had been accounted for with the off- going nurse at the change of shift. 2.- -The facility failed to ensure Licensed Staff G signed the individual control drug record for resident #26 after administering controlled medication. 3. The facility failed to ensure licensed staff (6 am -2pm) signed the temperature log for vaccines/ medications after verifying correct refrigerator temperature. These failures could place residents at risk for not receiving the intended therapeutic response of prescribed medications and drug diversion of controlled substances. The findings include: Medication carts -800 Hall An observation and interview on 01/29/25 at 11:35 PM with LVN G, revealed an Individual control drug record for one resident (#26) revealed the wrong remaining amount of medication when compared to blister packet. Per LVN G she iwas to adjust the medication count as soon as she administers medication to the resident to prevent drug diversion. Resident #26 Review of Resident #26 ' s Admission Record dated 01/30/25 revealed [AGE] year-old male was admitted on [DATE]. Review of Resident #26 's Diagnoses dated 01/16/2025 revealed Other Chronic Pain (any type of persistent pain lasting beyond the normal healing period). Review of Resident #26 's Quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief interview of mental status) of 15 indicating that residents cognitive function is considered intact. (continued on next page)

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	676060	A. Building B. Wing	01/31/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #26 's Care Plan dateds 1/16/25 revealed at risk for complications R/T receiving opioid medication. Interventions included: Administer medication as ordered, monthly pharmacy review for possible interactions, notify physician as needed, observe for increased drowsiness, and observe pain level daily. ADL self careself-care performance deficit r/t impaired balance, pain. Review of Resident #26's Medication Administration Record (MAR) dated January 2025 revealed Tramadol HCL tablet 50 MG give 2 tablets by mouth every 8 hours as needed for pain severe. An observation on 01/29/25 at 11:35 PM revealed resident 26's individual control drug record for medication Tramadol to reflect an inaccurate count of medication (14 tablets of tramadol remaining in blister packet, but count of 16 tablets reflected on individual control drug record). In an interview on 01/29/25 at 11:35 PM with LVN G, revealed that she had administered two tablets of medication to Resident #26 during morning medication pass and had not updated the individual control drug record. She stated that she has been trained to fill it out immediately after administering medication to resident. She stated that risk of not signing drug records in a timely manner can lead to a wrong medication count and reconciliation. An interview with DON, on 01/30/25 at 4:00 PM, revealed that nurses were trained to look at residents' orders, make sure it was the right medication for the right resident and administer medication, and sign the individual control drug record it as soon as they are done administering medication. She stated that the purpose of the individual control drug record is for tacking medication, ensuring accurate count and preventing drug diversion. Record Review of facility's Pharmacy Policy and Procedure Manual titled Controlled Medication Storage dated 11/30/2018 stated Medications included in the drug enforcement administration classification as a controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with A controlled medication accountability record is prepared when receiving inventory of a schedule II medication. Accountability record necessity for scheduled III, IV or V medications will depend on state regulations or a decision of the facility. The Following information is completed: Name of resident, prescription number, Name strength (if designated), and dosage form of medication, date received, quantity received, name of person receiving medication. -700 hall During an observation and interview on 01/29/25 at 12:02 PM with LVN H revealed, controlled medication monthly log was not signed for date 01/29/25 for morning hift. Per LVN H, he is to count and sign the controlled medication monthly log daily when oncoming with the off going shift. Medication Room During an observation and interview on 01/29/25 2:19 PM with LVN G, a tour of medication room in hallway between memory care unit and 800 hall revealed a temperature log for vaccines/ medications to not be signed in the morning shift slot for date 01/29/25. Per LVN G, temperature log was supposed to be done on a daily basis in the morning by morning nurse and in the evening by afternoon nurse. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of facility's Pharmacy Policy and Procedure Manual titled Controlled Medication Storage dated 11/30/2018 revealed at each shift change or when keys are rendered, a physical inventory of all Schedule II-V controlled medication, including the emergency supply, is conducted by two licensed nurses or per state regulation and is documented on the controlled substances accountability record or verification of controlled substances count report.

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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. 51010 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services that assured the accurate acquiring, receiving, dispensing, safe and secure storage of medications for 4 of 7 nurse carts checked for medication storage; 1 of 1 treatment carts checked for storage of supplies. -The facility failed to ensure liquid medication stored in medication carts on three halls (300, 700 and 800) did not have dried drippings on the sides of the bottles. - The facility failed to ensure bottle of Betadine stored in the treatment cart was free of dried drippings. These failures could affect residents that received medications at the facility by placing them at of risk cross contamination. The findings include: Medication cart 800 Hall In an observation and interview on 01/29/25 11:35 AM with LVN G revealed the medication cart to have a bottle of ProStat with dried drippings on side of bottle. Per LVN H she states that she was trained to have bottles clean after each time she pours out medication. She stated the risk of having dirty bottles in the cart is cross contamination. 700 Hall In an observation and interview on 01/29/25 at 12:02 PM with LVN H, revealed medication cart with a bottle of pro-stat with drippings on the side of bottle. Per LVN H, he was to have all bottles clean and free from drippings to prevent contamination. 300 Hall In an observation and interview with LVN I on 01/29/25 at 12:16 medication cart between 300 and 400 hall, revealed a pro-stat medication bottle and Valporic acid medication bottle with dry drippings on side of bottle. Per LVN I she stated that she was trained to keep medication bottle clean to prevent any cross contamination. Treatment cart (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview with LVN J on 01/29/25 at 1:14PM of the treatment cart revealed a bottle of povidone iodine with dry drippings on side of bottle. Per LVN J, she cleans bottles after every use. Risk of not cleaning bottle after use can lead to contamination. In an interview with DON on 01/30/25 03:45 PM interview with DON revealed that nurses were trained to keep medication carts clean and stored by route. Medication liquid bottles are to be kept clean and upright. The risk of having dirty dripping bottles in the medication cart was a potential for bacteria to manifest. Review of facility's policy and procedure on Storage and Expiration Dating of Medications and Biologicals dated 2025, revealed no specific instructions on keeping bottles clean and free of dried drippings.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 51012 Based on observation, interview, and record review the facility failed to provide foods which were palatable, attractive, and at an appetizing temperature for 1 of 1 meal observed for food preparation. (lunch 01/28/25) The facility did not serve food at an appetizing temperature for the lunch pureed, regular, and mechanical soft meals. The pureed diet fried zucchini and Albondiga (meatball) soup were below acceptable hot food temperature of 135 F or higher. The regular diet fried zucchini was below acceptable hot food temperature of 135 F or higher. The mechanical soft diet fried zucchini and Albondiga (meatball) soup were below acceptable hot food temperature of 135 F or higher. This failure could place residents who consumed food prepared in the kitchen at risk for reduced meal satisfaction and diminished nutritional intake. Findings included: During an observation and interview on 1/28/25 at 1:35 PM the CDM Interim stated he forgot his thermometer for temperature readings of sampling trays. At 1:38 PM CDM returned to conference room with thermometer and stated he forgot the alcohol swabs needed for sanitation for thermometer for in-between sampling of entrees. He returned at 1:42 PM for temperature readings. During an observation and interview on 1/28/25 at 1:43 p.m., the CDM Interim participated in sampling a regular diet, pureed diet, and mechanical soft diet tray. The pureed diet tray consisted of pureed fried zucchini, pureed bread roll, and pureed Albondiga (meatball) soup. The pureed fried zucchini was cold with a temperature reading of 131 F and the pureed Albondiga soup was cold at 131.2 F. The regular diet consisted of Albondiga soup, a bread roll, and fried zucchini. The regular diet fried zucchini was cold with a temperature reading of 123 F. The mechanical soft tray contained Albondiga soup, fried zucchini and bread. The fried zucchini was cold with a temperature reading 126.1 F. During an Interview with the CDM Interim on 1/28/25 at 1:43 PM, he stated he recalls lowest temperature of the sample trays were low 130's F. He states the sample trays did not meet serving temperature per their policy Food Holding and Service dated October 2018 of hot foods at a temperature of 135 F. He states, I believe it was in the cart between 15 minutes which lowered the temperature. Kitchen staff takes the temperatures of the food before serving. CDM Interim stated the risks of foods below the temperature of 135 F are abused by the temperature depending how long they are in the danger zone. He stated risks for hot food below the temperature of 135 F are at risk for salmonella or other food pathogens. He stated he has reviewed the Food Holding and Service policy and stated, the time given, I do not think we are in that abuse since it is being served within a 30-minute time frame. He stated the residents are already a high risk for illnesses and they were more susceptible to the food borne illness. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of facility's policy Food Holding and Service dated October 2018, read in part: 1. Serve all hot foods at a temperature of 135 F or greater and all cold food at 41 F or less.