STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676086	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldthwaite Health & Rehab Center	1207 S Reynolds St Goldthwaite, TX 76844

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on interview, and record review, the facility failed to ensure all residents had the right to formulate an advanced directive for 8 (Resident #3, #9, #16, #21, #22, #23, #33, and #49) of 18 residents reviewed for advanced directives. The facility failed to ensure Residents #3, #16, #21, #22, #23, and #33 DNR's were not missing information in the Physician Statement Section. The facility failed to ensure Resident #9's DNR was not missing information in the Witness Section. The facility failed to ensure Resident #49's DNR was not missing information in the Physicians Statement Section and a different DNR in her printed record that was missing information in the Physicians Statement Section. The facility's failure to ensure the accuracy of a residents advanced directive such as a DNR (Do Not Resuscitate), recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care could place residents a risk for not receiving healthcare as per their or their legal representatives wishes. Findings include: Resident #3 Record review of the face sheet dated [DATE] in the clinical record for Resident #3 revealed a [AGE] year-old male resident admitted to the facility originally on [DATE] and readmitted on [DATE] with diagnoses to include epilepsy (a disorder that causes abnormal brain function, seizures), major depressive disorder (mental illness causing sadness due to lack of chemicals in the brain that cause happiness), unspecified intellectual disabilities (a developmental disorder characterized by less than averaged intelligence and significant limitations in adaptive behavior), and schizophrenia, (a serious mental health disease that causes altered perception of reality). Under the section Advanced Directives Resident #3 was listed as a DNR. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the clinical record for Resident #3 revealed the last MDS completed was a quarterly dated [DATE] with a BIMS of 2 indicating he was severely cognitively impaired, and he required supervision with most of his activities. Record review of the clinical record for Resident #3 revealed a care plan with an admitted [DATE] with the following: Resident #3 had an order for Do Not Resuscitate (DNR)-Date initiated [DATE]. Record review of the clinical record for Resident #3 revealed an Order Summary with active orders as of [DATE] with the following order: DNR (with an order date of [DATE]) Record review of the clinical record for Resident #3 revealed a DNR dated [DATE] (signed by the physician) with the following: Section-Physician Statement-there was no license number for the physician's signature. Resident #9 Record review of the face sheet dated [DATE] in the clinical record for Resident #9 revealed a [AGE] year-old female resident admitted to the facility originally on [DATE] and readmitted on [DATE] with diagnoses to include dementia (cognitive loss), muscle wasting (breakdown of muscles), diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), atrial fibrillation (abnormal heartbeat), major depression (mental illness causing sadness due to lack of chemicals in the brain that cause happiness), cardia arrythmia (a condition in which the heart beats with an irregular or abnormal rhythm). Under the section Advanced Directives Resident #9 was listed as a DNR. Record review of the clinical record for Resident #9 revealed the last MDS completed was a quarterly dated [DATE] with a BIMS of 1 indicating she was severely cognitively impaired, and she was dependent on others to complete her activities of daily living. Record review of the clinical record for Resident #9 revealed a care plan with an admitted [DATE] with the following: Resident #9 had an order for Do Not Resuscitate (DNR)-Date initiated [DATE]. Record review of the clinical record for Resident #9 revealed an Order Summary with active orders as of [DATE] with the following order: DNR (with an order date of [DATE]) Record review of the clinical record for Resident #9 revealed a DNR dated [DATE] (signed by the resident) with the following: Section-Witnesses-there was no printed signature for either witness. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #16 Record review of the face sheet dated [DATE] in the clinical record for Resident #16 revealed a [AGE] year-old male resident admitted to the facility originally on [DATE] and readmitted on [DATE] with diagnoses to include diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), acute kidney failure (disease of the kidneys leading to kidney failure), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), heart failure (a chronic condition in which the heart dose not pump blood as well as it should). Under the section Advanced Directives Resident #16 was listed as a DNR. Record review of the clinical record for Resident #16 revealed the last MDS completed was a significant change of condition status dated [DATE] with a BIMS of 6 indicating he was severely cognitively impaired, and he required supervision with most of his activities. Record review of the clinical record for Resident #16 revealed a care plan with an admitted [DATE] with the following: Resident #16 had an order for Do Not Resuscitate (DNR)-Date initiated [DATE]. Record review of the clinical record for Resident #16 revealed an Order Summary with active orders as of [DATE] with the following order: DNR (with an order date of [DATE]) Record review of the clinical record for Resident #16 revealed a DNR dated [DATE] (signed by the physician) with the following: Section-Physician Statement-there was no printed signature for the physician. Resident #21 Record review of the face sheet dated [DATE] in the clinical record for Resident #21 revealed a [AGE] year-old female resident admitted to the facility originally on [DATE] and readmitted on [DATE] with diagnoses to include cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), hemiplegia (loss of use of the left side of the body), hypertension (high blood pressure), pain, major depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Under the section Advanced Directives Resident #21 was listed as a DNR. Record review of the clinical record for Resident #21 revealed the last MDS completed was a significant change of condition dated [DATE] with a BIMS of 15 indicating she was cognitively intact, and she was dependent on others to complete her activities of daily living. Record review of the clinical record for Resident #21 revealed a care plan with an admitted [DATE] with the following: Resident #21 had an order for Do Not Resuscitate (DNR)-Date initiated [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the clinical record for Resident #21 revealed an Order Summary with active orders as of [DATE] with the following order: DNR (with an order date of [DATE]) Record review of the clinical record for Resident #21 revealed a DNR dated [DATE] (signed by the resident) with the following: Section-Physician Statement-there was no printed signature for the physician. Resident #22 Record review of the face sheet dated [DATE] in the clinical record for Resident #22 revealed a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include Schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), alcohol use with alcohol-induced persisting dementia, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), hypertension(a condition in which the foresee of the blood against the artery walls is too high), pulmonary embolism(clot blocking blood flow to lungs. alcoholic cirrhosis of the liver (an advanced stage of alcoholic liver disease that cause your liver to become stiff, swollen, and barely able to do its job), chronic hepatitis (inflammation of the liver), alcohol-induced pancreatitis (an advanced stage of alcoholic disease that cause your pancreas to become stiff, swollen, and barely able to do its job). Under the section Advanced Directives Resident #22 was listed as a DNR. Record review of the clinical record for Resident #22 revealed the last MDS completed was a significant change of condition status dated [DATE] with a BIMS of 5 indicating he was severely cognitively impaired, and he required partial to moderate assistance with most of his activities. Record review of the clinical record for Resident #22 revealed a care plan with an admitted [DATE] with the following: Resident #22 had an order for Do Not Resuscitate (DNR)-Date initiated [DATE]. Record review of the clinical record for Resident #22 revealed an Order Summary with active orders as of [DATE] with the following order: DNR (with an order date of [DATE]) Record review of the clinical record for Resident #22 revealed a DNR dated [DATE] (signed by the physician) with the following: Section-Physician Statement-there was no license number provided for the physician. Resident #23 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the face sheet dated [DATE] in the clinical record for Resident #23 revealed a [AGE] year-old female resident admitted to the facility originally on [DATE] and readmitted on [DATE] with diagnoses to include myocardial infarction (heart attack), diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), coronary atherosclerotic heart disease (damage or disease in the hearts major blood vessels), unspecified psychosis(severe mental disorders that cause abnormal thinking and perceptions), dementia (a group of thinking and social symptoms that interferes with daily functioning), Under the section Advanced Directives Resident #23 was listed as a DNR. Record review of the clinical record for Resident #23 revealed the last MDS completed was a quarterly dated [DATE] with a BIMS of 3 indicating she was severely cognitively impaired, and she requires moderate to substantial assistance with all her activities of daily living. Record review of the clinical record for Resident #23 revealed a care plan with an admitted [DATE] with the following: Resident #23 had an order for Do Not Resuscitate (DNR)-Date initiated [DATE]. Record review of the clinical record for Resident #23 revealed an Order Summary with active orders as of [DATE] with the following order: DNR (with an order date of [DATE]) Record review of the clinical record for Resident #23 revealed a DNR dated [DATE] (signed by the physician) with the following: Section-Physician Statement-there was no license number provided for the physician. Resident #33 Record review of the face sheet dated [DATE] in the clinical record for Resident #33 revealed a [AGE] year-old female resident admitted to the facility originally on [DATE] and readmitted on [DATE] with diagnoses to include cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), paranoid schizophrenia(a disease that affects a person's ability to think, feel, and behave clearly), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), pain, hypertension (a condition in which the foresee of the blood against the artery walls is too high), hemiplegia (partial paralysis). Under the section Advanced Directives Resident #33 was listed as a DNR. Record review of the clinical record for Resident #33 revealed the last MDS completed was a quarterly dated [DATE] with a BIMS of 10 indicating she was moderately cognitively impaired, and she was dependent on staff for assistance with all her activities of daily living. Record review of the clinical record for Resident #33 revealed a care plan with an admitted [DATE] with the following: Resident #33 had an order for Do Not Resuscitate (DNR)-Date initiated [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the clinical record for Resident #33 revealed an Order Summary with active orders as of [DATE] with the following order: DNR (with an order date of [DATE]) Record review of the clinical record for Resident #33 revealed a DNR dated [DATE] (signed by the physician) with the following: Section-Physician Statement-there was no printed signature for the physician. Resident #49 Record review of the face sheet dated [DATE] in the clinical record for Resident #49 revealed a [AGE] year-old female resident admitted to the facility originally on [DATE] and readmitted on [DATE] with diagnoses to include pain, dysphagia (difficulty swallowing), dementia(a group of thinking and social symptoms that interferes with daily functioning), chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), diabetes(a chronic condition that affects the way the body processes blood sugar (glucose), hypertension (a condition in which the foresee of the blood against the artery walls is too high). Under the section Advanced Directives Resident #49 was listed as a DNR. Record review of the clinical record for Resident #49 revealed the last MDS completed was an admitted d [DATE] with a BIMS of 4 indicating she was severely cognitively impaired, and she required moderate to substantial assistance with all her activities of daily living. Record review of the clinical record for Resident #49 revealed a care plan with an admitted [DATE] with the following: Resident #49 had an order for Do Not Resuscitate (DNR)-Date initiated [DATE]. Record review of the clinical record for Resident #49 revealed an Order Summary with active orders as of [DATE] with the following order: DNR (with an order date of [DATE]) Record review of the clinical record for Resident #49 revealed the following: A DNR in Resident #49's electronic record dated [DATE] (signed by the adult child) with the following: Section-Physician Statement-there was no Physician Signature, no date of signature, no license number, and no printed signature. Section-All persons who have singed above must sign below, acknowledging that this document has bene properly completed. -There was no signature for Guardian/Agent/Proxy/Relative Signature. A DNR on the unit printed for staff to reference for Resident #49 dated [DATE] (signed by the physician) with the following: (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section-Physician Statement-there was no printed signature or license number provided for the physician. During an interview on [DATE] at 03:21 PM RN A reported that if a resident coded, he would check that resident's computer profiled to determine that residents code status and that the code status could also be found at the front of the residents basic (printed) chart that was kept on the unit. RN A pulled the basic chart for Resident #23 (that he was responsible for this shift) and pointed out that the first page of the chart indicated that Resident #23 was a DNR and therefore he would not start CPR if she was coding. RN A verified that a DNR had to have completed information in order for the DNR to be active or valid. RN A reviewed Resident #23's DNR, noted that the physicians license number was missing and reported the DNR was not completed. RN A reported that if Resident #23 was to code (stop breathing or her heart stopped) at this time he would perform CPR. RN A reviewed the other 7 residents DNR's that were missing information and reported that they were also invalid and therefor if the residents were to code, he would start CPR. During an interview on [DATE] at 03:25 PM RN B (the Treatment Nurse for the facility this shift) reported that to determine a resident's code status she would check the resident's basic (printed) chart on the unit. RN B pulled Resident #49's printed DNR that was in the basic chart on the unit and noted the first page in the provided chart was a copy of Resident #49's DNR. RN B reported that Resident #49 was a DNR and therefor if the resident was not breathing or Resident #49's heart stopped, RN B would withhold CPR. When asked to review Resident #49's DNR, RN B reviewed the DNR and noted the physicians printed signature and license number were missing (unlike the DNR provided to this surveyor by the DON printed from Resident #49's electronic chart that was missing the physician signature, date, printed signature, and license number). RN B reported that due to the missing information the DNR was not valid and therefor she would have to perform CPR on Resident 49 if she coded. Resident #49 would be considered a full code (which means staff will start CPR if Resident #49 codes) until the DNR is correctly completed. RN B reviewed the 7 other residents DNR's and verified they were also missing information and were not valid until they were corrected. During an interview on [DATE] at 09:02 AM the DON reported that all residents are offered the choice for code status at admission and then the chart to include the computer and printed chart on the unit are marked as directed. The DNR is uploaded to computer once completed. The DON reported that the BDM is the one responsible for offering and completing the DNR if the resident wishes that to be their code status. The BDM is responsible for completing the DNR because she is a notary. The DON reported that he is aware of the 8 residents that have missing information on their current active DNR's and that he has already started an in-service with the nurses to correct the issue. The DON also reported that the facility has started a full review of all the residents in the system to verify their code status and the accuracy of their information. The DON reviewed the 8 residents currently listed and verified that they were all missing information on their DNR form and therefor currently had invalid DNR's. The DON reported that the facility still considered these residents to be DNR's and would not perform CPR if they coded due to knowing each resident's wishes despite the invalid DNR. When asked what the consequences of the DNR process not being completed correctly the DON stated, It does not negate the residents wishes in my mind. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 09:20 AM the BDM verified that she completes all the DNR interviews with each resident at admission, that she helps the resident complete their section, she then completes the section for the witness since she is a notary, then she gives the form to medical records to send to the physician to complete. She reported that she is not responsible for making sure the DNR form is complete. During an interview on [DATE] at 09:31 AM MR C verified that she received the DNR form from the BDM, she then sends the form to the physician, and when the form is returned, she checks it and puts the form in the resident's chart. MR C stated, I guess I have missed some of the information that should have been in them. I have a lot of papers that I deal with, and I don't always catch everything. MR C verified that she has not been trained on how to accurately fill out a DNR. Record review of the facility provided training dated [DATE] revealed the following: Noted incomplete OOH DNR form in EMR. Please ensure that all required areas are filled out on the OOH DNR form prior to being sent for physician signature. Record review of facility provided policy titled Do Not Resuscitate Order, revised [DATE], revealed the following: The Out of Hospital DNR Form The Out of Hospital DNR form was designed by the Texas Department of Human Services to comply with the requirement as set forth in the Health and Safety Code for the purpose of instructing Emergency Medical personnel and other health care professionals to forgo resuscitation attempts. 11. All validly executed DNR orders will be honored by the facility. Record review of the facility provided policy titled Self Determination End of Life Measures, revised [DATE], revealed the following: 5. The facility will ensure compliance with the requirements of Texas law concerning appropriate health care provisions . 8. The residents right to execute and advanced directive or make changes to an existing advanced directive . will be recognized an applicable under Texas state law. Record review of OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER-TEXAS DEPARTMENT OF STATE HEALTH SERVICES, undated revealed the following: -The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professional

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48208 Based on record reviews and interviews, the facility failed to assess residents timely using the quarterly review instrument specified by the State, no later than 14 days from the ARD date for 1 of 18 residents (Resident #38) reviewed for MDS assessments. Resident #38's quarterly MDS was not completed fourteen days after the ARD date of 1/5/24. This failure can result in inadequate care and care plans not updated correctly. Findings include: Record review of Resident #38's clinical record revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #38 had diagnoses which included but not limited to dementia (group of symptoms that affects memory, thinking and interferes with daily life), hypertension (high blood pressure), syncope and collapse (sudden loss of consciousness and muscle strength), and edema (swelling due to excess fluid). Record review of Resident #38's quarterly MDS reflected a BIMS of 07, which indicated moderate cognitive impairment. Record review of Resident #38's Quarterly MDS ARD target date began 1/5/24, reflected a completion date of 1/23/24 which indicated 18 days after the ARD date. An interview on 1/31/24 at 10:02 AM with MDS N revealed she oversaw MDS assessments. MDS N stated she has a calendar to assist with assessment schedules. MDS N revealed a MDS was completed with the RN signature. A quarterly MDS assessment was completed every 92 days and must be completed within 14 days after the ARD date. MDS N stated Resident #38's MDS ARD date was 1/5/24 and was not completed until 1/23/24. MDS N stated Resident #38's MDS was late. MDS N stated the negative outcome for not completing a quarterly MDS on time was the resident's care plan was not updated . MDS N indicated she used the RAI manual for guidance with MDS assessments. Record review of the Resident Assessment Instrument 3.0, dated October 2023, Chapter two page 24 reflected the MDS completion date must be no later than 14 days after the ARD (ARD+ 14 calendar days. This date may be earlier than or the same as the CAA(s) completion date, but not later than.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48208 Based on interview and record review the facility failed to ensure new residents were not admitted with mental disorders, unless the State mental health authority had determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority prior to admission for 1 of 18 residents (Resident #44) reviewed for PASRR assessments . The facility failed to ensure Resident #44 had a PASRR Level 1 screening prior to admission. This failure could place residents at risk of not obtaining services related to mental illness, intellectual or development disabilities, or developmental disabilities. Findings include: Record review of Resident #44's face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #44had diagnoses which included, but not limited to, Alzheimer's Disease (type of dementia that affects memory, thinking and behavior), hypertension (high blood pressure) and hyperlipidemia (high cholesterol). Record review of Resident #44's level 1 PASRR screening reflected a completed date of 7/24/23, approximately 30 days after the resident was admitted to the facility. An interview on 1/31/24 at 1:39 PM with MDS N revealed she oversaw PASRR assessments when a resident was admitted . MDS N stated PASRR identified any mental illness. MDS N was provided with the admitted Resident #44 (6/7/23). MDS N stated Resident #44's PASRR was late and didn't know how that happened. MDS N stated a negative outcome depended, but she did not feel there would be one with no PASRR prior to admission for Resident #44 since she did not have a mental illness. MDS N stated PASRR identified if the resident had a mental illness and if a resident qualified for extra services . An interview on 11/31/24 at 2:30 PM, the DON stated there was not a PASRR policy in place as the facility followed the HHSC guidelines for PASRR assessments .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48208 Based on interview and record review, the facility failed to ensure comprehensive care plans were developed within 7 days after completion of the comprehensive assessment and reviewed and revised by the interdisciplinary team after each assessment which included both the comprehensive and quarterly review assessments for 7 of 18 residents (Residents #1, #3, #23, #31, #33, #35 and #38) reviewed for comprehensive care plans. The facility failed to update the comprehensive person-centered care plans to address the needs of Residents #1, #3, #23, #31, #33, #35 and #38 within 7 days after MDS assessments were completed. This deficient practice could place residents at risk of delayed treatment, care, and services that could result in residents not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being. Findings include: 1. Record review of Resident #1's face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included, but not limited to, Cerebral Palsy (neurological disorder that affect movement and muscle ton due to brain injury or malformation before, during, or after birth), psychotic disorder with delusions (mental health condition in which a person can't tell what's real from what's imagined), atherosclerotic heart disease of native coronary artery without angina pectoris (narrowed arteries close to the heart which can cause chest pain) and depression (mood disorder that causes a persistent feeling of sadness and loss of interest. Record review of Resident #1's MDS assessments, undated, reflected three MDS assessments with the following completed dates: 7/7/23 (Annual), 10/19/23 (Quarterly), and 1/7/24 (Quarterly). Record review of Resident #1's, undated, care plans reflected three care plans completed with the following dates: 6/15/23 (23 days prior to completion of annual MDS assessment), 9/12/23 (25 days prior to completion of quarterly MDS assessment, and 12/12/23 (26 days prior to completion of quarterly MDS assessment). 2. Record review of Resident #3's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included, but not limited to, Fragile X Chromosome (genetic disorder characterized by mild-to-moderate intellectual disability), borderline personality disorder (mental health disorder that impacts the way you think and feel about yourself and others, causing problems functioning in everyday life), unspecified intellectual disabilities (limitations in mental abilities that affect intelligence, learning, and everyday life skills), and epilepsy (neurological disorder that causes seizures or unusual sensations and behaviors). Record review of Resident #3's MDS assessments reflected the following dates the assessments were completed: 12/21/23 (Quarterly), 12/4/23 (Quarterly) and 9/10/23 (Quarterly). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's care plans reflected three care plans were completed with the following dates: 11/2/23 (49 days prior to completion of quarterly MDS assessment), 8/8/23 (33 days prior to MDS assessment completed 9/10/23) and 5/9/23. There were no additional care plans to correspond with the three dates provided for the MDS assessments. 3. Record review of Resident #23's face sheet, dated 1/29/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #23 had diagnoses which included, but were not limited to, unspecified dementia (group of symptoms that affects memory, thinking and interferes with daily life), type 2 diabetes (problem in the way the body regulates sugar), anxiety disorder (consistent fear and worry), and atherosclerotic heart disease of native coronary artery without angina pectoris (narrowed arteries close to the heart which can cause chest pain). Record review of Resident #23's MDS assessments reflected the following dates of completed assessments: 1/4/23 (Quarterly), 10/18/23 (Quarterly), and 7/17/23 (Quarterly). Record review of Resident #23's completed comprehensive care plans reflected the following dates: 1/3/24 (1 day prior to completion of MDS assessment), 11/8/23 (21 days after completion of MDS assessment), and 7/26/23 (9 days after completion of MDS assessment). 4. Record review of Resident #31's face sheet, dated 1/30/23, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #31 had diagnoses which included, but were not limited to, unspecified dementia (group of symptoms that affects memory, thinking and interferes with daily life), anxiety disorder (consistent fear and worry), insomnia (trouble falling or staying asleep), and major depressive disorder (persistent feeling of sadness and loss of interest). Record review of MDS assessments completed for Resident #31 reflected the following dates each assessment was completed: 10/4/23 (Quarterly), and 9/15/23 (Annual). Record review of completed comprehensive care plans for Resident #31 reflected two completed care plans dated 7/26/23 and 4/26/23. 5. Record review of Resident #33's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with a readmitted [DATE]. Resident #33 had diagnoses which included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis and diminished strength of one side of the body following a stroke), major depressive disorder (persistent feeling of sadness and loss of interest), anxiety disorder (consistent fear and worry), and central pain syndrome (rare disorder that makes the brain feel pain without any injury to the body). Record review of Resident #33's MDS assessments reflected the following completion dates: 11/19/23 (Quarterly), 8/29/23 (Quarterly), and 6/5/23 (Annual). Record review of Resident #33's care plans reflected the following completed dates: 1/3/24 (45 days after comprehensive assessment completed 11/19/23), 9/7/23 (9 days after MDS assessment completed on 8/29/23), and 4/26/23 (40 days prior to MDS assessment completed on 6/5/23). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Record review of Resident #35's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with a readmit on 11/18/23. Resident #35 had diagnoses which included, but were not limited to, heart failure, type 2 diabetes (problem in the way the body regulates sugar), obesity, major depressive disorder (persistent feeling of sadness and loss of interest), and anxiety disorder (consistent fear and worry). Record review of Resident #35's MDS assessments reflected the following completion dates: 1/4/24 (Annual), 11/13/23 (Quarterly), and 8/16/23 (Quarterly). Record review of Resident #35's care plans reflected the following completed dates: 1/17/24 (13 days after the completed MDS assessment dated [DATE]). No care plan was completed for MDS assessment dated [DATE]. 7. Record review of Resident #38's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #38 had diagnoses which included, but were not limited to, dementia (group of symptoms that affects memory, thinking and interferes with daily life), hypertension (high blood pressure), syncope and collapse (sudden loss of consciousness and muscle strength), and edema (swelling due to excess fluid). Record review of Resident #38's MDS assessments reflected an assessment was completed on 1/23/24. Record review of Resident #38's care plan reflected a completed date of 1/3/24 (20 days prior to the completion of the MDS assessment on 1/23/24). An interview on 01/31/24 at 10:02 AM, MDS N stated care plans should be completed 7 days after the MDS assessment is completed. MDS N stated the DON started the care plan. MDS N stated a negative outcome was staff didn't have an accurate care plan and the care plans were not updated. An interview on 01/31/24 at 10:18 AM, the DON stated he was responsible for care plans. The DON stated the SW did a care plan when the resident was to return home but about 95% of it was the DON. The DON stated care plans were done quarterly but care plans were all updated in real time and there were many areas the care areas were pulled from. The DON stated the EMR was not perfect with it. The DON stated the care plan were updated with anything specific to medication, specific to admission (readmission). If the resident was out for several months, the DON stated he reactivated them but didn't change the date. MDS N oversaw uploading the care plans. The DON stated there was no negative outcome because care plans were comprehensive; there was nothing in the MDS that was not already in the care plan. The DON stated he was unaware where care areas were pulled from. Record review of the facility policy titled Care Plans, revised 10/4/22, reflected on line 3, The comprehensive care plan must be developed within seven days after completion of the comprehensive assessment. Line 4. The comprehensive care plan will be reviewed regularly, as per guideline, and/or with significant change and revised by a team of qualified person after each assessment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled IDT Inservice- Care Plans, updated 2/7/23, reflected on the third bullet point- The comprehensive care plan needs to be completed no later than day 21 or the date signed on the care plan decisions on the MDS. The Fourth bullet point read- There needs to be a care plan review with each completed MDS (Quarterly, Annual, Sig . Change). Under heading Care Plan Meeting, it read: - Care plan will be scheduled about 2 weeks after the ARD . - MDS Coordinator will complete the MDS and do the care plan review before the care plan meeting. Record review of the Resident Assessment Instrument 3.0, dated October 2023, Chapter two page 17-18 reflected a table showing when items should be completed with a comprehensive assessment. Under heading Care Plan Completion Date- Admission (Comprehensive), Annual (Comprehensive), Significant Change in Status (SCSA) (Comprehensive), and Significant Correction to Prior Comprehensive (SCPA) (Comprehensive), all are noted to be timed at CAA(s) Completion date plus 7 calendar days.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31882 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with the professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure foods were properly stored, labeled, and dated. 2. The facility failed to ensure general cleanliness was maintained in the kitchen. 3. The facility failed to ensure hairnets were worn. 4. The facility failed to ensure staff did not use hands when serving food. These failures could place residents who ate food served by the kitchen at risk of food-borne illness. Findings include: Observation of the freezer on [DATE] @ 9:05 AM revealed the following: 1. (3) bags of tater tots, no label or date, not in the original box. 2. (1) bag of frozen dumplings, no label or date, not in the original box. Observation of the kitchen food prep area on [DATE] at 9:10 am revealed the following: 1. 1 opened bottle of coca cola, money, and a lady's purse on the kitchen prep area counter. 2. Several bottles of decorating sugar with a best by date of ,d+[DATE] 3. A container of baking powder with a use by date of [DATE] 4. A bottle of creole seasoning with a use by date of [DATE] 5. A bottle of celery salt with a best by date of ,d+[DATE]. 6. A bottle of nutmeg with a best by date of [DATE] 7. A metal container of flour was observed with a large flour bag on top of the loose flour inside the bin. The bin was grimy and sticky to the touch. The lid was not properly secured on the bin. 8. A metal container of rice was grimy and sticky to the touch. The lid was not properly secured on the bin. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. Bags of Pasta, Stuffing and French-fried onions were stored inside pots and pans in the kitchen prep area. Observation of the cooler on [DATE] at 9:14 am, revealed a package of cheese, no label or date, not in original box. In an observation and interview of the lunch service on [DATE] at 12:00 pm, [NAME] G was observed touching kitchen surfaces with gloved hands in the kitchen. [NAME] G touched the steam table, took foil off pans of food, and picked up serving utensils and plates during the noon meal service. [NAME] G did not wash her hands or change her gloves. During that time, [NAME] G began plating the food then picked up a biscuit with her gloved hand and placed the roll on the plate. This was done 2 times before surveyor intervention. The DM was also present and observed [NAME] G pick up a biscuit with her gloved hand. [NAME] G did not wash hands or change gloves between tasks. [NAME] G stated she just forgot and was supposed to use tongs when touching bread. [NAME] G stated not changing gloves and using tongs could cause cross contamination and illness for the residents. The DM stated she oversaw training, and she talked to the staff all the time about hand washing and the use of tongs. The DM stated [NAME] G knows better than to use her hands and was nervous. The DM stated this could cause cross contamination for the residents. Observation on [DATE] at 1:25 pm revealed [NAME] H was in the kitchen prep area with no hairnet. He stated, I rub my head and it just comes off. Observation of the kitchen food prep area on ,d+[DATE] /24 at 1:30 pm revealed metal containers of flour, and rice were sticky and grimy to the touch. The container lids had food crumbs on the top and were sticky to the touch. The lids were not secured. The flour bin had bags of additional flour sitting on top of the loose flour in the bin. In an observation and an interview on [DATE] at 2:47 pm, [NAME] H was observed in the kitchen dishwashing area with no hairnet. [NAME] H stated he did not realize he did not have it on. [NAME] H stated he had just come back into the kitchen and had forgotten. [NAME] H stated the consequences of not wearing a hairnet was hair in the kitchen. In an interview and a walk through with the DM on [DATE] at 2:15 pm, the DM stated of the issues with the food grime and crumbs on the containers of the rice and flour containers and the expired spices in the kitchen that she is sorry they had missed it and she will get it cleaned. The DM stated she expects all staff to be cleaning daily. The DM stated she had been out of the facility, and it was just missed. The DM stated she trained the staff on cleaning practices and the labeling and dating of foods. The DM stated she expects all staff to label and date all food items after they use the package. The DM stated the consequences of not labeling and dating foods could cause residents to have food borne illnesses. The DM stated the consequences of not storing food properly would possibly make the residents sick if consumed. She further stated residents could get sick from the food not being covered or refrigerated after being opened. The DM stated she was aware staff were to always wear hairnets in the kitchen and had been telling [NAME] H to put one on all day. The DM stated a consequence of not having hairnets on would be hair in the food and on kitchen surfaces. The DM stated [NAME] G was just nervous when she touched the bread without tongs. The DM stated [NAME] G knew she was supposed to use tongs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record Review of the policy dated 2012, titled Sanitation and Food Handling documented: Hair nets are to be always worn. Handle all utensils and dishes so the food or customer contact surfaces are not touched. Do not handle food with bare hands. Use the proper utensils or wear disposable gloves. Remember to change the gloves after touching anything that should not contact food, including hair, clothing, doorknobs, etc. All unused food must be securely covered. All items are to be labeled and dated as to their contents. Store items in their original container Record Review of the policy dated 2012, titled Work Conduct documented: All personal belongings (cigarette packages, sweaters, papers, books, cell phones and purses) must be kept out of the food preparation area. There is to be no eating while on duty, except in the employee dining area during scheduled breaks. Record Review of the policy dated 2012, titled Infection Control documented: Hair is to be covered with an effective hair restraint. Careful handwashing will be done between handling of cooked and uncooked foods, between handling of dirty dishes, boxes, or equipment and handling clean food or utensils. All kitchen ware and food contact used in the preparation and /or serving of food are cleaned and sanitized before use and after each meal preparation. There shall be no bare hand contact. All kitchen ware and food contact surfaces will be cleaned and sanitized after each use. Record Review of the policy dated 2012, titled Food Safety documented: Food is to be tightly wrapped or sealed in covered containers. Opened food shall be covered, labeled, and dated. Never store scoops ladle or other food contact equipment directly in the food container. Do not keep food past the labeled expiration date. Gloves must be worn for preparation and service of foods that do not require further cooking. Record Review of the policy dated 2012, titled Dry Storage and Supplies documented: Dry bulk foods will be stored in seamless metal or plastic containers with tight lids or covers which are easily sanitized. Scoops should not be left in bins. Containers are cleaned regularly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39813 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 (CNA D and CNA E) of 5 staff observed for resident care. -CNA D did not wash her hands or place supplies properly while performing incontinent care. -CNA E did not wash her hands while performing incontinent care. This deficient practice has the potential to affect residents in the facility receiving incontinent care by exposing them to care that could lead to the spread of infections, tissue breakdown, and feelings of isolation related to poor hygiene. Findings include: During an observation on 1-30-2024 at 09:52 AM of incontinent care performed by CNA D (Primary) with CNA E (Assisting), both CNAs were noted entering the residents room and did not wash their hands or use ABHR. CNA D removed a new brief and package of wipes from the Residents dresser and placed them directly on the resident mattress next to the resident. CNA D then put on gloves. CNA E put on gloves and removed the Residents covers. CNA D removed several wipes and placed them along with the new brief on the mattress sheets next to the resident leg. CNA D then pulled the residents brief down and cleaned the resident perineal and vaginal area with 3 separate wipes. CNA E rolled the resident to her side with CNA D's assistance. CNA D used a wipe to clean the resident's rectal area. CNA D then picked up the new brief and placed it under the resident and assisted CNA E to roll the resident to her back. CNA D finished placing/pulling up the new brief and secured it. CNA D removed her gloves for the first time since starting the procedure and placed them in the trash. CNA E removed her gloves for the first time since starting the procedure and placed them in the trash. CNA D and CNA E placed the resident in a position of comfort and exited the room. No hand hygiene was performed an anytime while in the resident's room. During an interview on 1-30-2024 at 10:00 AM CNA D and CNA E both verified that they did not perform any hand hygiene while in the room during the incontinent care. CNA E reported they did use ABHR prior to entering the room (this was not witnessed by this surveyor) but did not perform any hand hygiene while in the room performing care. Both verified that they should have performed hand hygiene to include handwashing upon entry to the room and before placing a new brief. CNA D reported that it can lead to poor hygiene for the resident, that the new brief was probably soiled. Both reported that if incontinent care is not performed correctly then a resident could develop an infection and there would be cross contamination. Both verified that not preforming hand hygiene upon completion of incontinent care and prior to leaving the room can result in carrying an infection to the next resident they provide care for. During an interview on 1-30-2024 at 02:49 PM CNA D reported that CNA E went home at 2PM and was not available. CNA D reported that her training for incontinent care and handwashing was performed by LVN F who was unavailable today and that the training was completed about a month ago. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1-31-2024 at 09:12 AM the DON reported that he expects his staff to perform hand hygiene constantly. They should perform hand hygiene when they do any resident care, patient care, or toileting. With incontinent care they should perform hand hygiene prior to starting the care, any time they go from the dirty to clean portion of the care, and upon completion. The DON reported that staff should perform hand hygiene before exiting a resident's room especially when providing resident care to prevent the risk of cross contamination. The DON reported that If a staff members hands are soiled, they should perform handwashing, otherwise use of ABHR can suffice. The DON reported that if hand hygiene is not performed correctly then infection control will be violated and the potential for spreading infection will be great. Record review of the competency assessment titled Certified Nurse Aide Competency Verification completed for CNA D on 2-17-2023 revealed the following: Demonstrates Proficiency in performing technical procedures safely . Grooming/Hygiene B-Wash Hands-Results: Competent, experienced, . C. Observed infection control Practices; Appropriated use of PPE (gloves .)-Results: Competent, experienced, . D. Observed infection control Practices; Cross Contamination .-Results: Competent, experienced, . F. Provide Peri-Care-Results: Competent, experienced, . J. Wash Hands-Results: Competent, experienced, . -Competency Assessment: Hand Hygiene: Washing hands is the single most important thing you can do to prevent the spread of disease to yourself and others. Wash hands before and after using the restroom, after touching any body substance, after handling contaminated items, before putting on gloves, immediately after removing gloves . between all contact with persons in your care . -Signed by CNA D on 2-17-2023. Record review of the competency assessment titled Certified Nurse Aide Competency Verification completed for CNA E on 11-01-2023 revealed the following: Demonstrates Proficiency in performing technical procedures safely . Grooming/Hygiene B-Wash Hands-Results: Competent, experienced, . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Observed infection control Practices; Appropriated use of PPE (gloves .)-Results: Competent, experienced, . D. Observed infection control Practices; Cross Contamination .-Results: Competent, experienced, . F. Provide Peri-Care-Results: Competent, experienced, . J. Wash Hands-Results: Competent, experienced, . -Competency Assessment: Hand Hygiene: Washing hands is the single most important thing you can do to prevent the spread of disease to yourself and others. Wash hands before and after using the restroom, after touching any body substance, after handling contaminated items, before putting on gloves, immediately after removing gloves . between all contact with persons in your care . -Signed by CNA E on 11-01-2023. Record review of the facility provided policy titled Perineal Care dated 12-8-2009, revealed the following: (Noted this policy was provided as part of CNA D and CNA E's competency evaluations) Procedural Guidelines: A Beginning steps. a. Wash hands B. If requires, remove all items form the residents beside table, place a barrier towel on the table, and items required to perfume care can be placed on the able. H. Wash hands and put on clean gloves for perineal care. I. Gently wash the perineal area. h. change gloves J. Cleaning the rectal and buttock area. b. gently wash the rectal and buttocks c. Change gloves K. Closing steps. a. If gloved, removed and discard gloves. Wash hands.