STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676104	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grapevine Medical Lodge	1005 Ira E. Woods Parkway Grapevine, TX 76051

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review the facility failed to develop and implement a person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #75) of 1 resident reviewed for Care plan in that: The facility failed to care plan Resident #75 self-feeding via the g-tube three times a day since admission on 04/02/2025. This failure could place residents at risk of needs not being met and a decline in resident's health. Findings included: Review of Resident #75's admission record dated 04/13/25, revealed she was a [AGE] year-old female with an initial admitted [DATE] and readmitted [DATE]. Her primary diagnosis was lack of coordination. Her secondary diagnoses included progressive systemic sclerosis (this is an autoimmune disease that causes the body to produce too much collagen which causes the skin and internal organs to harden and tighten), dysphagia/oropharyngeal phase (difficulty swallowing), idiopathic nonspecific intestinal pneumonitis (this is an unknown cause of chronic lung diseases), unspecified severe protein calorie malnutrition, Reynaud's syndrome without gangrene (this is a condition in which some areas of the body feel numb and cool), idiopathic hypotension (low blood pressure upon standing with an unknown cause) and gastroparesis (a stomach condition affects stomach muscles). Resident #75 was her own responsible party. Review of Resident #75's quarterly MDS dated [DATE] reflected Resident #75 had a BIMS score of 15, indicating she was cognitively intact. She makes herself understood, and she understands others. The document reflected Resident #75 had a feeding tube and received 51% or more of her nutrition through the feeding tube. The document also reflected Resident #75 required supervision or touching assistant with eating ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. Review of Resident#75's April 2025 physician orders reflected . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Enteral Feed Order every shift Enteral: Enteral Nutrition via Bolus: [Brand name] 1.5 calorie 120 ml TID per day via bolus via peg tube with meals.1.5kcal,17 grams protein, 50ml free water before and after bolus feeding to provide a total of 575ml free water/day from formula. - Enteral Feed Order every shift Enteral: Check tube placement via residual and tube visualization before initiation of formula, medication administration, and flushing tube - Regular/Enhanced diet, regular texture, Regular consistency, for diet - Enteral Feed Order every 4 hours Enteral: Flush feeding tube with 180 ml of free water per every four hours. - Torsemide Tablet 20 MG Give 4 tablet orally two times a day for edema (swelling) -Physician orders did not reflect self-administration of enteral feeding by Resident #75 Review of Resident #75's care plan initiated on 04/10/25, revealed Resident #75 requires gastrostomy tube feeding related to swallowing problem. She also had an order to eat via mouth. The goal was Resident#75 would remain free of side effects or complications related to tube feeding through review date. The resident will maintain adequate nutritional and hydration status, as evidenced by weight stable, no signs and symptoms of malnutrition or dehydration through review date. The interventions were to Check for tube placement and gastric contents/residual volume per facility protocol and to record, to observe/document/report PRN any s/sx of: Aspiration- fever, Shortness of breath, Tube dislodged, Infection at tube site, Self-extubation (pulling out g-tube), Tube dysfunction or malfunction, Abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydration. Further review of care plan revealed Resident #75 has an ADL self-care performance deficit related to Disease Process, Fatigue, Impaired balance, Limited Mobility, Musculoskeletal impairment. The goal was for the resident to maintain the current level of function through the review date. Interventions for EATING: Resident requires assistance with eating. The care plan did not reflect Resident #75 was assessed and care planned to self-administer her own g-tube bolus feeding three times a day via the g-tube. Review of Resident #75's vitals and weights from 12/18/24 to 04/03/25 revealed no concerns with weight loss. Resident #75 maintained weight of 79.2 to 84 pounds. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview with Resident #75 on 04/13/25 at 1:50 PM, Resident #75 was in her room. She stated she had eaten some lunch, but she had a very poor appetite. She said she was going to do her own bolus feeding via her g-tube. Resident #75 had five cartons of formula, a clear cup with water, a syringe dated 04/13/25 on it and extra clear cups with measuring numbers printed on them. She stated she had been trained by two awesome nurses that were no longer working for the facility. She stated she was very comfortable doing her own formula feeding, but she gets tired of doing all 3 meals by herself. She said some nurses observed or supervised when she first admitted (12/18/24), but now they just bring her the formular cartons and set up a new syringe and change her dressing every night. She stated it would be nice if the facility staff could help her with some tasks and not just assume she could do everything by herself. She stated she had informed the nurses, but she could not remember the names of those who she had complained to. In an interview with LVN C on 04/14/25 at 09:13 AM, it was revealed that she was assigned to Resident #75, and she was going to monitor Resident #75 with her bolus feedings. She stated Resident #75 had been trained to self-administer her own feeding during her multiple stays at the facility. She said she was allowed to do it with us watching her and I make sure that I watch her when she is doing her own feedings. She said whenever Resident #75 had any questions about her g-tube use LVN C had educated her. LVN C stated she monitored Resident #75 as she did her own feeding, and she had no concerns with the procedure. LVN C stated she did not do an assessment for Resident #75 to self-feed, and she did not do the care plans for the residents. In an interview with ADON on 04/14/25 at 11:45 AM, she said she was aware of Resident #75 requesting more help with her bolus feeding. She said Resident #75 told her that she was getting tired of doing all her own feeds. ADON said she educated Resident #75 on Friday (04/11/25) that with the new order of increased fluid intake of 180 ml free water every 4 hours and decreases of Torsemide Tablet from 40 mg to 20 mg, the nurses were now going to be doing all of Resident #75's feedings and water flushes via g-tube. ADON said Resident #75 can be forgetful at times and may have forgotten that the nurses would be doing her feeds and water flushes now. ADON stated she had communicated with the nurses, and they were all aware that they were required to do the feedings and water flushes for Resident #75. ADON stated she is not sure who had brought into Resident #75's room the formula cartons because she took everything out of her room Friday after she had a conversation and an understanding that nursing would do all feeds and water. ADON said they are monitoring Resident #75's weight and that the G-tube was for supplemental due to poor oral intake. ADON said the expectation was that the nurses would give the feeding and water. ADON stated she believes that Resident #75 was care planned and assessed to self-administer. In an interview with MDS Nurse on 04/15/25 at 1:15 PM, it was revealed that MDS nurses with the IDT (nursing, dietary, ADON, MDS, DON) completed care plans and if a resident was able to self-administer then it should be care planned. She said Resident #75 had been admitted several times and she had been trained on g-tube self-administration because she was discharging home by herself, and she was also assessed that she could administer her own feeding without any issues. MDS nurse said nursing had notes stating that Resident #75 was receiving training for g-tube management before going back to the hospital on 3/24/25. She said she would not speculate the risk to the resident without confirming with the DON that the care plan and assessments for self-administration were not completed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview with the dietician on 04/15/25 at 01:33 PM, it was revealed that Resident #75 was being monitored for weight loss. She said nursing was responsible for assessing and care planning for Resident #75's g-tube self-administration. She stated Resident #75 was admitted to the facility in December 2024 on tube feeding as a supplemental nutrition due to being underweight. She said it was important to assess the resident so that you can know volume being taken in, frequency of feeding, know that she will have water needed before and after each feeding, what to do if she is unable to tolerate the feeding. The Dietitian said she had not input on the care plan and assessment, and she cannot edit any of the documents, however she would tell nursing her recommendations to ensure the resident is meeting nutritional need and maintaining current weight. In an interview with LVN E on 04/15/25 at 02:53 PM, she said she had been at the facility for six months. She said she was in-serviced on removing all formula and feeding from Resident #75's room because the nurses will be doing all her bolus feeding and water flushes. She said the times that she has taken care of Resident #75 she always supervised her feedings. She said Resident #75 can check the residual by pulling the syringe back to check the amount and she knows how to do flushes before feeding and after. She said as long as the resident was trained in how to do her feeding correctly there was no harm. She said it was important to monitor her feeding so that they can record her input. LVN E said she did not investigate the g-tube assessments and care planning because it was not in her scope of practice to complete care plans as an LVN. She said the MDS, ADON or DON completed the care plans. In an interview with DON on 04/15/25 at 02:29 PM, she said training for g-tube use was provided for Resident #75 before she went home in a previous visit. She said Resident #75 was trained by nursing and NP to self-feed. She said she was responsible for making sure that all care areas were care planned. She said the expectation was that nurse supervises the resident during feeding. She stated she would not speculate on the risk because the issue was that, it was just a paper trail miss and it did not impact the resident's wellbeing. Review of facility policy Care plans, comprehensive Person Centered revised January 2025 revealed . 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident .11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review the facility failed to ensure residents receiving enteral feeding received appropriate care and services to prevent complications of enteral feedings for 1 (Resident # 75) of 1 residents reviewed for enteral feedings The facility failed to assess Resident #75 to self-administer her feeds via the g-tube three times a day since admission on 04/02/2025. This failure could place residents at risk of needs not being met and a decline in resident's health. Findings included: Review of Resident #75's admission record dated 04/13/25, revealed she was a [AGE] year-old female with an initial admitted [DATE] and readmitted [DATE]. Her primary diagnosis was lack of coordination. Her secondary diagnoses included progressive systemic sclerosis (this is an autoimmune disease that causes the body to produce too much collagen which causes the skin and internal organs to harden and tighten), dysphagia/oropharyngeal phase (difficulty swallowing), idiopathic nonspecific intestinal pneumonitis (this is an unknown cause of chronic lung diseases), unspecified severe protein calorie malnutrition, Reynaud's syndrome without gangrene (this is a condition in which some areas of the body feel numb and cool), idiopathic hypotension (low blood pressure upon standing with an unknown cause) and gastroparesis (a stomach condition affects stomach muscles). Resident #75 was her own responsible party. Review of Resident #75's quarterly MDS dated [DATE] reflected Resident #75 had a BIMS score of 15, indicating she was cognitively intact. She makes herself understood, and she understands others. The document reflected Resident #75 had a feeding tube and received 51% or more of her nutrition through the feeding tube. The document also reflected Resident #75 required supervision or touching assistant with eating ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. Review of Resident#75's April 2025 physician orders reflected . - Enteral Feed Order every shift Enteral: Enteral Nutrition via Bolus: [Brand name] 1.5 calorie 120 ml TID per day via bolus via peg tube with meals.1.5kcal,17 grams protein, 50ml free water before and after bolus feeding to provide a total of 575ml free water/day from formula. - Enteral Feed Order every shift Enteral: Check tube placement via residual and tube visualization before initiation of formula, medication administration, and flushing tube - Regular/Enhanced diet, regular texture, Regular consistency, for diet - Enteral Feed Order every 4 hours Enteral: Flush feeding tube with 180 ml of free water per every four hours. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Torsemide Tablet 20 MG Give 4 tablet orally two times a day for edema -Physician orders did not reflect self-administration of enteral feeding by Resident #75 Review of Resident #75's care plan initiated on 04/10/25, revealed Resident #75 requires gastrostomy tube feeding related to swallowing problem. She also had an order to eat via mouth. The goal was Resident#75 would remain free of side effects or complications related to tube feeding through review date. The resident will maintain adequate nutritional and hydration status, as evidenced by weight stable, no signs and symptoms of malnutrition or dehydration through review date. The interventions were to Check for tube placement and gastric contents/residual volume per facility protocol. and record, to observe/document/report PRN any s/sx of: Aspiration- fever, Shortness of breath, Tube dislodged, Infection at tube site, Self-extubation (pulling out g-tube), Tube dysfunction or malfunction, Abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydration. Further review of care plan revealed Resident #75 has an ADL self-care performance deficit related to Disease Process, Fatigue, Impaired balance, Limited Mobility, Musculoskeletal impairment. The goal was for the resident to maintain the current level of function through the review date. Interventions for EATING: Resident requires assistance with eating. The care plan did not reflect Resident #75 was assessed and care planned to self-administer her own g-tube bolus feeding three times a day via the g-tube. Review of Resident #75's assessment for self-administration of bolus feeds reflected it was not completed on initial admission on 12/18/24 and on current admission on 04/02/25. Review of Resident #75's vitals and weights from 12/18/24 to 04/03/25 revealed no concerns with weight loss. Resident #75 maintained weight of 79.2 to 84 pounds. In an observation and interview with Resident #75 on 04/13/25 at 1:50 PM, Resident #75 was in her room. She stated she had eaten some lunch, but she had a very poor appetite. She said she was going to do her bolus feeding via her g-tube. Resident #75 had five cartons of formula, a clear cup with water, a syringe dated 04/13/25 on it and extra clear cups with measuring numbers printed on them. She stated she had been trained by two awesome nurses that were no longer working for the facility. She stated she was very comfortable doing her own formula feeding, but she gets tired of doing all 3 meals by herself. She stated it would be nice if the facility staff could help her with some tasks and not just assume she could do everything by herself. She said some nurses observed or supervised when she first admitted (12/18/24), but now they just bring her the formular cartons and set up a new syringe and change her dressing every night. She stated she had informed the nurses, but she could not remember the names of those who she had complained to. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LVN C on 04/14/25 at 09:13 AM, it was revealed that she was assigned to Resident #75, and she was going to monitor Resident #75 with her bolus feedings. She stated Resident #75 had been trained to self-administer her own feeding during her multiple stays at the facility. She said she was allowed to do it with us watching her and I make sure that I watch her when she is doing her own feedings. She said whenever Resident #75 had any questions about her g-tube use LVN C had educated her. LVN C stated she monitored Resident #75 as she did her own feeding, and she had no concerns with the procedure. LVN C stated she did not do an assessment for Resident #75 to self-feed, and she did not do the care plans for the residents. In an interview with ADON on 04/14/25 at 11:45 AM, she said she was aware of Resident #75 requesting more help with her bolus feeding. She said Resident #75 told her that she was getting tired of doing all her own feeds. ADON said she educated Resident #75 on Friday (04/11/25) that with the new order of increased fluid intake of 180 ml free water every 4 hours and decreases of Torsemide Tablet from 40 mg to 20 mg, the nurses were now going to be doing all of Resident #75's feedings and water flushes via g-tube. ADON said Resident #75 can be forgetful at times and may have forgotten that the nurses would be doing her feeds and water flushes now. ADON stated she had communicated with the nurses, and they were all aware that they were required to do the feedings and water flushes for Resident #75. ADON stated she is not sure who had brought into Resident #75's room the formula cartons because she took everything out of her room Friday after she had a conversation and an understanding that nursing would do all feeds and water. ADON said they are monitoring Resident #75's weight and that the G-tube was for supplemental due to poor oral intake. ADON said the expectation was that the nurses would give the feeding and water. ADON stated she believes that Resident #75 was care planned and assessed to self-administer. In an interview with MDS Nurse on 04/15/25 at 1:15 PM, it was revealed that MDS nurses with the IDT (nursing, dietary, ADON, MDS, DON) completed care plans and if a resident was able to self-administer then it should be care planned. She said Resident #75 had been admitted several times and she had been trained on g-tube self-administration because she was discharging home by herself, and she was also assessed that she could administer her own feeding without any issues. MDS nurse said nursing had notes stating that Resident #75 was receiving training for g-tube management before going back to the hospital on 3/24/25. She said she would not speculate the risk to the resident without confirming with the DON that the care plan and assessments for self-administration were not completed. In a phone interview with the dietician on 04/15/25 at 01:33 PM, it was revealed that Resident #75 was being monitored for weight loss. She said nursing was responsible for assessing and care planning for Resident #75's g-tube self-administration. She stated Resident #75 was admitted to the facility in December 2024 on tube feeding as a supplemental nutrition due to being underweight. She said it was important to assess the resident so that you can know volume being taken in, frequency of feeding, know that she will have water needed before and after each feeding, what to do if she is unable to tolerate the feeding. The Dietitian said she was not responsible for completing the care plans and assessment, and she cannot edit any of the documents, however she would tell nursing her recommendations to ensure the resident was meeting nutritional need and maintaining current weight. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LVN E on 04/15/25 at 02:53 PM, she said she had been at the facility for six months. She said she was in-serviced on removing all formula and feeding from Resident #75's room because the nurses will be doing all her bolus feeding and water flushes. She said the times that she has taken care of Resident #75 she always supervised her feedings. She said Resident #75 can check the residual by pulling the syringe back to check the amount and she knows how to do flushes before feeding and after. She said as long as the resident was trained in how to do her feeding correctly there was no harm. She said it was important to monitor her feeding so that they can record her input. LVN E said she did not investigate the g-tube assessments and care planning because it was not in her scope of practice to complete care plans as an LVN. She said the MDS, ADON or DON completed the care plans. In an interview with DON on 04/15/25 at 02:29 PM, she said training for g-tube use was provided for Resident #75 before she went home in a previous visit. She said Resident #75 was trained by nursing and NP to self-feed. She said she was responsible for making sure that all care areas of the residents were care planned. She said the expectation was that the nurse supervised the resident during feeding. She stated she would not speculate on the risk because the issue was that, it was just a paper trail that was missed and it did not impact the residents wellbeing. Review of facility Policy Enteral Nutrition revised November 2018 reflected in part: 8. The dietitian monitors residents who are receiving enteral nutrition and makes appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings. 9. The nursing staff and provider monitor the resident for signs and symptoms of inadequate nutrition, altered hydration, hypo- or hyperglycemia, and altered electrolytes. The nursing staff and provider also monitor the resident for worsening of conditions that place the resident at risk for the above. 17.Residents receiving enteral nutrition are periodically reassessed for the continued appropriateness and necessity of the feeding tube. Results of these assessments are documented, and any changes are made to the care plan. Input from the resident or legal representative is included in the assessment .

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and review, the facility failed to ensure Parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders for one (Resident #246) of four residents reviewed for intravenous fluids. The facility failed to change Resident #246's PICC line dressing which was loose, unsealed, and not intact before administering her antibiotic on 04/13/25. This failure could place residents at risk for catheter related blood stream infection. Findings included: Review of Resident #246's admission record dated 04/13/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Her primary diagnoses were osteoarthritis of right knee (pain and swelling of right knee) and osteomyelitis of the vertebra lumbar region (bone infection in the spine area). Secondary diagnoses were surgical aftercare following orthopedic surgery, reduced mobility (movement), mixed cholesterol, pain in right knee, idiopathic (unknown cause) peripheral automatic neuropathy (nerve damage). unspecified dementia (this is a brain disease that alters brain function and causes cognitive decline), and insomnia (trouble falling asleep). Review of Resident #246's April 2025 physician order on 04/13/25, reflected: -Monitor IV site for signs and symptoms of infection or infiltration (liquid/swelling across barrier of skin). If negative findings inform MD. Every shift for monitoring. -Piperacillin Sodium-Tazobactam Solution Reconstituted 3-0.375 Gram Use 3.375 gram intravenously every 8 hours for Lumbar 3-Lumbar 4 Abscess (pus)/osteomyelitis (bone infection)/Discitis (disc infection) for 6 Weeks. - Daptomycin-Sodium Chloride Intravenous Solution 350-0.9 Milligram/50 Milliliter-% (Daptomycin-Sodium Chloride). Use 350 Milligram intravenously one time a day for Complicated skin infection due to Enterococcus faecalis bacteria for 6 Weeks. -Change peripheral IV site and tubing every 72 hours or as needed Review of Resident #246's care plan initiated on 04/11/25 revealed she was on IV medication. The goal was that Resident #246 would have no complications related to IV therapy through the review date. The interventions were to Monitor IV site for signs and symptoms of infection or infiltration. If negative findings to notify MD, to change dressing as ordered, to change IV site and tubing as ordered, and to Flush IV as ordered. Review of Resident #246's admission MDS dated [DATE] did not reflect a BIMS score. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 04/13/25 at 12:17 PM, Resident #246 was lying on her back in her bed with family at bedside. She was attached to an IV pole getting IV medication. The medication was an antibiotic Daptomycin350 mg in 0.9% Sodium Chloride set at 100 milters/hour on the IV line. She had a single lumen PICC (lumen is a part of the IV catheter port for access from vein to the outside of the skin) on her right upper arm. Her PICC line dressing was loose, lifted on the right side, unsealed, and the bio patch that secures the PICC line was intact but exposed to air on the right outer side. The PICC line dressing was coming off and appears to have been reinforced previously with paper tape that was hanging off the edge but not sealing the PICC line dressing. The PICC line entry site window was visible, and it did not appear red, no signs and symptoms of infection or infiltration were observed, and it was clean. The PICC line dressing was dated 4/6/25. Resident #246 was non interviewable. Resident #246's family stated Resident #246 was admitted five days ago due to an infection in her back after getting back surgery. Family said she was not sure if the PICC line was replaced when Resident #246 admitted to the facility, or it was the same one inserted while she was in the hospital. Family stated Resident #246 may have been itching and scratching and could have caused the tape to become loose. She said she did not know if the dressing was changed. An interview with LVN B on 04/13/25 at 12:38 PM revealed he was Resident #246's nurse and he was the one that started the antibiotics for Resident #246 today. LVN B said he saw the dressing was loose and not intact when he started the antibiotic [Daptomycin] which takes almost an hour to complete and after that, he would hang another antibiotic [Piperacillin] and, when he was finished with the two antibiotics, he was planning on changing the PICC line dressing. He stated, I wanted to finish the antibiotics first before I changed the dressing. He said he did not know how often Resident #246's PICC line dressing was scheduled to be changed without looking in the computer to see her orders for PICC line dressing. He said normally it was every 7 days on Wednesday. He stated that he knew how to perform a PICC line dressing change, and he had been trained, and he was going to change Resident #246's after he was done with the antibiotics. He stated he had not changed it yet even if it was loose and unsealed because he was planning on doing it later. He stated it was important to make sure that PICC line dressing was sealed and intact for infection control. LVN B stated that he would notify the surveyors to observe the PICC line dressing change. An interview with LVN C on 04/14/25 at 8:44 AM revealed Resident #246's PICC line dressing was changed yesterday (04/13/25). She said, PICC line dressing changes were to be completed whenever they were soiled, loose, or as ordered every Wednesday unless the date fell before Wednesday then it was changed on the due date. LVN C said PICC line dressing was to be changed using a sterile kit per policy and procedure and documentation of dressing changes were to be charted in the MAR . An interview with the DON on 04/14/25 at 07:12 AM revealed PICC line dressing changes were to be completed by the assigned nurses as needed and or every Wednesday. She said when dressing was loose and coming off it should be changed or reinforced so that it was sealed for infection control, to keep the site clean, and for protection. She said LVN B was in-serviced immediately. In an interview with LVN E on 04/15/25 at 02:53 PM, she said she had been at the facility for six months. She said she had been in-serviced about IV dressings and infection control. She said IV dressings are expected to be changed every Wednesday or unless the due date falls on a different day then they are changed on that day. She said the PICC line dressing should be clean, dry, and intact. She said it was important to protect the integrity on the line and to prevent infection. (continued on next page)

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	676104	A. Building B. Wing	04/15/2025

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 04/15/25 at 3:17 PM, DON stated she was not informed by LVN B that surveyor wanted to observe the PICC line dressing change for Resident #246. She stated she would not speculate on the risk to the resident, however, the expectation was that the nursing staff would follow policy and procedure for changing PICC line dressing as needed and every 7 days per policy. An interview with the ADM on 04/15/25 at 3:49 PM revealed that all nurses were responsible for following policy and procedures for assessing PICC line dressings and completing dressing changes as ordered. He stated he could not speculate on the risk of not doing a PICC line dressing change but the expectation was that all staff follow company policies and procedures and to always use the best nursing judgement when taking care of the residents. Review of Resident #75's MAR on 04/14/25 revealed Change PICC dressing every seven days or as indicated for soiled or damaged dressing. External length 0cm and arm circumference 7cm. Notify MD of negative findings. Change stabilization device and injection caps with each dressing change. Every shift every Wed for maintenance was completed on 04/13/2025 at 4:31 PM by ADON. Review of nurse competency, nurse check off and Midline (this is a type of IV, a soft, flexible catheter inserted into a vein used for short-term antibiotic therapy) and CVAD dressing change certificate dated 04/14/25 revealed LVN B had completed all training on 04/14/25. Review of facility in-service dated 04/14/25, titled Infection control, pain medication, OTC medication at bed side, giving medications with meals and Locking Medication led by DON revealed eleven nursing staff had completed the in-service. Record review of the facility's policy titled Midline dressing changes revision date April 2016, reflected: Policy: The purpose of this procedure is to prevent catheter-related infections associated with contaminated, loosened, or soiled catheter-site dressings Change midline catheter dressing 24 hours after catheter insertion, every 5-7 days, or if it is wet, dirty, not intact, or compromised in any way .

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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** 44894 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring and administering of all drugs to meet the needs of the residents, for two Residents (Res#24 and Res#196) of two residents reviewed for medication use, in that: MA administered Resident #24's Gabapentin (ordered for treatment of pain) and Resident #196's Creon Oral Capsule Delayed Release Particles 3000-9500 Unit (ordered for Exocrine Pancreatic Insufficiency) greater than one hour after the scheduled administration time. Resident #24 and Resident #196 did not receive their scheduled 8:00 am medications until after 9:30 am on 04/14/2025. MA was arriving on the Hall 4 with medication cart to begin the Med pass at 9:30 am. This failure could place Res #24 at risk for continued pain and Res #196 at risk for not being able to digest and absorb important nutrients with each meal. The findings were: Record review of Resident # 24's face sheet dated 04/15/2025, revealed a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included: Other Specified Disorders of the Muscle (specific types of muscle tightness, dysfunctions of individual muscles, and metabolic disorders affecting muscle function): Cellulitis of Right Lower Limb (a bacterial infection of the skin and underlying tissues, often affecting the lower leg); Non-pressure Chronic Ulcer of Other Part of Right Foot with Fat Layer Exposed (a long-lasting open sore that develops on a specific area of the foot); Charcot Joint, Unspecified Site (a progressive condition that causes the bones and joints in the foot to degenerate). Record review of Resident #24's admission MDS assessment, dated 03/22/2025, reflected Resident #24 had a BIMS of 15, indicating he was cognitively intact. Record review of Resident #24's care plan, dated 11/02/17, revealed Resident #24 has discomfort r/t Neuropathy (any nerve damage that causes pain, numbness, tingling, swelling, or weakness in different parts of the body), Arthritis Disease, and Planter Foot pain. The Approach was to administer medication as ordered per MD (Medical Doctor). Record review of Resident #24's April MAR revealed the following order: Gabapentin Tablet 600 MG, Give 1 tablet by mouth three times a day for neuropathy. Times: 8:00 am, 1400 pm, 2000 pm. Start date of 03/22/2025. In an interview on 04/14/2025 at 9:30 AM with Resident #24 he said he had not received his 8:00 AM pain medications. Medication had not been initialed as given at 8:00 am on 04/14/2025 on the April MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/14/2025 with Resident #24 revealed that his feet were hurting at that time, and he was uncomfortable. Resident #24 should have gotten his pain medication at 8:00 am. In an interview on 04/14/2025 at 9:30 am the MA revealed that she was just arriving on Hall 4 to start passing the medications. The MA was responsible to give Resident #24's and Resident #196's medications to them. In an interview on 04/14/2025 at 9:40 am the ADON revealed that the MA was late because she had participated in Med Pass observation with the Nurse Surveyor at 6:30 AM. This was the reason for the Med Aide to be late passing her 8:00 AM medications. Record Review of Resident #196's face sheet dated 04/15/2025, revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: Bullous Pemphigoid (a rare condition causing large fluid-filled blisters); Exocrine Pancreatic Insufficiency (a digestive disorder that occurs when the pancreas doesn't produce enough digestive enzymes, or the enzymes it does produce do not function properly); Other Specified Diseases of Pancreas (Inflammation of the pancreas caused by its own digestive chemicals); Antineoplastic Chemotherapy Induced Pancytopenia (condition where patient undergoing chemotherapy experiences a significant decrease in all blood cell types: red blood cells (anemia), white blood cells (neutropenia), and platelets (thrombocytopenia). Record review of Resident #196's admission MDS assessment, dated 04/13/2025, reflected Resident #196 had a BIMS of 15, indicating he was cognitively intact. Record review of Resident #196's care plan, dated 04/14/2025, reflected Resident #196 has an alteration in gastrointestinal status r/t Bullous Pemphigoid, Exocrine Pancreatic Insufficiency, Gastroesophageal reflux (stomach acid or bile irritates the food pipe lining), Other Specific Disease of Pancreas. The approach was to administer medications as ordered with meals. Record review of Resident #196's April MAR revealed the following order: Creon Oral Capsule Delayed Release Particles 3000-9500 Unit (Pancrelipase Lipase-Protease-Amylase). Give 3 capsules by mouth with meals for Exocrine Pancreatic Insufficiency. Times: 8:00 am, 1200 pm, 1700 pm. Start date of 04/11/2025. Medication had not been initialed as given at 8:00 am on 04/14/2025 on the April MAR. Interview on 04/15/2025 at 9:15 am with Resident #196 revealed that he had not received his Creon medication that his physician ordered for him to take with each meal to help with his food digestion. Interview on 04/15/2025 at 03:15 pm with the DON revealed the MA was late in passing the morning medications on 04/14/2025 r/t she had completed the medication pass with the state surveyor at 6:30 am. For this reason, her schedule was behind. The MA passes the medications for Hall 1 and Hall 4. The DON revealed that the Medication Administration Policy includes the one hour before and one hour after times and follow a liberal medication pass according to resident's preferences. DON stated she would not speculate on risk of medications not being given to residents as ordered. The DON revealed that the medication for Resident #196 will be placed on the nurse's medication cart to ensure that he received his medication with each meal. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/15/2025 at 3:30 pm with the ADM revealed that he expects the staff to follow the policy on medication administration. The ADM stated he would not speculate the risk of medications not being given to residents as ordered. Record review of the facility's policy on, Administering Medications, dated April 2019 revealed, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

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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. 48520 Based on observation, interview, and record review, the facility failed to ensure medication was stored in locked compartments for 1 of 8 medication carts (Med Cart A) reviewed for drug security. The facility did not lock Med cart A when unattended and not in use on 04/13/25. This deficient practice could place residents at risk of medications loss, drug diversion, or harm due to accidental ingestion of unprescribed medications. Findings Include: In an observation on 04/13/25 at 08:58 AM and at 09:13 AM, it was revealed Med Cart A was unlocked and unattended with the lock mechanism out (indicating it was unlocked) by the main nursing station facing outwards to the entrance foyer. Residents, family, staff and four surveyors were walking by the unlocked medication cart. No facility staff was attending to or using Med Cart A; it was not in use and unlocked. Observation and Interview on 04/13/25 at 09:13 AM, revealed LVN D approached the surveyor who was standing by the unlocked Med Cart A. LVN D stated she was the charge nurse, and she did not know who Med Cart A belonged to. LVN D pulled the top drawer open and placed the empty medication packs inside Med cart A and locked it. Inside Med cart A was insulin, over the counter and prescription medication. LVN D stated Med cart A should have been locked when not in use. She stated she would address the issue in the morning shift huddle. She stated the cart should be locked so that the Residents and others without authority do not have access to the cart for accidental drug ingestion. In an interview with CNA A on 04/14/25 at 06:07 AM, she said she was trained to report to the nurse, charge nurse or DON when there was any medication that was not secured. She said even when medication is at the bedside such as prescribed creams, it needs to be reported immediately. She said all medications even over the counter need to be reported if not secured or at the bedside. Interview on 04/15/25 at 10:10 AM with DON revealed, the expectation was the medication cart should be locked when staff was not directly working with the cart. She stated she would not speculate on the risk however, the expectation was that the nursing staff would follow policy and procedure and lock and secure the medication cart when not in use. She said all nursing staff were responsible for securing medications when not in use. She stated an in-service was completed with the nursing staff. Interview on 04/15/25 at 3:49 PM with Administrator revealed, the medication cart should be locked if it was out of sight and staff were not actively working in the cart. The expectation was that all staff would follow company policies and procedures and to always use the best nursing judgement when taking care of the residents. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility in-service dated 04/14/25, titled Infection control, pain medication, OTC medication at bed side, giving medications with meals and Locking Medication led by DON revealed eleven nursing staff had completed the in-service. Review of facility policy Storage of Medication revised in April 2019 reflected The facility stores all drugs and biologicals in a safe, secure, and orderly manner. 9. Unlocked medication carts are not left unattended.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43843 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. 1. The facility failed to ensure that containers in the refrigerator were covered and labeled. 2. The facility failed to ensure that prepared food was tightly covered in the facility's only refrigerator. These failures could place residents at risk for food-borne illnesses. Findings include: Observation of the facility's only refrigerator on 04/13/2025 at 9:17 AM revealed a plastic container uncovered with breadcrumbs not labeled sitting on the bottom shelf of the refrigerator. Observation of the facility's only refrigerator on 04/13/2025 at 9:19 AM revealed a package of blueberries sitting on top of premade pies covered with parchment paper touching the crust of the pie. Interview with [NAME] A on 04/13/2025 at 9:18 AM revealed, she stated the food in the plastic container was breadcrumbs used for meatloaf. She stated that the item should not have been placed in the refrigerator without a cover and label. She stated that she does not know who placed the container in the refrigerator and removed the uncovered plastic container from the refrigerator. Interview on 04/15/2025 at 2:28 PMm with Dietary Manager revealed, she stated her expectation is that food in the refrigerator have a cover on it and be labeled and dated. The risk is potential harm to the resident in the form of bacteria or e coli. The pies were covered with wax paper and the item was placed on top of the wax paper to secure the paper in place because the vent fan in the refrigerator will cause the wax paper to lift. She stated each pie should have been individually wrapped. She stated that the risk of placing an item on top of the pies is that it could leak into the pies and contaminate the pies. Interview on 04/15/2025 at 3:;16 PM with DON revealed, she stated the expectation is dining staff follow the policy regarding food storage and handling to ensure that food is kept fresh. She stated that she could not speculate regarding the risk of not following the food policy. Interview on 04/15/2025 at 3:48 PM with Administrator revealed, the dining staff should follow food storage and handling procedure to ensure that food is not wasted. He stated that he could not speculate on the risk to the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Food Storage policy, dated 12/01/2011, reflected: All refrigerated foods are dated, labeled and tightly sealed, including leftovers, using clean, nonabsorbent, covered containers that are approved for food storage. All leftovers are used within 48 hours. Items that are over 48 hours old are discarded. Review of the U.S. Public Health Service Food Code, dated 2017, reflected: .3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the food: (1) In a clean, dry location; . Review of the U.S. Public Health Service Food Code, dated 2017, reflected: .3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A food specified in 3-501.17(A) or (B) shall be discarded if it: (2) Is in a container or package that does not bear a date or day; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when packaging food using a reduced oxygen packaging method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, ready-to eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1 . Review of the U.S. Public Health Service Food Code, dated 2017, reflected: .3-302.11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(d) below, separating raw animal foods during storage, preparation, holding, and display from: (a) Raw ready-to-eat food including other raw animal food such as fish for sushi or molluscan shellfish or other raw ready-to-eat food such as fruits and vegetables, (b) Cooked ready-to-eat, and (c) Fruits and vegetables before they are washed; (d) Frozen, commercially processed and packaged raw animal food may be stored or displayed with or above frozen, commercially processed and packaged, ready-to-eat food. (2) Except when combined as ingredients, separating types of raw animal foods from each other such as beef, fish, lamb, pork, and poultry during storage, preparation, holding, and display .