STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676136	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huebner Creek Health & Rehabilitation Center	8306 Huebner Rd San Antonio, TX 78240

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observation, interview, and record review, the facility failed to ensure the resident had a right to a safe, clean, comfortable, and homelike environment for 2 (Residents #39 and #43's) of 20 resident rooms reviewed for environment, in that: 1. A strong urine odor was coming from from Resident #39's room, and there were urine and feces found on his sheets. 2. The toilet in Resident #43's restroom was loose and wobbled when Resident #43 used the toilet. These failures could result in resident injury and psychosocial harm due to diminished quality of life. The findings were: 1. Record review of Resident #39's face sheet dated 01/12/2025 revealed he was an [AGE] year old man who had an admitted [DATE], with diagnoses which included: Dementia (a general term for loss of memory, language, problem-solving and other thinking abilities); Overactive bladder (a problem with bladder function that causes the sudden need to urinate); Hearing Loss and Need for assistance with personal care. Record review of Resident #39's quarterly MDS assessment dated [DATE] revealed he had a BIMS score of 08, indicating moderate cognitive impairment. Further review revealed he was assessed as needing substantial/maximal assist with toileting hygiene and bathing self and partial/moderate assistance with chair/bed-to chair transfer and toilet transfer and was frequently incontinent of urine and bowel. Record review of Resident #39's Care Plan initiated 5/03/2021 revealed focus areas which included: - bladder incontinence - with interventions which included incontinent care at least every 2 hours; - bowel incontinence - with interventions which included peri-care after every incontinent episode; and (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- ADL self-care performance deficit r/t dementia - with interventions which included assist with personal hygiene as required and as needed. Observation on 01/12/2025 at 11:00a.m. revealed the presence of a strong urine smell emanating from Resident #39's room, both the bedroom area and restroom. Resident #39 was observed sleeping in bed. Resident #39's roommate was not in room, is currently admitted to hospital. Observation on 01/12/2025 at 01:18 p.m. revealed continued strong urine and feces smell emanating from Resident #39's room, and observation of a large, soiled area on his bed sheet, containing both urine and feces in the center of the bed sheet. Resident #39 was dressed, sitting up in a wheelchair next to his bed and appeared to be sleeping again, and did not arouse when spoken to. Observation on 01/12/2025 at 1:48 p.m. revealed continued strong urine and feces smell emanating from Resident #39's room, with Resident #39 still napping while sitting in his wheelchair next to the bed and a large, soiled area of urine and feces remained on the sheet. During this observation, he was observed to have an untouched meal tray on his bedside table on the other side of the bed from where he was sitting. During an interview with LVN F on 01/12/2025 at 1:50 p.m., LVN F confirmed the presence of a strong urine and feces smell and the presence of urine and feces on Resident #39's bedsheets. LVN F stated that he was not aware of the soiled sheets and last saw Resident #39 this morning about 8:30 a.m. and no soiled sheets were noted at that time. LVN F stated that there was only one CNA working this morning, and that is most likely why the sheets had not been cleaned earlier. When asked how Resident #39 had gotten dressed, LVN F stated that Resident #39 can walk about his room and into bathroom by holding onto the wall and prefers to dress himself. When asked if Resident #39 would have cleaned himself before getting dressed in his clothes, LVN F stated, probably not. LVN F stated Resident #39 always smelled of urine. Observation and interview on 01/12/2025 at 01:59 p.m. with CNA E in Resident #39's room revealed the soiled bedsheets had been removed from the bed, but a strong urine odor remained. CNA E confirmed there was a strong urine odor and stated she had last checked on Resident #39 this morning about 08:30a.m. and he was sleeping in bed at that time. CNA E stated that Resident #39 can walk to the bathroom on his own and will dress himself without asking for help. When asked if he could and would clean himself before getting dressed, CNA E answered no. CNA E further stated that she was the only CNA assigned to work during the 6a-2p shift this morning for the whole facility, and that is why she never had time to come back and check on Resident #39 later in the day, as she was answering call lights and assisting residents in other areas of the facility. Record review of facility staff schedule sign-in sheet dated 01/12/2025 revealed for shift 6a-2p, there was one LVN assigned to hall 500, one LVN assigned to halls 800 and 700 and just one CNA (CNA E). (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with the Maintenance Supervisor (MNT-SV) on 01/13/2025 at 01:20 p.m. in Resident #39's room revealed the restroom, and bedsheets were clean, but a strong urine smell remained evident, and was strongest coming from the toilet area. The MNT-SV acknowledged the odor, and stated he believed the odor was due to urine having been absorbed through the vinyl flooring. The MNT-SV stated that about 2 weeks ago, he had his assistant use a special enzymatic cleaner, let it soak on the floor and thoroughly scrub the floor in Resident #39's restroom, which reduced the smell but did not eliminate it. The MNT-SV stated that Resident #39 had flagged him down in the past when he needed something fixed, such as his TV, but has never complained to him about the smell in the bathroom. Observation and interview with the Housekeeping Supervisor (HSK-SV) in Resident #39's room, revealed the HSK-SV and 2 other housekeepers were cleaning the floors, fixtures and flooring in Resident #39's restroom. HSK-SV stated she was the Housekeeping Supervisor at a nearby sister facility and had been asked to come help clean Resident #39's room and remove the smell. HSK- SV explained that they were cleaning the walls and door frames with an enzymatic cleaner thoroughly, pointing out yellow/brown stains on the doorframe, and stated Resident #39 walks by holding onto the wall, and if his hands were not clean, the urine and feces were spread onto the wall. 2. Record review of Resident #43's face sheet revealed she was a [AGE] year-old woman, admitted on [DATE] with diagnoses which included: Cerebral Infarction (stroke); difficulty in walking and legal blindness (term used to describe when a person's vision is so impaired it is considered legally disabling). Record review of Resident #43's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, indicating intact cognition. Further review revealed she was assessed as needing use of walker and wheelchair for mobility and needing partial/moderate assistance for toilet transfers. Record review of Resident #43's Care Plan Initiated 07/17/2024 revealed focus areas which included: hemiplegia/hemiparesis r/t CVA (weakness/paralysis of one side of body related to stroke) with intervention to assist with ADL's mobility as needed; and risk for falls r/t impaired mobility with interventions which included keep furniture in locked position. During an interview with Resident #43 on 01/12//2025 at 11:10 a.m., Resident #43 stated that she was concerned about the toilet in her restroom, noting it was always running, had overflowed into the hallway once and that it wobbled when she sat on it and especially when she got up off the toilet. She stated there were handrails on either side of the toilet she could hold onto, but the wobbly toilet still scared her a little. During further interview, Resident #43 stated that the toilet had been loose since her admission and she had told several staff, but nothing ever got fixed, so she stopped asking. Observation of the toilet in Resident #43's restroom on 01/12/2025 at 11:14 a.m. revealed the toilet was running, and was loose at the bottom, and would wobble back and forth when pushed slightly from the side. There did not appear to be any bolts at base of toilet. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/13/2025 at 01:30 p.m. with the MNT-SV and observation of the toilet in Resident #43's restroom, the MNT-SV confirmed that when the toilet was pushed slightly it wobbled back and forth lifting off the floor around the edges and stated he was not aware of it being loose and had not received any work orders regarding the loose toilet. The MNT-SV stated that Resident #43 is usually very good about letting him know if anything was broken and needed to be fixed, noting that about a month ago, Resident #43 had complained of the toilet overflowing into the hallways and he had come and fixed it, finding it stuffed with wipes. The MNT-SV stated he had educated Resident #43 about not placing wipes in the toilet, and there have been no further problems with clogged toilet, He stated he had not observed the toilet to be loose at that time and would have fixed it then if he had. Further interview revealed the MNT-SV stated that work orders should be sent to him via Maintenance Care by the staff if they become aware of something needing to be fixed but stated that most of his work requests come directly from the residents themselves as he walks the halls and talks with them. He stated that if staff do not put in work orders when something is found to need fixing, it increases the safety risk to residents and can result in simple maintenance needs becoming larger problems. Interview on 01/15/2025 at 02:53 p.m. with the ADO and the ADM-2 revealed there was now new management staff in place, and that there was a process in place for maintenance requests, which was a software with a QR code at every Nurse's station where staff can put in work requests, and the ADO stated that when Resident #43 complained of the wobbly toilet, staff should have placed the work request to get it fixed using that system. In addition, the ADO noted that they had a program called Champions Rounds, a process where management staff were assigned different rooms/residents to monitor and check on every day to assess any needs, which did not appear to have been done, but now with the new management staff in place, the process would be implemented to ensure resident's environment are clean and safe and their needs are being met. Record review of facility policy titled Resident Rights (undated), revealed The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safety. The facility must provide - 2. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior . Record review of facility policy titled Linens (undated) revealed 1. Resident linens must be clean and dry and changed regularly and 7. Collect and remove soiled linens immediately. Soiled linens will be transported to the laundry processing area in a covered laundry hamper. Record review of facility policy titled Resident Rooms - Daily, part of the Housekeeping Policy and Procedure 2022, revealed It is the policy of this facility to maintain cleanliness in an orderly manner. The goal is to keep facilities clean and odor free, while providing the residents, their families and staff with the safest environment possible and projecting a positive image.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on interview and record review, the facility failed to develop a baseline care plan which included the minimum healthcare information necessary to properly care for the resident within 48 hours of the resident's admission, for 2 (Residents #12 and #29) of 8 residents reviewed:: 1) Resident #12's baseline care plan was not completed within 48 hours of admission. 2) Resident #29's baseline care plan was not completed within 48 hours of admission. This failure could place newly admitted residents at risks of not receiving the proper care and continuity of services. The findings were: 1)Record review of Resident #12's face sheet, dated 01/13/2025, revealed she was an [AGE] year-old woman admitted to the facility on [DATE] with diagnoses which included: Dementia (a general term for loss of memory, language, and other cognitive abilities); Dehydration (a dangerous loss of body fluid caused by illness, sweating or inadequate fluid intake); Chronic Respiratory Failure with Hypoxia (condition where lungs are unable to adequately exchange oxygen resulting in low level of oxygen in blood) and Generalized Anxiety Disorder (mental health disorder characterized by feelings of worry, fear and anxiety strong enough to interfere with daily life). Record review of Resident #12's 5-Day MDS assessment dated [DATE] revealed a BIMS score of 13, indicating intact cognition. Further review revealed she was assessed as using a manual wheelchair for mobility and was totally dependent in toileting hygiene and needed maximal assistance for chair/bed to chair transfers. Record review of Resident #12's Care Plans Screen in her clinical record as of 01/14/2025, revealed the initial Care Plan completed for her was the Comprehensive Care Plan initiated on 12/30/2024, 18 days after her admission on 12/12/2024. 2) Record review of Resident #29's face sheet, dated 01/13/2025 revealed she was a [AGE] year-old woman who was admitted on [DATE] with diagnoses which included: Dementia (a general term for loss of memory, language, and other cognitive abilities); Type 2 Diabetes (chronic condition where the body has trouble regulating blood sugar); Depression (mental health condition involving feelings of sadness, hopelessness and loss of interest), and Anxiety Disorder (mental health disorder characterized by feelings of worry, fear and anxiety strong enough to interfere with daily life. Record review of Resident #29's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 5, indicating severe cognitive impairment. Further review revealed she was assessed as being dependent, where helper does all the effort in toileting hygiene and bathing and personal hygiene. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #29's Care Plans Screen in her clinical record as of 01/13/2025, revealed the initial Care Plan completed for Resident #29 was the Comprehensive Care Plan initiated on 12/02/2024, 11 days after her admission on 11/21/2024. During an interview with MDS-A on 01/14/2025 at 02:58 p.m., MDS-A acknowledged that Resident #12 and Resident #29's Baseline Care Plans were not initiated within the 48-hour timeframe required, and stated it was the admitting Nurse who was responsible for completing the Baseline Care Plans. MDS-A stated that not having the Baseline Care Plan completed within 48 hours could result in staff not having all the information they needed to provide good care to the newly admitted residents. Interview with the DON, CN and DIR on 01/14/2025 at 4:05 p.m. revealed that all Baseline Care Plans should be implemented within 48 hours of admission, to ensure staff have the information needed to provide for each resident's needs from admission. Record review of the facility policy titled, Base Line Care Plans, undated, revealed, The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan will be developed within 48 hours of a resident's admission.

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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** 33866 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and time frames to meet residents' mental, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and to ensure that the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including the right to refuse treatment for 1 of 8 residents (Resident #12) reviewed for care plans. Resident #12's diagnoses of Depression, Generalized Anxiety Disorder and Dementia, along with active orders for anti-anxiety and anti-psychotic medications were not addressed in her comprehensive care plan This failure could affect residents who have care areas not addressed by the care plans by not having their needs met and putting them at risk of not receiving appropriate care. The findings included: Record review of Resident #12's face sheet, dated 01/13/2025, revealed she was an [AGE] year-old woman admitted on [DATE] with diagnoses which included: Dementia (a general term for loss of memory, language, and other cognitive abilities); Generalized Anxiety Disorder (mental health disorder characterized by feelings of worry, fear and anxiety strong enough to interfere with daily life) and Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #12's 5-Day MDS assessment dated [DATE] revealed a BIMS score of 13, indicating intact cognition. Further review revealed she was assessed as feeling down, depressed, or hopeless on 7-11 days over the past 2 weeks and had diagnosis of Non-Alzheimer's Dementia, Anxiety Disorder and Depression. Record review of Resident #12's Order Summary dated 01/13/2025 revealed physician orders which included: - Alprazolam ER Oral Tablet Extended Release 24Hour 1 mg Give 1 tablet by mouth at bedtime for severe anxiety with a start date of 12/19/2024;and -Olanzapine Oral Tablet 5 mg Give 1 tablet by mouth one time a day for Anxiety with an order date of 12/13/2024; and -Rivastigmine Transdermal Patch 24 Hour 13.3 mg/24hr Apply 1 application transdermally one time a day related to depression unspecified, unspecified dementia . With a start date of 12/13/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #12's Comprehensive Care Plan initiated 12/20/2024 revealed there were no focus areas addressing the resident's diagnoses of Generalized Anxiety Disorder, Depression or Dementia, and no focus areas indicating the resident's active orders for anti-anxiety, and anti-psychotic medications. During an interview with MDS-A on 01/14/2025 at 02:58 p.m., MDS-A stated that Resident #12's Comprehensive Care Plan did not address her diagnoses of Anxiety, Depression or Dementia, and did not address her active orders for anti-anxiety and anti-psychotic medications but should have. MDS-A acknowledged that these diagnoses and medications were ordered/documented prior to her Care Plan being completed, so should have been included on her Comprehensive Care Plan. MDS-A stated that these diagnoses and medications should automatically trigger a Care Area Assessment (CAA) area and she did not know why they were not triggered or why they were missed. MDS-A stated that she is responsible for the quarterly and annual assessments of the Comprehensive Care Plan, and noted they used to have two MDS Nurse's, but at the current time, she is the only MDS Nurse here. MDS-A further stated that it was important for these diagnoses and medications be addressed in the Care Plan so staff have the information needed to meet the resident's specific care needs Interview with the DON, CN and DIR on 01/14/2025 at 4:05 p.m. confirmed that Comprehensive Care Plans needed to address and include all of the residents' nursing, mental and psychosocial needs, and contain the interventions and services the resident would need to meet these needs. The DON noted that there has been a recent change in management staff, and this is his first week here as DON, and he would be assessing and in-servicing staff to ensure resident needs are being met to include completion of assessments and Care Plans. Record review of the facility policy titled Comprehensive Care Planning, undated, revealed Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 33866 Based on observations, interviews, and record review, the facility failed to review and revise resident care plans after each assessment for 1 of 8 residents (Resident #39) reviewed for care plan revision/timing. The facility failed to ensure Resident #39's care plan was revised to reflect 3 falls in a 4-hour time period. This deficient practice could affect residents' care and services and may cause a delay in treatment and/or decline in health. Findings included: Record review of Resident #39's face sheet dated 01/12/2025 revealed he was an [AGE] year old man, who as admitted to the facility on [DATE], with diagnoses which included: Dementia (a general term for loss of memory, language, and other cognitive abilities); Overactive Bladder (a problem with bladder function which causes sudden needs to urinate); Hearing Loss and Unsteadiness on Feet. Record review of Resident #39's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 08, indicating moderate cognitive impairment. Record review of Resident #39's Nursing Progress note dated 01/08/2025 at 12:20a.m. revealed Resident had a fall. Location: Hallway Fall information: Slid out of chair. Patient going down the 500 hall slipped out of his wheelchair and fell on his knees was helped back to his wheelchair taken to his room and helped to bed. No pain. Interventions in place prior to fall: Low bed. Interventions initiated in response to fall: frequent monitoring redirected him to bed. Record review of Resident #39's Nursing Progress note dated 01/08/2025 at 12:31a.m. revealed Resident had a fall. Location: first fall in patients room [ROOM NUMBER]nd fall in hallway. Fall information: Unwitnessed, discovered on floor, next to bed .The fall caused a skin tear to right foot. Size of the skin tear in cm: 0.5. New/bleeding . Further review of the progress notes revealed the wound was cleaned and dressed and he was sent to Methodist ER for evaluation, MD and RP notified. Record review of Resident #39's Nursing Progress Note dated 01/08/2025 at 01:07 a.m. revealed the following entry: [Resident #39] was transferred to a Hospital on 01/08/2025 1:18 AM related to patient falls 3 times in a 4 hour period says he has pain in his left knee sustained a small cut to top of right foot the patient has not had a fall in several months it is abnormal for him to fall this frequently. Further review revealed he was discharged back to the facility by 05:30 a.m. with no new orders and the only noted injury being the skin tear on his right foot. Neuro checks were implemented. Record review of Resident #39's Care Plan initiated 05/03/2021 revealed a focus area for had an actual fall, initiated 05/03/2021 and last revised on 10/18/2022, with the most recent intervention to Refer to PT to eval initiated 07/12/2024. There were no interventions or revisions to this focus area since 07/12/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with MDS A on 01/14/2025 at 2:17p.m., MDS A stated she remembers discussing Resident #39's falls during the morning meeting that next day as they were unusual for him, and stated they did review his Care Plan, noting he was already receiving physical therapy, so agreed to have him evaluated by Occupational Therapy as well. She checked his record and stated that he received an Occupational Therapy evaluation on 01/09/2025. MDS A further stated that the intervention the team discussed should have been added to his Care Plan and stated that the DON is responsible for revising the Care Plan after acute changes such as falls, and that the person who was DON at the time of his falls is no long here, they now have a new DON. Interview on 01/14//2025 at 4:05p.m with the new DON, the CN and the DIR revealed that Resident #39's falls had been reviewed in the morning meeting by the team, and they noted that all 3 of the falls occurred the evening of 01/07/2025, were unusual for him, so he was sent to the Hospital for evaluation. The DIR noted there was no medical cause for the falls found, noting that his vital signs were normal and there were no orders or new findings from the ER. She stated the team agreed that since the cause of the falls was uncertain, they were going to monitor him more closely and ask for continued physical therapy, and an Occupational Therapy evaluation. The DIR admitted that these interventions were not added to Resident #39's Care Plan but should have been so that all staff members have the information needed to provide for his needs. Record review of facility policy titled Comprehensive Care Planning (undated) revealed: the comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives, interventions are the specific care and services that will be implemented Further review of policy revealed: The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

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	676136	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huebner Creek Health & Rehabilitation Center	8306 Huebner Rd San Antonio, TX 78240

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observation, interview, and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practices, the comprehensive care plan, and the residents' choices and based on the comprehensive assessment of a resident for 1 of 2 residents (Resident #37) reviewed for wound care. The facility failed to ensure wound dressings and leg wrapping were applied daily for Resident #37. This failure could place residents at risk of pain and lead to systemic infections. Findings included: Record review of Resident #37's face sheet dated 01/13/2025 revealed the resident was a [AGE] year-old woman who was admitted to the facility on [DATE] with diagnoses which included: Lichen Simplex Chronicus (skin condition that causes chronic itching); Obesity (chronic complex disease defined by excessive fat deposits that can impair health); difficulty in walking and need for assistance with personal care. Review of Resident #37's quarterly MDS assessment dated [DATE], revealed Resident #37 had a BIMS score of 15, indicating intact cognition and was assessed as being dependent in toileting hygiene and needing maximal assistance for bathing and chair/bed-to-chair transfers. Further review revealed she was assessed as being occasionally incontinent of urine and frequently incontinent of bowel, with moisture associated skin damage. Record review of Resident #37's Care Plan initiated 11/23/2022 revealed focus areas which included: -The resident has MASD to Right Posterior Thigh initiated 10/09/2024 which included an intervention to Treat per providers order, notify for non-healing or worsening wounds; and -the resident has a pressure ulcer or potential for pressure ulcer development which had as an intervention to Follow facility policies/protocols for the prevention/treatment of skin breakdown. - Record review of Resident #37's Order Summary dated 01/14/2025 revealed orders for: -Cleanse Right Posterior thigh with wound cleanser; pat dry with 4x4 gauze; Apply triad cream cover with Super Absorbent Adhesive dressing daily every day shift for sound management Start date 12/10//2024; and . -Wrap bilateral lower extremities to help with lymphedema, start date 12/21/2024. Record review of Resident #37's Treatment Administration Record (TAR) for January 2025 revealed wound care and leg wrapping was left blank on the Tar on: 1/9/2025, 1/11/2025 and 1/13/2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/12/2025 at 11:40 a.m. revealed Resident #37 was sitting in a wheelchair in her room, and there were no wrappings observed on her legs. Observation on 01/14/2025 at 10:35 a.m. of peri-care being done for Resident #37 by CNA B revealed Resident #37 did not have any wrappings on her legs and did not have any dressings in place on her right posterior thigh when the soiled brief was removed during the peri-care observation. Resident #37 was observed to have some reddened areas at base of bilateral buttocks/posterior thigh. During the performance of the peri-care for Resident #37, CNA B asked if she could apply barrier cream on the reddened areas, and then stated she was not aware of any orders for cream and would check first and she then proceeded with peri-care for Resident #37. Interview with LVN C on 01/14/2025 at 11:52 a.m. revealed LVN C was the Treatment Nurse and she confirmed there were orders for Resident #37 for daily wound cleansing and dressing application for the wound on her posterior thigh, and for daily leg wrapping for the lymphedema. When asked about the leg wrappings not being on Resident #37's legs during observations on 01/12/2025 and 01/14/2025, she stated that Resident #37 leg wrappings sometimes fall off. When asked about no dressing in place prior to peri-care being done this morning, LVN C stated she has not done wound care treatment yet today for Resident #37. When asked about the blanks noted on the TAR for 1/9/2025, 1/11/2025 and 1/13//2025, LVN C admitted she was not able to do the dressing change and apply the leg wrappings the day before (1/13/2025) because she ran out of time, noting she is the only treatment Nurse and has a high work load. LVN C stated that she was not on duty on 1/11/2025, so does not know why it was not done then but stated in her absence the Nurse assigned to Resident #37 is supposed to apply the leg wrappings and dressing. During an interview with the DON on 01/14/2025 at 12:42 p.m., the DON stated he had already been made aware of the situation and that the orders for wound care of Resident #37's posterior thigh and the daily leg wrappings were physician orders and needed to be performed as ordered. The DON stated he directed LVN C to notify the physician of treatment not being provided. The DON further stated that by not carrying out the wound care and leg wrapping as ordered, it could result in slow healing and infection. Record review of the facility policy titled Skin Integrity Management revised October 5, 2016, revealed wound care should be performed as ordered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 50760 Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments for the only medication room and one of seven nurse medication carts (Hall 500 nurse medication cart) observed for drug storage and usage, as evidenced by: 1. The facility failed to ensure the controlled medication compartment inside the refrigerator of the medication room was locked. 2. The facility failed to ensure three medications for Resident #54 were stored and locked inside the Hall 500 medication cart. These failures could place residents at risk of misappropriation of medication, ingesting medications not prescribed or drug diversion. The findings included: 1. During an observation on 01/14/25 at 10:00 AM of the medication storage room with the DON and LVN D, it was observed that the affixed bin inside the refrigerator for storing controlled substances was unlocked and contained the controlled medication lorazepam. During an interview with the DON on 01/14/25 at 10:05 AM, when asked what could happen if the controlled medication storage compartment was not locked, the DON stated drug diversion could occur and the bin should be locked. Review of the facility's policy titled Storage and Documentation of Controlled Medications dated 2003, listed all controlled medications will be stored under double lock and checked for accountability at each change of shift by the nurse going off duty and the nursing coming on duty. 2. Record review of Resident #54's face sheet dated 01/14/2025 revealed he was a [AGE] year-old man admitted to facility on 02/26/2024, with diagnoses which included: Hemiplegia and Hemiparesis following cerebral infarction affecting left non-dominate side (left side weakness/paralysis due to stroke); and Type 2 Diabetes Mellitus (long-term condition in which the body has trouble controlling blood sugar and using it for energy). Record review of Resident #54's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 12, indicating moderate cognitive impairment. Further review revealed Resident #54 was assessed as being on medications which included: a hypoglycemic (medication to lower blood sugar and control diabetes). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 01/14/2025 at 07:18 a.m. at Nursing Station Two revealed there were medications sitting on top of an unattended Medication Cart (Hall 500) which was parked outside of the circular Nurse's station, near the entrance to Hall 500. There was a Nurse (LVN D) sitting inside the circular Nurse's station, working on paperwork. Review of the medications on top of the unattended 500 Hall Cart revealed the medications were for Resident #54 and consisted of: Tradjenta 5 mg tablets (used to treat Type 2 diabetes), Metformin 500 mg tablets (to treat Type 2 diabetes) and Potassium Chloride 10% (used to prevent or treat low blood levels of potassium) When Surveyor asked LVN D who had the 500 Hall medication cart, LVN D immediately jumped up and went to the medication cart, stated she had forgotten about the medications on top of the cart, grabbed the medications, and gave them to another nurse to place in the medication room. During an interview with LVN D on 01/14/2025 at 7:20 a.m., LVN D stated that she had been going through the medication cart earlier, removing old and discontinued medications and organizing them, and then had been distracted by something that required her attention at the Nurse's desk and she forgot to secure the medications back into the medication cart. LVN D stated that all medications needed to be locked in the medication carts at all times and stated that leaving the medications out on top of the medication cart unattended could result in theft of the medications or misappropriation of the medication by a resident. During an interview with the DON on 01/14/2025 at 12:42 p.m., the DON stated he had been made aware of the medications being left out this morning and confirmed that all medications should be secured and kept locked at all times inside the medication cart. The DON further stated that if left out unsecured and unattended, the medications could be taken by anyone, resident, staff or visitor. The DON stated that he had already started in-servicing all the Nurse's and medication aides about keeping medications locked at all times. Record review of facility policy titled Medication Carts (undated) revealed The carts are to be locked when not in use or under the direct supervision of the designated nurse

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 47611 Based on interview and record review the facility failed to develop, implement, and maintain an effective training program for all new and existing staff for 5 (CNA G, LVN H, LVN I, LVN J and PT) of 25 employees reviewed for training requirements. The facility failed to ensure required trainings were provided to CNA G, LVN H, LVN I, LVN J, and PT annually. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. Findings included: Record review of personnel records for CNA G revealed a hire date of 3/21/2018. Further review of a training log, provided by the HR Manager revealed no evidence of annual training for Resident Rights, Dementia, Behavioral Health, HIV, Falls, Restraints and Emergency Preparedness. Record review of personnel records for LVN H revealed a hire date of 6/21/2016. Further review of a training log, provided by the HR Manager revealed no evidence of annual training for Resident Rights, Dementia, QAPI, Ethics, Behavioral Health, HIV, Restraints, Emergency Preparedness Record review of personnel records for LVN I revealed a hire date of 6/16/2021. Further review of a training log, provided by the HR Manager revealed no evidence of annual training for Resident Rights and HIV Record review of personnel records for LVN J revealed a hire date of 8/15/2023. Further review of a training log, provided by the HR Manager revealed no evidence of annual training for Communication, Abuse, QAPI, Infection Control, Ethics, Behavioral Health, HIV, Falls, Restraints, Emergency Preparedness. Record review of personnel records for PT revealed a hire date of 4/4/2023. Further review of a training log, provided by the HR Manager revealed no evidence of annual training for Communication, Resident Rights, Dementia, QAPI, Infection Control, Ethics, Behavioral Health, HIV, Falls, Restraints, Emergency Preparedness Interview on 1/15/2025 at 2:15 pm with HR revealed the facility used an online system, RELIAS, to train staff on their initial and annual trainings. HR stated with recent change in administration, staff and new hires, she missed some of the required training for staff. Review of Nursing Policy and Procedure Manual revised 3/29/18, showed, The facility will train through orientation and on-going in-services on issues related to abuse/neglect prohibition practices regularly.