STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676142	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emory Health and Rehab	983 N Texas Street Emory, TX 75440

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on interview and record review, the facility failed to notify the resident's representative and consult the physician immediately when there was a significant change in the resident's physical, mental, or psychosocial status that is, a deterioration of health, mental, or psychosocial status in either life-threatening conditions or clinical complications for 1 of 4 residents (Resident #30) reviewed for notification of changes. The facility failed to consult Resident #30's physician and notify the resident representative when Resident #30 refused to have a CMP (complete metabolic panel lab draw to provide information about the body's chemical balance) and a HBA1C (glycated hemoglobin test that measure the average amount of blood sugar) lab drawn on 05/09/24, 05/10/24, and 05/13/24. This failure could place residents' representative/physician at risk of not being aware of any changes in their conditions and could result in delay in treatment and decline in residents' health and well-being. Findings included: 1. Record review of a face sheet dated 06/28/2024 indicated, Resident #30 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included vascular dementia with other behavioral disturbance (a condition in which a person loses the ability to think, remember, learn and make decisions and solve problems), deep vein thrombosis (blood clot), hypertension (high blood pressure), and chronic pain. Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #30 was understood and was able to understand others. The MDS assessment indicated Resident #30 had a BIMS score of 11, which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #30 required partial/moderate assistance for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. Record review of the physician orders dated July 2024, indicated Resident #30 had an order with a start date of 02/07/2024 for a CMP, HGBA1C every 3 months. Record review of the care plan dated 02/14/2024 indicated, Resident #30 had a history of stroke with interventions to give meds as ordered and monitor labs and report abnormal values to physician. (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: 676142	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Emory Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 983 N Texas Street Emory, TX 75440	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #30's medical record indicated no lab results for the May 2024 - July 2024. Record review of Resident #30's progress notes did not indicate Resident #30 had refused any labs from May 2024 - July 2024. The progress notes did not indicate Resident #30's representative or physician had been notified of Resident #30's lab refusals. During an interview on 07/09/2024 at 01:59 PM, the ADON said the facility failed to notify the family member and the physician of Resident #30's refusal of lab draws on 05/09/2024, 05/10/2024, and 05/13/2024 because she had not received any notification from the lab until today (07/09/2024) when surveyor inquired. The ADON said the resident's family and physician should have been notified of Resident #30's refusal to prevent any issues, delays in treatments and serve as coordination of care. During an interview on 07/10/2024 at 2:24 PM, the DON said Resident #30's family and physician should have been notified regarding Resident #30's refusal of the lab draws when it happened. The DON said the family members and physician of Resident #30 should have been notified of the lab draw refusal because it was a change in condition, and they should have been made aware of new areas of concerns, orders, etc. The DON said it was the responsibility of the charge nurse to notify the family of any changes in condition of the residents. During an interview on 07/10/2024 at 2:42 PM, the Administrator said she expected the residents' representatives and the physician to be notified of any changes in the resident's care. The Administrator said she expected the staff to document the notification of the family and the physician. The Administrator said Resident #30's family and physician should have been notified of the lab draw refusal because the residents' family could have communicated to Resident #30 and explained the needs of the lab draws being completed. The Administrator said the charge nurse was responsible for notifying the resident's representative and physician. Record review of the facility's policy Change in Resident's Condition or Status revised May 2017 indicated . Our facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and or status .1. F. refusal of treatment or medication two or more consecutive times .Notify resident's responsible party . 3. Document in the medical chart who was notified and when.

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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 33249

Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable homelike environment for 4 of 4 resident's (Resident #'s 4, 17, 25, and 34) reviewed for a homelike environment.

The facility failed to ensure Resident #25's wall behind her bed was free from deep gouges into the sheetrock measuring 4 inch wide and 2 feet long.

The facility failed to ensure Resident #17's and Resident #34's bed linens were changed.

The facility failed to ensure Resident #34 had hot water available in the bathroom.

The facility failed to ensure Resident #34 had a toilet seat that was free from peeling paint.

The facility failed to ensure Resident #34's toilet was flushing properly.

The facility failed to ensure Resident #4's hot water in the bathroom sink was not running continuously, and Resident #4 had cold water available.

These failures could place residents at risk for an uncomfortable, unhomelike environment, and a diminished quality of life.

Findings included:

1. Record review of a face sheet dated 5/17/2024 indicated Resident #25 was a [AGE] year-old female who admitted on [DATE] with diagnoses of diabetes and high blood pressure.

Record review of the Annual MDS dated [DATE] indicated Resident #25 was usually understood, and usually understood others. The MDS indicated Resident #25's decision making capacities were severely impaired, and she had a memory problem. The MDS failed to indicate Resident #25's BIMS score.

During an observation on 7/07/2024 at 8:57 a.m., Resident #25 was lying in her bed awake, she was facing the wall. Resident #25's wall directly behind her bed had deep gouges down to the sheetrock measuring 3 inches wide and 2 feet in length behind her bed. Resident #25 was unable to be interviewed regarding the wall damage due to her cognitive state.

During an observation and interview on 7/10/2024 at 2:29 p.m., the maintenance supervisor said when he observed the deep gouges in Resident #25's wall said he had not focused on resident rooms for maintenance problems, but relied on the nursing staff to inform him of the repair needs in specific resident rooms. The maintenance supervisor said not having a homelike environment could be a dignity issue.

(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 7/10/2024 at 2:44 p.m., the DON said resident rooms should be repaired, and maintained repaired. The DON said this was the resident's rooms and should be nice and homelike. The DON said the maintenance supervisor was responsible for repair of resident rooms. During an interview on 7/10/2024 at 3:41 p.m., the Administrator said she expected the maintenance supervisor to make rounds in the resident rooms monitoring for repairs, she expected empty rooms to be repaired prior to another resident occupying the rooms, and she expected all other staff to use the maintenance repair book to log needed repairs when they were found. The Administrator said she had made rounds in the facility but had not seen the gouges in Resident #25's wall. 2. Record review of a face sheet dated 06/28/2024 indicated, Resident #17 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included hypertension (high blood pressure), hyperlipidemia (high levels of fat particles in the blood), history of stroke, benign prostatic hyperplasia (prostate gland enlargement resulting in difficulty with urination) and acquired absence of limb. Record review of the quarterly MDS dated [DATE] indicated, Resident #17 was understood by others and understood others. The MDS indicated Resident #17 had a BIMS of 10 and was moderately cognitively impaired. The MDS indicated Resident #17 was independent with toileting, supervision and required touching assistance for lower body dressing, and putting on and taking off footwear. Resident #17 required set up/clean-up assistance with bathing and with upper body dressing. In section GG0120 Mobility devices the MDS indicated in the last 7 days Resident #1 used a wheelchair. Record review of the comprehensive care plan dated 05/19/2023 indicated, Resident #17 had an activities of daily living (ADL) self-care performance deficit. The care plan indicated interventions included Resident #17 required assistance with showering, dress according to climate, assist with daily hygiene, provide peri care as indicated. During an observation and interview on 07/07/2024 at 10:30 AM, Resident #17 said the linens on his bed had not been changed in two weeks. The linens had dirty yellow and orange stains on them, and the pillowcase was light brownish tinged. There were two large pinkish stains on the bottom half of the top linen. There was a musty odor in the room. Resident #17 said he should not have to ask the CNAs to change his linens they should be doing this as scheduled. During an observation on 07/08/2024 at 11:14 AM, Resident's #17 linens had dirty yellow and orange stains on them, and the pillowcase was light brownish tinged. There were two large pinkish stains on the bottom half of the top linen. There was a musty odor in the room. During an observation on 07/09/2024 at 01:30 PM, Resident's #17 linens had dirty yellow and orange stains on them, and the pillowcase was light brownish tinged. There were two large pinkish stains on the bottom half of the top linen. There was a musty odor in the room. 3. Record review of the face sheet dated 06/28/2024 indicated, Resident #34 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included acute kidney failure, hypertension (high blood pressure), deep vein embolism (blood clot), diabetes mellitus (a group of diseases that result in too much sugar in the blood. (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	Record review of the quarterly MDS dated [DATE] indicated, Resident #34 was understood by others and understood others. The MDS indicated Resident #34 had a BIMS of 12 and was moderately cognitively impaired. The MDS indicated Resident #34 was independent with toileting, upper and lower body dressing, and putting on and taking off footwear, and he required set up/clean-up assistance with bathing. In section GG0120 Mobility devices the MDS indicated in the last 7 days Resident #34 used a wheelchair. Record review of the comprehensive care plan dated 11/16/23 indicated, Resident #34 had an activities of daily living (ADL) self-care performance deficit. The care plan indicated interventions included Resident #34 required assistance with showering, dress according to climate, assist with daily hygiene, provide peri care as indicated. During an observation and interview on 07/07/2024 at 10:40 AM, Resident #34 said his bed linens had not been changed in two weeks. Resident #34's linens had dirty brownish stains on the top portion, and the pillowcase had a light browning tinge to it. There was a strong urine smell in Resident #34's bathroom. There was dark yellow/orange colored water in the toilet. Resident #34's toilet seat lid had multiple areas that were peeling and multiple chipped paint areas which revealed the brown wood underneath it. Resident #34 said the toilet was hard to flush. He said he had to hold the handle down a long time to make it flush. Resident #34 said it always smelled like urine in his bathroom. An observation was made, and there was no hot water in Resident #34's bathroom sink (temperature of Resident #34's hot water was tested at 72 degrees), the sink would not drain the water timely, and the toilet was not flushing properly (urine remained in the toilet after flushed). Resident #34 said the toilet had not flushed and the sink had not drained for several months. Resident #34 said he told the Administrator a month or so ago about the clogged sink, not having hot water, and the bed linens not being changed. Resident #34 said the maintenance man had come in a few times and worked on the sink, but the water never got hot, the sink never drained right, and the toilet never flushed all the way. Resident #34 said the facility was his home, but it did not feel like a home when they did not have clean beds or a working bathroom. During an observation and interview on 07/08/2024 at 11:26 AM, Resident #34 said the bed linens did not get changed last night after he got a shower. Resident #34's sheets had dirty brownish stains on the top portion, and the pillowcase had a light browning tinge to it. Resident #34's toilet had light yellow water in the toilet bowl with a urine smell. There was no hot water in Resident # 34's bathroom sink. There was 1-2 inches of standing water in Resident #34's sink. During an observation on 07/09/2024 at 01:32 PM, Resident #34's sheets had dirty brownish stains on the top portion, and the pillowcase had a light browning tinge to it. There was no hot water in Resident # 34's bathroom sink. The sink would not drain the water timely and water was staying in the sink about 2 inches up. (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 observation and interview on 07/09/2024 at 02:08 PM, the Maintenance Supervisor said he had not noticed the peeling and chipped paint on the toilet seat because the toilet lid was always closed when he was in Resident #34's bathroom. The Maintenance Supervisor stated he had unclogged Resident #34's sink before, but he was not aware of Resident #34 not having hot water. The Maintenance Supervisor took the temperature of Resident #34's bathroom sink water and it was 72 degrees Fahrenheit. The Maintenance Supervisor said the water temperature should be between 98-110 degrees Fahrenheit within 3 seconds. The Maintenance Supervisor said Resident #17 and Resident #34 should have a sink with hot water, a toilet that flushed, and a sink that would drain timely. The Maintenance Supervisor said it was important for the residents to have hot water for proper handwashing and to decrease the chances of spreading contaminants. The Maintenance Supervisor said the residents should have a working bathroom so that it feels like their own home. 4. Record review of the face sheet dated 06/28/2024 indicated, Resident #4 was an [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning), atrial fibrillation(an irregular, often rapid heart rate that commonly causes poor blood flow), congestive heart failure (a chronic condition in which the heart doesn't pump as well as it should), hyperlipidemia (abnormally high concentration of fats in the blood). Record review of the quarterly MDS dated [DATE] indicated, Resident #4 was understood by others and understood others. The MDS indicated Resident #4 had a BIMS of 12 and was moderately cognitively impaired. The MDS indicated Resident #4 was independent with toileting, upper and lower body dressing, putting on and taking off footwear, and with bathing. In section GG0120 Mobility devices the MDS indicated in the last 7 days Resident #4 did not use a wheelchair. Record review of the comprehensive care plan dated 11/22/23 indicated, Resident #4 had an activities of daily living (ADL) self-care performance deficit. The care plan indicated interventions included Resident #4 required assistance with showering, dress according to climate, assist with daily hygiene, provide peri care as indicated. During an interview and observation on 07/07/2024 at 09:42 AM, Resident #4 said the hot water in his bathroom ran continuously. Resident #4 said he told the Maintenance Supervisor in May of 2024 about the running water. Resident #4 said he had complained about the running water in the Resident Council Meeting during the month of May 2024. Resident #4 said the Maintenance Supervisor told him he was busy painting the outside of the building but would fix the faucet once he finished painting. Resident #4 said it was aggravating that the water ran all the time because he worried about it since it was such a heavy stream of water flowing. An observation was made of the water faucet in Resident #4's bathroom running warm water at a continuous flow. During an interview on 07/10/2024 at 02:02 PM, CNA F said she was not he assigned CNA for resident #4. However, she said the CNAs were responsible for giving the residents their showers and for ensuring the bed linens were changed after showers/baths. CNA F said there was a shower schedule posted at the nurse's station to let the CNAs know who needed a shower on what day and shift and that included linen changes. CNA F said it was important for residents to receive their showers and have clean bedding to maintain the resident's cleanliness. CNA F said if a resident refused, or linens were not changed for a resident she reported to her charge nurse. CNA F said it was the charge nurse's responsibility to follow up on refusals or if linens were not changed after it was communicated to them by the CNAs. (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 attempted phone interview on 07/10/2024 at 09:00 AM, 10:00 AM, 01:40 PM, Aide L. assigned to resident #4, was unable to be reached. During an interview on 07/10/2024 at 02:14 PM, LVN D said the CNA should report when a resident's linens were not changed to the charge nurse. LVN D said it was the charge nurse's responsibility to follow up on refusals or linens that were not changed after communicated by the CNAs. LVN D said the charge nurse should verify the shower sheets daily to ensure all showers were documented by the CNAs. LVN D said she expected the residents to receive their scheduled showers and linen changes to prevent infections, maintain skin integrity, and maintain hygiene. LVN D said there was a shower schedule and required linen changes posted at the nurse's station to let the CNAs know who needed a shower/linen change on what day and shift . LVN D said no staff reported a refusal of showering/bathing or linen changes to her. LVN D said ultimately if showers and bathing were not completed, she notified the ADON or DON. During an interview on 07/10/2024 at 2:24 PM, the DON said it was the CNAs responsibility to give the residents their showers and change the residents' linens at the time of their showers. The DON said there was a shower list that identified what resident received a shower/linen change on which day and shift. The DON said the CNAs performed showers and linen changes on the residents, but any of the nursing staff could and should perform showers and linen changes when needed. The DON said she expected the CNAs to communicate with the charge nurses daily to ensure the residents' needs were met. The DON expected the shower sheets to be completed by the CNAs daily, and for them to turn the shower sheets into the shower logbook daily. The DON said she expected the charge nurses to verify the showers/linen changes were completed by the CNAs daily by checking the shower logbook. The DON said if a resident refused, she expected staff to try again a couple times or send a different staff member to ask the resident. The DON said if a resident continued to refuse, she expected staff to report the refusal to the family and document the refusal. The DON said she was responsible for monitoring that the residents were bathed/showered, and that linens were changed appropriately according to the resident's plan of care. The DON said she expected the Maintenance Supervisor to inspect and fix the resident's rooms to promote a homelike environment. The DON said the importance of the residents receiving their scheduled showers and linen changes was to maintain dignity, hygiene, skin integrity, skin inspections and prevent skin infections. During an interview 07/10/2024 at 02:42 PM, the Administrator said she expected baths/showers/linen changes as scheduled or as requested by the resident. The Administrator said clinical staff were responsible for making sure the baths/showers/linen changes were provided for the residents. The Administrator said if the residents refused ADL care, the staff educated the residents. The Administrator said if a resident refused, she expected staff to try again a couple of times or send a different staff member to ask the resident. The Administrator said if a resident continued to refuse, she expected staff to report the refusal to the family and document the refusal. The Administrator said it was important for the residents to receive baths/showers/linen changes for hygiene purposes, to make the residents feel good, for infection control, and for their dignity. The Administrator said she expected the Maintenance Supervisor to maintain the building with working faucets and toilets and have access to hot and cold water at all times. The Administrator said it was the responsibility of all staff to take notice and report when there was a resident's room that required attention, so the resident had a homelike environment that promoted dignity and a healthy wellbeing. Record review of the Resident Council Meeting dated 05/24/2024 indicated a complaint of Resident #4's concerns regarding the leaking bathroom faucet. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Maintenance Logbook for 2024 did not indicate any repairs were needed for Resident #4's, Resident #17's, Resident #34's rooms. Record review of facility policy and procedure titled, Homelike Environment revised on February 2021, indicated . Residents are provided with a safe, clean comfortable and homelike environment and encouraged to use their personal belongings to the extent possible .a. clean, sanitary and orderly environment; .e. clean bed and bath linens that are in good condition .

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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** 30527 Based on observations, interview, and record review, the facility failed to ensure comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 3 of 31 residents (Resident #17, and Resident #14 and Resident #1) reviewed for comprehensive care plans. The facility failed to ensure Resident #17's care plan indicated he smoked. The facility failed to ensure Resident #14's care plan indicated he wandered. This failure could place residents at risk of not having individual needs met and a decreased quality of life. Findings included: 1. Record review of the face sheet dated 06/28/2024 indicated, Resident #17 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included hypertension (high blood pressure), hyperlipidemia (high levels of fat particles in the blood), history of stroke, benign prostatic hyperplasia (prostate gland enlargement resulting in difficulty with urination) and acquired absence of limb. Record review of the quarterly MDS dated [DATE] indicated, Resident #17 was understood by others and understood others. The MDS indicated Resident #17 had a BIMS of 10 and was moderately cognitively impaired. The MDS indicated Resident #17 was independent with toileting, supervision and touching assistance for lower body dressing, and putting on and taking off footwear, set up/clean-up assistance with bathing and with upper body dressing. In section GG0120 Mobility devices the MDS indicated in the last 7 days Resident #17 used a wheelchair. Record review of the care plan dated on 03/16/2023 did not indicate Resident #17 used tobacco or smoked cigarettes. Record review of the Smoking Risk Assessment completed on 06/12/2024 indicated Resident #17 used cigarettes and was a safe smoker. During and observation and interview on 07/08/2024 at 11:18 AM., Resident #17 was smoking a cigarette during the scheduled smoke break. Resident #17 said he had smoked cigarettes for as long as he could recall. During an interview on 07/10/2024 at 10:40 AM, the ADON said she was responsible for updating the care plans. The ADON said Resident #17's care plan should have reflected and included that he smoked. The ADON said it was important for his care plan to include that he smoked to make sure he was safe to smoke, and everyone knew that he smoked. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/10/2024 at 11:02 AM, the DON said the ADON was responsible for updating the care plans. The DON said Resident #17's care plan should have reflected and included that he smoked. The DON said Resident #17's care plan should have included that he smoked. The DON said she did not know why it was not in his care plan. The DON said it was important to include in the care plan that Resident #17 so that staff knew if he was eligible to smoke or if he failed the smoking assessment or if he needed a assistance with smoking. During an interview on 07/10/2024 at 2:42 PM, the Administrator said she expected the ADON to update and implement the care plans of the residents quarterly and yearly. The Administrator said Resident #17's should have had a care plan for smoking. The Administrator stated it was important for the care plan to be accurate to ensure all residents were provided with continuity of care. 2. Record review of the face sheet dated 06/28/2024 indicated, Resident #14 was an [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included chronic obstruction pulmonary disease (a group of lung diseases that block airflow making it difficult to breath), hypertension (high blood pressure), hypokalemia ((low potassium level in the blood). Record review of the quarterly MDS dated [DATE] indicated, Resident #14 was usually understood by others and usually understood others. The MDS indicated Resident #14 had a BIMS of 99 and was unable to complete the assessment. The MDS indicated Resident #14 was dependent with toileting, lower body dressing, and putting on and taking off footwear, bathing, and with upper body dressing. In section GG0120 Mobility devices the MDS indicated in the last 7 days Resident #14 used a wheelchair. Record review of the comprehensive care plan dated 09/14/2023 indicated Resident #14 had no care plan for wandering. During an observation on 07/07/2024 at 08:20 AM., Resident #14 was observed wandering into another resident's room and drinking from a cup on the bedside table. During an observation on 07/07/2024 at 10:11 AM., Resident #14 was observed wandering on hall 1 and exit seeking. During an observation on 07/07/2024 at 11:18 AM., Resident #14 was observed wandering in the front lobby and exit seeking. During an interview on 07/10/2024 at 10:40 AM, the ADON said she was responsible for updating the care plans. The ADON said Resident #14 wandered. The ADON said Resident #14's care plan should have reflected and included that he wandered and required redirection. The ADON said it was important for his care plan to include that he wandered to make sure he was safe. During an interview on 07/10/2024 at 11:02 AM, the DON said the ADON was responsible for updating the care plans. The DON said Resident #14 should have been care planned for wandering and wandering not being care planned place the residents at risk for getting out and getting lost and with them going in other residents' rooms the other residents could get upset. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676142	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Emory Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 983 N Texas Street Emory, TX 75440	

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/10/2024 at 2:42 PM, the Administrator said she expected the ADON to update and implement the care plans of the residents quarterly and yearly. The Administrator said Resident #14 should have had a care plan for wandering. The Administrator stated it was important for the care plan to be accurate to ensure all residents were provided with continuity of care as the care plan dictates the resident's care pathway. Record review of the comprehensive care plan last revised on 11/01/2023 indicated Resident #1 had no care plan for wound care to the left breast. Record review of Resident #1's order summary report with a date range of 11/01/2023 - 03/06/2024 indicated cleanse the non-pressure wound of the left breast with normal saline, pat dry, apply over the counter miconazole powder, cover with Calcium Alginate, and cover with border gauze every day, until healed every shift. Record review of Resident #1's progress note dated 11/01/2023 indicated left breast continues with a non-pressure wound related to cellulitis of the breast that has subsided. Wound measured as a cluster 9.5 x 6 x 0.3 cm with beefy red wound bed and a moderate amount of serious exudated . No improvements over the last 7 days. Continue calcium alginate and bordered gauze dressing daily. Record review of Resident #1's physician's wound evaluation management summary dated 11/08/2023 indicated non pressure wound of the left breast due to trauma/injury- full thickness. Wound size 10.5 x 5.5 x 0.2 cm, surface area of 57.76 cm, cluster wound open ulceration with moderate serous exudate. During an interview on 03/07/2024 at 01:00 PM, the MDS Coordinator stated she is responsible to update the care plans quarterly and yearly. The MDS Coordinator stated the ADONs, and DON were responsible for all other updates to the care plans. The MDS Coordinator stated it was important for the plan of care to accurately reflect the resident's needs for proper care. During an interview on 03/07/2024 at 01:32 PM, the DON stated the MDS Coordinator was responsible for ensuring everything for the resident's care was included in the care plans yearly and quarterly. The DON stated she was responsible for the updates for care plans. The DON stated Resident #1 should have had a care plan for wound care services being provided daily. The DON stated she did not know why it was not in the care plan. The DON stated it was important for Resident #1's wound care services to be included in her care plan because it is the map of providing care of the resident and resulted in continuity of care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the policy and procedure Comprehensive Assessment and the Care Delivery Process revised December 2016 indicated, a comprehensive, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring result and adjusting interventions .person-centered care plan that includes measurable objectives and timetables to meet he resident's physical, psychosocial and functional needs is developed and implemented for each resident. The services provided or arranged by the facility, as outlined by the comprehensive care plan, are provided by qualified persons, are culturally competent and trauma informed. 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. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 8. The comprehensive, person-centered care plan will: g. Incorporate identified problem areas, h. Incorporate risk factors associated with identified problems . Record review of the Care Plan and Care Area Assessments policy, revised on 05/06/2021, stated This identification and implementation of a plan of care will begin at admission with the initial care plan and be completed throughout assessment process for developing a comprehensive plan of care. The policy further indicated, Acute Care Plans o As acute problems or changes to intervention or goals are identified, an appropriate care plan will be developed or modified by a Nursing staff member. o CMMs are only responsible for care plans that relate to the MDS triggers at the time of assessment completion.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observations, interviews, and record review the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain personal hygiene for 2 of 4 residents (Resident #'s 140 and 17) reviewed for ADLs. The facility failed to ensure Resident #140's face was free from facial hair. The facility failed to ensure Resident #17 received routine scheduled showers. These failures could place residents at risk for not receiving services/care and a decreased quality of life. 1) Record review of a face sheet dated 6/10/2024 indicated Resident #140 was a [AGE] year-old female who admitted on [DATE] with the diagnoses of profound intellectual disabilities (the inability to live alone, and care for themselves). Record review of the Admission MDS dated [DATE] indicated Resident #140 was rarely/never understood, and rarely/never understood others. The MDS indicated the BIMS assessment was not conducted. The MDS indicated Resident #140 had severely impaired daily decision-making cognitive skills. The MDS indicated Resident #140 had not displayed any rejection of care in Section E-Behavior. The MDS indicated Resident #140 was dependent on staff for personal hygiene. Record review of the Comprehensive Care Plan dated 6/19/2024 indicated Resident #140 required assistance with ADL's. The care plan goal was Resident #140 would maintain a sense of dignity by being clean, dry, odor free, well groomed, and dressed appropriately. The intervention of the care plan for Resident #140 was to assist with daily hygiene needs. Record review of the Daily CNA Shower Report Sheet for Monday-Wednesday-Friday indicated Resident #140 was to be routinely showered, shaved, provided hair and nail care. The Daily CNA Shower Report Sheet indicated: 6/12/2024: shower was provided, shaving, hair, and nails not completed. 6/14/2024: no shower sheet was provided. 6/17/2024: shower was provided, shaving, hair, and nails not completed. 6/19/2024: shower was provided, shaving, hair, and nails not completed. 6/21/2024: shower was provided, shaving, hair, and nails not completed. 6/24/2024: shower was provided, shaving, hair, and nails not completed. 6/26/2024: shower was provided, shaving, hair, and nails not completed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/28/2024: no shower sheet was provided. 7/03/2024: shower was provided, shaving, hair, and nails not completed. 7/05/2024: no shower sheet was provided. 7/08/2024: Shower, hair and nails was completed but not shaved . Record review of the CNA Flowsheet dated June 2024 indicated in the section of Shower on scheduled days there were no documented times Resident #140 was showered. The section of daily nail care indicated Resident #140 received nail care on June 10th, 11th, and 13th for the month of June. The CNA Flowsheet failed to have an entry for shaving. Record review of the ADL sheets dated July 2024 indicated Resident #140's shaving daily as needed was blank for July 1-7. The ADL sheets indicated Resident #140 received a shower on 7/02/2024. During an observation on 7/07/2024 at 9:31 a.m., Resident #140 was sitting in her reclining chair. She openeds her eyes when you touched her but she did has not have a verbal response. Resident #140 had facial hair 1/4 inches long to her upper lip and her chin area. During an observation on 7/07/2024 at 1:10 p.m., Resident #140 continues to have facial hair 1/4 inches long to her upper lip and her chin. Resident #140 appeared s to have dandruff (flaking white scalp material) to her scalp. During an observation on 7/08/2024 at 8:34 a.m., Resident #140 continues to have facial hair 1/4 inches long to her upper lip and chin. During an interview on 7/10/2024 at 1:21 p.m., CNA E said she provided care to Resident #140. CNA E said she was responsible for shaving residents of undesired facial hair. CNA E said the facial hair should be removed on shower days especially but any other day as well. CNA E said she thought a woman having facial hair was a preference . CNA E said she would not want to have facial hair, appearing to be a mustache. During an interview on 7/10/2024 at 1:35 p.m., LVN D said she expected residents to be free from undesired facial hair. LVN D said Resident #140 was showered by her on 7/08/2024 but she failed to shave Resident #140. LVN D said she would not want to have facial hair and having facial hair would not make her feel like a woman. LVN D said the CNAs were responsible for the ADLs and the nurses were responsible for monitoring. During an interview on 7/10/2024 at 2:26 p.m., the ADON said the CNAs were responsible for the provision of ADLs including shaving. The ADON said the nurses were responsible for monitoring the provision of ADLs. The ADON said facial hair should be removed if not desired. The ADON said Resident #140 should have been shaved to remove the facial hair. The ADON said not maintaining ADLs could be a dignity issue. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/10/2024 at 2:42 p.m., the DON said she expected the residents male or female to have undesired facial hair removed. The DON said the nursing staff were responsible for ensuring the ADLs were completed according to the schedule. The DON said she believed the system for the provision of ADLs was being monitored . The DON said not having facial hair removed when desired could be a dignity issue. The DON said monitored the bath sheets and made walking rounds to monitor ADLs. During an interview on 7/10/2024 at 3:33 p.m., the Administrator said the nursing staff should clarify with Resident #140's family member their desired outcomes as it related to shaving of facial hair. The Administrator said not shaving undesired facial hair could be a dignity issue. 30527 2. Record review of the face sheet dated 06/28/2024 indicated, Resident #17 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included hypertension (high blood pressure), hyperlipidemia (high levels of fat particles in the blood), history of stroke, benign prostatic hyperplasia (prostate gland enlargement resulting in difficulty with urination) and acquired absence of limb. Record review of the quarterly MDS dated [DATE] indicated, Resident #17 was understood by others and understood others. The MDS indicated Resident #17 had a BIMS of 10 and was moderately cognitively impaired. The MDS indicated Resident #17 was independent with toileting, supervision and touching assistance for lower body dressing, and putting on and taking off footwear, set up/clean-up assistance with bathing and with upper body dressing. In section GG0120 Mobility devices the MDS indicated in the last 7 days Resident #17 used a wheelchair. Record review of the comprehensive care plan dated 05/19/2023 indicated, Resident #17 had an activities of daily living (ADL) self-care performance deficit. The care plan indicated interventions included Resident #17 required showering, dress according to climate, assist with daily hygiene, provide peri care as indicated. Record Review of the Daily CNA (Certified Nurse Aide) Shower Report Sheet dated 06/01/2024 indicated Resident #17 was scheduled for showers 3 times weekly. Record review of the Daily CNA (Certified Nurse Aide) Shower Report Sheets dated 06/01/24, 06/04/2024, 06/11/2024, 06/15/2024, 06/18/2024, 06/20/24, 06/27/2024, 07/06/2024 indicated Resident #17 had not received a shower. Record review of the nursing notes dated 06/01/2024 through 07/06/2024 showed no refusals of showering/bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 07/07/2024 at 10:30 AM, Resident #17 said he had not received a shower in two weeks. Resident #17 said that he was supposed to receive a shower three times weekly on Tuesday, Thursday, and Saturday. Resident #17 said he had not refused to shower, but a shower had not been offered. Resident #17 said he could not recall the exact date of his last shower, but it was at least two weeks. Resident #17 said he should not need to ask for help with a shower because the staff was aware of the shower schedule. Resident #17 said it was degrading and he felt disrespected when his shower was not offered. Resident #17 was observed with oily hair and a strong musty odor lingered in the room. During an interview on 07/10/2024 at 02:02 PM, CNA F said the CNAs were responsible for giving the residents their showers. CNA F said there was a shower schedule posted at the nurse's station to let the CNAs know who needed a shower on what day and shift. CNA F said it was important for residents to receive their showers so staff could observe their skin and to maintain the resident's cleanliness. CNA F said if a Resident refused, or a shower/bath was not given to a resident she reported to her charge nurse. CNA F said it was the charge nurse's responsibility to follow up on refusals or baths that were not completed after communicated by the CNAs. During an interview on 07/10/2024 at 02:14 PM, LVN D said the CNA should report when a resident was not showered/bathed to the charge nurse. LVN D said it was the charge nurse's responsibility to follow up on refusals or baths not completed after communicated by the CNAs. LVN D said she expected the residents to receive their scheduled showers to prevent infections, maintain skin integrity, and maintain hygiene. LVN D said there was a shower schedule posted at the nurse's station to let the CNAs know who needed a shower on what day and shift. LVN D said no staff reported a refusal of showering/bathing to her. LVN D said ultimately if showers and bathing were un-resolved, she notified the ADON or DON. During an interview on 07/10/2024 at 2:24 PM, the DON said it was the CNAs responsibility to give the residents their showers. The DON said there was a shower list that identified what resident received a shower on which day and shift. The DON said the CNAs performed showers on the residents, but any of the nursing staff could and should perform showers when needed. During an interview on The DON said she expected the CNAs to communicate with the charge nurses daily to ensure resident's needs met. The DON expected the shower sheets to be completed by the CNAs and turned into the shower logbook daily. The DON said she expected the charge nurses to verify the showers given by the CNAs daily by checking the shower logbook. The DON said if a resident refused, she expected staff to try again a couple times or send a different staff member to ask the resident. The DON said if a resident continued to refuse, she expected staff to report the refusal to the family and document the refusal. The DON said she was responsible to ensure the oversight of resident 's bathed and showered appropriately according to the resident's Plan of Care. The DON said the importance of the residents receiving their scheduled showers was to maintain dignity, hygiene, skin integrity, skin inspections and prevent skin infections. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview 07/10/2024 at 02:42 PM, the Administrator said she expected baths/showers as scheduled or as requested by the resident. The Administrator said clinical staff were responsible for making sure the baths/showers were provided for the residents. The Administrator said if the residents refused ADL care, the staff educated the residents. The Administrator said if a resident refused, she expected staff to try again a couple times or send a different staff member to ask the resident. The DON said if a resident continued to refuse, she expected staff to report the refusal to the family and document the refusal. The Administrator said it was important for the residents to receive baths/showers for hygiene purposes and to make the residents feel good, infection control and dignity. Record review of the Shaving the Resident policy and procedure dated February 2018 indicated the purpose of the procedure was to promote cleanliness and to provide skin care. Preparations: 1. Review the resident's care plan to assess for any special needs of the resident. Documentation: 1. The date and time that the procedure was performed 5. If the resident refused thee treatment, the reasons why and the interventions taken. Reporting: 1. Notify the supervisor if the resident refuses the procedure. Record review of facility policy and procedure titled, Bath, Shower/Tub with a revised date of February 2018 indicated, The purposes for this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin .Documentation - 1. The date and time the shower/tub bath was performed .Documentation - of the resident refused the shower/tub bath, reason .Reporting - notify the supervisor if the resident refuses the shower/tub bath

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 30527

Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided with professional standards of practice for 1 of 3 residents (Resident #7) reviewed for respiratory care and services.

The facility failed to properly store Resident #7's nebulizer (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) mask while not in use.

This failure could place residents who require respiratory care at risk for respiratory infections and exacerbation of respiratory distress.

Findings include:

1. Record review of Resident #7's order summary report, dated for the month of July 2024, indicated Resident #7 was a [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included diabetes mellitus (a group of diseases that result in too much sugar in the blood), chronic pulmonary edema (excessive fluid in the lungs), essential hypertension (high blood pressure), and atrial fibrillation (irregular, often rapid heart rate).

Record review of Resident #61's order summary report, dated for the month of July 2024, indicated Resident #7 received albuterol 0.083% 1 via nebulizer every 4 hours as needed for wheezing and change Nebulizer tubing weekly.

Record review of Resident #7's admission MDS assessment, dated 06/04/2024, indicated Resident #7 understood others and made herself understood. The assessment indicated Resident #7 was moderately cognitive impaired with a BIMS score of 9. The assessment indicated Resident #71 did not reject care necessary to achieve the resident's goals for health or well-being. The MDS indicated Resident #7 required partial/moderate assistance for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing.

Record review of Resident #7's care plan, with a revision date of 08/04/2022, indicated Resident #7 had an impaired respiratory status related to chronic pulmonary edema The care plan interventions included provide nebulizer therapy as ordered.

During an observation and interview on 07/07/2024 at 10:05 a.m., Resident #7 was sitting in her bed. Resident #7 said she had not received a nebulizer treatment that she could recall. The nebulizer mask was laying on the table at bedside uncovered.

During an observation on 07/08/2024 at 11:30 AM., Resident #7 was sitting in chair. The nebulizer mask was laying on the table at bedside uncovered.

During an observation on 07/09/2024 at 3:43 PM., Resident #7 was asleep in bed. The nebulizer mask was laying on the table at bedside uncovered.

(continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, interview, and record review on 07/10/2024 at 2:06 PM., LVN D stated she was Resident #7's 6a-6p charge nurse, LVN A stated Resident #7 had an order for PRN nebulizer treatments. LVN D observed with the surveyor Resident #7's nebulizer mask on the bedside table not covered. LVN D stated Resident #7's nebulizer mask should be covered when not in use. LVN D stated she had not administered Resident #7 a breathing treatment this week on her shift . LVN D stated all nursing staff were responsible for ensuring infection control was provided for each resident. LVN D stated these failures could potentially put residents at risk for respiratory infection. During an interview on 07/10/2024 at 2:24 PM, the DON said she expected Resident #7's nebulizer mask be stored in a bag when not in use. The DON stated the 10 PM to 6 AM charge nurses were responsible for changing out nebulizer mask and oxygen tubing every Wednesday night. The DON stated the charge nurses were responsible for monitoring to ensure respiratory equipment was returned to designed bag after each use. The DON stated, she was responsible for monitoring the charge nurses. The DON stated these failures could potentially cause a decrease in respiratory status. During an interview on 07/10/2024 at 2:42 PM, the Administrator said she expected nebulizers stored in bags when not in use, tubing to be changed and dated per orders and filters to be placed on O2 concentrators. The Administrator stated this was monitored by the DON. The Administrator stated these failures put residents at risk for respiratory infection due to particles that could accumulate on the mask. Record review of the facility's Administering Medications through a Small Volume (Handheld) Nebulizer policy, revised October 2010, indicated, .29. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observations, interview, and record reviews, the facility failed to ensure correct installation, use and maintenance of bedrails for 1 of 1 resident (Resident #21) reviewed for bedrails. 1.The facility failed to assess Resident #s 21 for the risk of entrapment from bed rails prior to installation. 2. The facility failed to document the attempt of alternatives to meet Resident #21's needs. These failures could place residents at risk for entrapment with serious injury and even death. Findings included: Record review of a face sheet dated 5/17/2024 indicated Resident #21 was a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnosis of end stage dementia. Record review of the Consolidated Physician's orders dated July 2024 indicated Resident #21 was not ordered a bedrail device. Record review of the Significant Change MDS dated [DATE] indicated Resident #21 was rarely understood, and rarely understands others. The MDS indicated Resident #21's BIMS score was not determined due to his inability to understand. Section GG-Functional Abilities and Goals indicated Resident #21 was dependent on staff for rolling left and right, sit to lying, lying to sitting, sit to stand, chair/bed-to-chair transfers, and tub/shower transfers. The MDS in section P-Restraints indicated Resident #21 a bedrail restraint was not used. Record review of the Comprehensive Care Plan dated 3/20/2024 and updated on 6/25/2024 indicated Resident #21 required assistance with his ADLs. The care plan indicated Resident #21 required substantial assistance with sitting to lying, lying to sitting, sit to stand, chair to bed, and bed mobility. The interventions included Resident #21 would receive assistance with transfers, turning and repositioning, peri-care, daily hygiene, and meals. The comprehensive care plan indicated Resident #21 was transferred using a mechanical device. The goal of the care plan was Resident #21 would be out of the bed daily. The care plan interventions included staff to get resident #21 up out of bed daily and use two staff with the mechanical lift. The comprehensive care plan failed to address the use of a bedrail. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676142	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Emory Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 983 N Texas Street Emory, TX 75440	

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Side Rail assessment dated [DATE] indicated Resident #21 had a top left side rail available for use. The Side Rail Assessment indicated the side rail was used at all times. The Side Rail Assessment was not answered in the section does the side rail impede the resident's freedom. The Side Rail Assessment indicated the reason for the side rail use was the resident and responsible party requested. The Side Rail Assessment indicated clinical standards recommended side rails as an enabler. The Side Rail Assessment indicated the reason for the recommendation was to assist with transfers and bed mobility. The Side Rail Assessment in the section of medical symptom being treated was left blank. The Side Rail Assessment failed to indicate alternative measures implemented or considered prior to use of the side rail . The Side Rail Assessment was dated and signed by the ADON on 6/19/2024. During an observation on 7/07/2024 at 8:29 a.m., Resident #21 was lying on his left side in his bed facing the wall. Resident #21's bed had a half rail to the right side of his bed. Resident #21 was not able to be interviewed. During an observation on 7/08/2024 at 8:21 a.m., Resident #21 was lying in his bed facing the right side of his bed toward the half bed rail. During an interview on 7/10/2024 at 9:29 a.m., CNA E said Resident #21 had stopped over the last month using his bedrail for bed mobility or transfers. CNA E said Resident #21 was much weaker and could not use his bed rail. During an interview on 7/10/2024 at 1:35 p.m., LVN D said Resident #21 was unable to use a bed rail for bed mobility or transfers. LVN D said she expected the side rail assessment to accurately reflect the use of the side rail. LVN D said there was a risk Resident #21 could get injured from the use of a side rail since his inability to use the side rail over the last month. During an interview on 7/10/2024 at 2:26 p.m., the ADON said Resident #21 had a recent decline over the last month and had become unable to use his side rail for bed mobility and transfers. The ADON said she had not performed another assessment since Resident #21's decline in condition for the use of the side rail but should have. During an interview on 7/10/2024 at 2:42 p.m., the DON said Resident #21 used the side rail at one time for transfers and bed mobility but currently he was unable to use the side rail. The DON said the side rail assessment should be completed with the care plan. The DON said nursing was responsible for updating the assessment to accurately reflect the use of a side rail as an enabler. The DON said Resident #21 could be injured without an accurate assessment of the use of side rail. The DON said nurse managers were responsible for ensuring the side rail assessment was completed and completed accurately. During an interview on 7/10/2024 at 3:35 p.m., the Administrator said she expected the side rail assessment to be updated with changes in condition, as a part of the care planning process. The Administrator said nursing was responsible for updating the side rail assessment. The Administrator said the side rail should be removed from Resident #21's bed to prevent any injuries. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Bed Safety policy dated December 2007 indicated the facility shall strive to provide a safe sleeping environment for the resident .2. To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, foot board, and bed accessories), the facility shall promote the following approaches: .e. Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (altered mental status, and restlessness). 5. If side rails are used, there shall be an interdisciplinary assessment of the resident, consultation with the attending physician, and input form the resident and/or legal representative. 8. Side rails may be used If assessment and consultation with the attending physician has determined that they are needed to help manage a medical symptom or condition or to help the resident reposition or move in bed and transfer, and no other reasonable alternative can be identified. 9. Before using the side rails for any reason, the staff shall inform he resident and family about the benefits and potential hazards associated with side rails.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on observation, interview and record review, the facility failed to ensure residents received therapeutic diets that were prescibed by the attending physician for 1 of 13 residents (Resident #28) reviewed for therapeutic diets. The facility did not ensure Resident #28 was given double protein portion as ordered by the physician. This failure could place residents at risk for poor intake, weight loss, unmet nutritional needs, and a loss of dignity. Findings Included: Record review of the face sheet, dated 05/17/2024, indicated Resident #28 was an [AGE] year-old male, originally admitted to the facility on [DATE] with diagnoses which included Type 2 Diabetes Mellitus (chronic condition that affects the way the body processes blood sugar) Record review of the physician orders dated 02/07/2024, indicated Resident #28 had an order, which started on 02/07/2024, extra portions of meat with meals. Record review of the quarterly MDS assessment, dated 02/20/2024, indicated Resident #28 usually made himself understood and rarely/never understood others. Resident #28 had short term/long term memory problems. Resident #28 had severely impaired decision-making skills. Resident #28 had no behaviors or refusal of care. Resident #28 did not have weight loss. Resident #28 was on a mechanically altered diet. Record review of the comprehensive care plan, dated 04/23/2024, indicated Resident #28 was on a pureed diet. The interventions included: serve diet as ordered and offer substituted if less than 50% was eaten, monitor intake, and supervision with meals. During an observation and record review on 07/07/2024 at 12:55 p.m., Resident #28 lunch meal ticket stated, extra meat portions. Resident #28 received a single serving of the entree which was steak fingers. During an interview on 07/07/2024 at 12:57 p.m., the Dietary Manager was asked by the surveyor if Resident #28 entree was considered double. The Dietary Manager stated no and went back to the kitchen to request for another serving of protein. During an attempted interview on 07/07/2024 at 1:02 p.m. with Resident #28, indicated she was non-interview able. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/07/2024 at 1:10 p.m., RN A stated nurses were responsible for checking trays prior to giving them out to residents. RN A stated Resident #28 should have gotten double protein serving. RN A stated, it was her mistake that Resident #28 did not receive double protein serving. RN A stated this failure could put Resident #28 at risk for further weight loss. During an interview on 07/10/2024 at 1:24 p.m., [NAME] C stated Resident #28 should have gotten two servings of steak fingers instead of one. [NAME] C stated she was nervous because the surveyor was present. [NAME] C stated it was the Dietary Manager and nursing staff responsibility to ensure the trays were correct before serving a resident. [NAME] C stated this failure could potentially put Resident #28 at risk for weight loss. During an interview on 07/10/2024 at 1:46 p.m., the Dietary Manager stated Resident #28 should have gotten two servings of steak fingers. The Dietary Manager stated he expected physician orders to be followed. The Dietary Manager stated the cook, himself and the nursing staff were responsible for checking the trays prior to the residents served. The Dietary Manager stated ultimately the nursing department were responsible for ensuring the trays were correct before serving a resident. The Dietary Manager stated he was responsible for overseeing and monitoring by checking the trays in the dining and residents' room at least five days a week. The Dietary Manager stated if he caught a tray incorrect before leaving the kitchen, he would have the staff to redo the tray or noticed an issue while making rounds he will have the cook to redo the tray. The Dietary Manager stated staff were verbally in-serviced immediately. The Dietary Manager stated this failure could put residents at risk for weight loss. During an interview on 07/10/2024 at 3:21 p.m., the Administrator stated she expected food trays to be checked and residents to receive the correct diet. The Administrator stated it was important for residents to receive the correct diet order to prevent weight loss. The Administrator stated the dietary was responsible for monitoring and overseeing. Record review of the facility's policy titled Food and Nutrition Services revised 10/2017 indicated each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident .7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident .a. if an incorrect meal is provided to a resident . nursing staff will report it to the Food Service Manager so that a new food tray can be issued .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 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. The facility failed to ensure: 1. Food items were labeled and dated. 2. Hair restraints worn. 3. The microwave was clean and free of food debris. 4. The toaster was clean and free of food debris. 5. Expired food item was discarded. 6. Refrigerator/Freezer log was kept up to date. 7. Personal drinks were kept out of facility refrigerator. These failures could place residents at risk for foodborne illness. Findings included: During an observation and interview on [DATE] at 8:00 a.m., [NAME] C was in the kitchen without wearing a hair restraint. [NAME] C stated the one she had on her head had ripped. [NAME] C stated she was going to get another one but got sidetracked. [NAME] C stated it was important to wear a hairnet while in the kitchen to prevent food contamination. During the initial tour observation and interview with the [NAME] C on [DATE] between 8:21 a.m. and 8:50 a. m., the following was revealed: 1. Plastic storage bag that was identified by the Dietary Aide B as sliced turkey ham undated and unlabeled. 2. Plastic bottle labeled Ice Pop Prime Hydration drink noted in refrigerator. [NAME] C stated the drink belonged to her. [NAME] C stated she put the drink in the fridge to get cold. 3. Large serving pan labeled chicken dated [DATE]. [NAME] C stated the chicken should be discarded after 4 days. 4. [NAME] storage bin that was identified by Dietary Aide B as onions undated and unlabeled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Toaster with food particles noted. 6. Microwave with several brown substance noted. 7. Refrigerator/Freezer temperature log was missing temperatures on [DATE], [DATE], [DATE]. During an interview on [DATE] at 1:16 p.m., Dietary Aide B stated all kitchen staff were responsible for labeling and dating food products. Dietary Aide B stated the cook was responsible for discarding the chicken after 3 days, cleaning the toaster/microwave and logging the temperature on every shift. Dietary Aide B stated personal drinks should go in the breakroom fridge. Dietary Aide B stated these failures could put residents at risk for food borne illness and contamination. During an interview on [DATE] at 1:24 p.m., [NAME] C stated whoever took the food products out the original package should have labeled and dated the item. [NAME] C stated she thought food should be discarded after 4 days until the Dietary Manager in-serviced her. [NAME] C stated the cooks were responsible for cleaning the toaster and microwave daily and as needed. [NAME] C stated the cooks were responsible for logging the refrigerator/freezer temperature right after breakfast. [NAME] C stated she should have put her personal drink in the back closet or in the staff breakroom. [NAME] C stated these failures could cause foodborne illness and contamination. During an interview on [DATE] at 1:46 p.m., the Dietary Manager stated cleanliness was important in the kitchen, so her staff are not spreading germs or contaminating anything. The Dietary Manager stated she was responsible for making sure the kitchen was cleaned appropriately. The Dietary Manager stated all food should be labeled with date received and the date it was opened. The Dietary Manager stated personal drinks should be kept in the staff refrigerator. The Dietary Manager stated that chicken that was in the serving pan should have been discarded after 3 days. The Dietary Manager stated cooks were responsible for cleaning the toaster and microwave daily and as needed. The Dietary Manager stated the refrigerator/freezer log should have been completed as soon as the cook got there in the morning and at the end of night shift. The Dietary Manager stated hairnets should be worn while in the kitchen. The Dietary Manager stated he was responsible for monitoring and overseeing by daily walk throughs and when there was an issue staff were verbally in serviced immediately. The Dietary Manager stated if the issues continued to happen a full in serviced was done by conducting a meeting with all kitchen staff. The Dietary Manager stated these failures could potentially put residents at risk for cross contamination, foreign debris getting into food and food borne illness. During an interview on [DATE] at 3:21 p.m., the Administrator stated she expected the kitchen to be clean and staff preventing cross contamination. The Administrator stated she expected all food to be labeled and dated. The Administrator stated she expected food to be discarded after day 3, microwave/toaster cleaned after each use and hairnets always worn. The Administrator stated the refrigerator/freezer log should be completed first thing in the morning and at the end of night shift. The Administrator stated she did walk throughs Monday-Friday and if she noticed an issue, it was addressed immediately. The Administrator stated the Dietary Manager was responsible for overseeing and monitoring. The Administrator stated it was important to ensure these things listed above were complying to ensure the health and safety of the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility's policy titled, Sanitization, revised ,d+[DATE] indicated, .the food service area shall be maintained in a clean and sanitary manner . 11. For fixed equipment or utensils that do not fit in the dishwashing machine, washing shall consist of the following steps: a. equipment will be disassembled as necessary to allow access of the detergent/solution to all parts; b. removeable components will be scraped to remove food particles accumulation and washed according to manual or dishwashing procedures . Record review of the facility's undated policy titled, Thaw Frozen Leftovers Safely, indicated, . this policy outlines the safe methods for thawing frozen leftovers to ensure food safety and prevent foodborne illness 1. Refrigerator Thawing . thawed food should be used within 3 days . Record review of the facility's policy titled, Food Receiving and Storage, revised ,d+[DATE] indicated, . food shall be received and stored in a manner that complies with safe food handling practices .7. Dry foods that are stored in bins will be removed from original packaging, labeled and dated .8. All foods stored in the refrigerator or freezer will be covered, labeled and dated . Record review of the facility's undated policy titled, Hair Restraint in Food Services, indicated, .the purpose of this policy to establish guidelines for employees to follow when it comes to hair restraint in food service kitchens. Hair restraint is an essential component of maintaining a safe and sanitary environment in a food service kitchen and is necessary to prevent contamination of food 1. All employees working in the kitchen or food preparation areas must always wear a hair restraint Record review of the facility's undated policy titled, Refrigerator and Freezer Log Maintenance indicated, . to ensure the safety and quality of food storage, this policy outlines the importance and procedures for maintaining a refrigerator and freezer log twice a day. Regular monitoring and documentation of temperatures are crucial in preventing food spoilage and ensuring compliance with food safety standards . maintaining a refrigerator and freezer log twice a day is mandatory in our establishment .5. Log Review . Logs will be reviewed daily by the kitchen supervisor to ensure compliance and to address any issues promptly

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 1 resident (Resident # 21) reviewed for hospice services. The facility failed to obtain Resident #21's most recent updated hospice plan of care. The facility failed to ensure Resident #21's hospice plan of care accurately reflect his medication regimen. This deficient practice could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. Findings included: Record review of a face sheet dated 5/17/2024 indicated Resident #21 was a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] with the diagnosis of end stage dementia. Record review of the Significant Change MDS dated [DATE] indicated Resident #21 was rarely understood, and rarely understands others. The MDS indicated Resident #21's BIMS score was not determined due to his inability to understand. Section O-Special Treatments, Procedures, and Programs was marked indicating Resident #21 received hospice care. Record review of the Comprehensive Care Plan dated 3/20/2024 and updated on 6/25/2024 indicated Resident #21 had been diagnosed with an end stage disease and had elected to have hospice services. The goal of the care plan indicated the facility would in accordance with the palliative care, implement measures to diminish the effects to the extent possible. The interventions of the care plan included to notify hospice of any significant changes in condition. Record review of the Hospice Comprehensive Assessment and Plan of Care Updated Report dated and printed on 5/13/2024 at 2:37 p.m., was the last Hospice Comprehensive Assessment and Plan of Care form in Resident #21's hospice medical record binder. The Hospice Comprehensive Assessment and Plan of Care indicated Resident #21 was started on hospice services on 3/11/2024 the diagnosis of senile degeneration of the brain (dementia). The Plan of Care indicated Resident #21's medication regimen included acetaminophen, bisacodyl suppository, hydrocodone, hyoscyamine, lorazepam, milk of magnesia, morphine, omeprazole, tamsulosin, and trazodone. The IDT Assessment and Plan of Care failed to reveal Resident #21's medication regimen included Zoloft, Alfuzosin, Zaditor, Robitussin, Zyrtec, Zofran, and Phenergan. Record review of the Consolidated Physician's Orders dated July 2024 indicated Resident #21 was ordered these medications but not indicated on the hospice plan of care: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Zoloft 25 milligrams daily; Alfuzosin ER 10 milligrams twice daily; Zaditor eye drops one drop both eyes twice daily; Robitussin DM 2 teaspoons every 4 hours as needed for cough; Zyrtec 10 milligrams daily as needed for allergies; Zofran 4 milligrams one tablet every 4 hours as needed for nausea/vomiting; and Phenergan 25 milligrams one tablet by mouth every 6 hours as needed for nausea/vomiting. During an interview on 7/08/2024 at 10:56 a.m., the hospice nurse said Resident #21's hospice binder should have been updated with the current plan of care to ensure the continuity of care and the coordination of care with the facility and Resident #21. The hospice nurse indicated she was responsible for ensuring Resident #21's care was coordinated with the facility and the binder should be updated with the most recent plan of care coordination. During a telephone interview on 7/10/2024 at 10:34 a.m., the hospice program manager said she expected Resident #21's hospice binder to be current with the most recent hospice plan of care. The hospice program manager said the medication regimens should match and accurately reflect the medications Resident #21 received. The hospice program manager said when the Plans of Care were not readily available and were not accurately reflective of Resident #21's care there could be a risk of the care coordination. During an interview on 7/10/2024 at 1:35 p.m., LVN D said she was the nurse for Resident #21, and she expected the hospice records to be updated timely, and accurately. LVN D said when the hospice plan of care was not updated timely and accurately Resident #21 could receive care not desired or not according to his plan of care. LVN D said the hospice provider was responsible for ensuring the delivery of the hospice plan of care to ensure continuity of care. During an interview on 7/10/2024 at 2:30 p.m., the ADON said she expected the hospice plan of care to be current and available. The ADON said she expected the medication regimen and the care plans to match and coordinate the care Resident #21 desired. The ADON said she had not been monitoring the timely coordination of care with Resident #21's hospice provider. The ADON said the nursing staff were responsible for ensuring the continuity of care. During an interview on 7/10/2024 at 2:46 p.m., the DON said she expected the hospice plan of care to be provided to the facility timely and accurately to reflect and coordinate the care Resident #21 desired. The DON said she had not been monitoring the coordination of the care with Resident #21's hospice provider but would now implement monitoring. The DON said the nursing staff was responsible for the coordination of care with the hospice provider. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/2024 at 3:43 p.m., the Administrator said she expected the hospice provider to provide the coordination of care with the nursing staff for Resident #21. The Administrator said the coordination of care was important to ensure the continuity of care for Resident #21. The Administrator said nurse managers were responsible for ensuring the coordination of care. Record review of the Palliative Care Program policy dated 2001 indicated the 1. Palliative care was to provide to all resident with persistent or recurring health conditions that adversely affect daily functions or reduce life expectancy 2. The palliative care plan was based on a comprehensive interdisciplinary assessment of the resident and family. 3. The palliative plan of care is based on the expressed values, goals, and needs of the resident and family. 9. Community resources are identified and utilized to ensure continuity of care throughout the illness trajectory. This includes establishing ongoing collaborative relationships with hospice and acute care providers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 30527 Based on observation, interview, and record review the facility failed to ensure an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 7 staff (Laundry Aides G, H, and K) reviewed for infection control practices on 2 of 4 halls (halls 1 and 2). The facility failed to ensure that Laundry Aides G , H, and K covered the laundry cart while delivering the resident's clothing. This failure could place residents and staff at risk for cross-contamination and the spread of infection. Findings included: During an observation on 07/07/2024 at 8:17 AM., Laundry Aide K was observed in hall 2 pushing an uncovered laundry cart with clean clothes exposed. During an observation on 07/08/20244 at 9:20 AM., Laundry Aide K was observed in hall 1 pushing an uncovered laundry cart with clean clothes exposed. During an observation on 07/09/2024 at 10:00 AM, Laundry Aide H was observed in hall 2 pushing an uncovered laundry cart with clean clothes exposed. During an interview on 07/09/2024 at 4:07 PM, Laundry Aide G said the laundry cart should remain covered while transporting the residents' clean linens from the outside laundry facility to the inside of the facility. Laundry Aide G said the laundry cart could be uncovered while inside the facility delivering to residents. Laundry Aide G said the purpose of the covered laundry cart was to prevent contaminants from getting on the residents' clothing and linens. Laundry Aide G said she was educated at hire and in-serviced a month or so ago regarding transporting laundry. Laundry Aide G said soiled laundry should always be covered and clean laundry did not have to be covered inside the facility. During an attempted phone interview on 07/10/202 at 01:00 PM, Laundry Aide K was unable to be reached. During an interview on 07/10/2024 at 2:10 PM, Laundry Aide H said until the in-service on today's date (07/10/24), he thought the laundry cart should remain covered while transporting the residents' clean linens from the outside laundry facility to the inside of the facility and did not have to remain covered while delivering inside the building. Laundry Aide H said he was told on today's date that the laundry cart should remain covered at all times to prevent cross contamination by sneezing or residents touching the clothing while delivered to the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676142	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Emory Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 983 N Texas Street Emory, TX 75440	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/10/2024 at 1:34 PM, the Maintenance Supervisor said he was responsible for the laundry staff. The Maintenance Supervisor said he had educated the laundry aides and expected the staff to keep the clean laundry covered while it was transported from the laundry building outside. The Maintenance Supervisor said the laundry cart with clean clothing should be covered while clothing was delivered to the residents to prevent cross contamination. During an interview on 07/10/2024 at 2:42 PM, the Administrator said she expected the Maintenance Supervisor to provide oversight and education to the laundry staff on proper transport of clean and soiled linen. The Administrator said she was responsible to ensure the Maintenance Supervisor was doing his responsibilities. The Administrator said she expected the staff to keep the clean laundry covered while it was transported from the laundry building outside. The Administrator said she expected the staff to cover the laundry cart of clean clothing while clothing was delivered to the residents to prevent cross contamination. Record Review of in-service titled Infection Control and Laundry Services dated May 2024 indicated Laundry Aides G, H, and K had been in serviced. Record review of the facility's policy titled, Infection Control Policy and Procedure Manual, revised in October 2018, indicated, . Laundry and bedding shall be handled, transported and processed according to best practices for infection prevention and control Items being transported should remain covered .

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interview and record review, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy and providing written rationale, by the provider, when an antibiotic was used despite criteria, to determine the appropriate the use of an antibiotic for 1 of 4 residents (Resident #1) reviewed for antibiotic use. The facility failed to ensure Resident #1 had documented appropriate lab work and diagnoses to support the use of prescribed antibiotics. This failure could place residents receiving antibiotics at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased antibiotic-resistant infections. Findings included: Record review of Resident #1's face sheet, dated 06/28/2024, indicated Resident #1 was an [AGE] year-old female, readmitted to the facility on [DATE] with a diagnosis which included multiple sclerosis (chronic, progressive disease involving damage to the sheaths of nerves cells in the brain and spinal cord causing numbness, impairment of speech, and of muscular coordination, blurred vison and sever fatigue). Record review of Resident #1's annual MDS, dated [DATE], indicated Resident #1 usually understood others, and usually sometimes made herself understood. Resident #1 had a BIMS score of 9, which indicated her cognition was moderately impaired. The assessment did not address Resident #1's current antibiotic use. Record review of Resident #1's care plan, reviewed on 02/21/2024, indicated Resident #1 was incontinent of bowel and bladder. The care plan interventions included, monitor for s/sx incontinent, provide peri care as indicated and report to physician or representative any complications. Record review of a progress note dated 06/05/2024 completed by the Medical Director indicated Resident #1 c/o burning with urination while making rounds. Record review of a progress note dated 06/05/2024 completed by LVN D indicated a new order was received from the Medical Director for Macrobid (antibiotic) 100 mg po twice a day x 7 days for UTI. Record review of the MAR dated 06/01/2024-06/30/2024, revealed Resident #1 received Macrobid on 06/05/2024, 06/06/2024, 06/07/2024, 06/08/2024, 06/09/2024, 06/10/2024 and 06/11/2024. Record review of a progress note dated 07/05/2024 completed by ADON indicated a new order was received from the Medical Director for Augmentin 875 mg po twice a day x 7 days for UTI. Record review of the MAR dated 07/01/2024-07/31/2024, revealed Resident #1 received Augmentin on 07/05/2024, 07/06/2024, 07/07/2024, 07/08/2024, and 07/09/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676142	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER: Emory Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 983 N Texas Street Emory, TX 75440	

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An attempted telephone interview on 07/09/2024 at 11:28 AM with the Medical Director, was unsuccessful. During an interview on 07/10/2024 at 2:08 p.m., the ADON stated her, and the DON were the Infection Control Preventionist for the facility. The ADON stated the process for antibiotic stewardship included the nurse that received the order must complete an infection report and initiate the antibiotic. The ADON stated her, or the DON would review the infection report and complete a facility map and color coordinating infection categories. The ADON stated there was no tool to determine whether an infection met criteria for starting an antibiotic. The ADON stated Resident #1 was given an antibiotic on 07/05/2024 due to increase anxiety and different behaviors. The ADON stated a urine specimen was not collected on 06/05/2024 or 07/05/2024. The ADON stated it was important to ensure residents meet the criteria so the resident would not get resistant to antibiotics. The ADON stated this failure put residents at risk for a multi drug resistant organism. During an interview on 07/10/2024 at 2:33 p.m., the DON stated her and the ADON were the Infection Control Preventionist. The DON stated ultimately, she was responsible for tracking and trending infections. The DON stated by monitored by reviewing the infection report and nurses notes daily. The DON stated if a lab or x -ray was done she would also review them. The DON stated there was no tool to determine whether an infection met criteria for starting an antibiotic. The DON stated a urine specimen/culture was not collected for Resident #1 on 06/05/2024 nor 07/05/2024. The DON stated it was important to ensure residents meet the criteria so they would not become resistant to antibiotic or put them at risk for multi drug resistant. During an interview on 07/10/2024 at 3:21 p.m., the Administrator stated the Infection Control Preventionist was responsible for monitoring and overseeing the infection control program. The Administrator stated this failure could potentially put residents at risk for a multi drug resistant organism. Record review of the facility's policy titled Antibiotic Stewardship Program, dated 11/2017, indicated, the facility has a formal antibiotic stewardship program to optimize the treatment of infections, reduce the risk of adverse events including the development of antibiotic-resistant organisms and employs a facility-wide system to monitor the appropriate use of antibiotics .2. A set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. This can be accomplished through improving antibiotic prescribing, administration and management practices, thus reducing inappropriate use to ensure that residents recue the right antibiotic for the right indication dose and duration .