STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676154	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Hill Nursing Center	215 Fm 161 Business South Hughes Springs, TX 75656

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 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44596

46062

Based on observation, interviews, and record review, the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 5 of 13 residents (Resident #31, Resident #18, Resident #38, Resident #33, and Resident #30) reviewed for resident rights.

1. The facility failed to ensure Resident #31 had a dignified existence by allowing her to use the working bathroom commode in her room.

2.The facility failed to ask Resident #18 to remove a food item from her plate prior to reaching into her plate during her lunch meal.

3.The facility failed to provide Resident #38 with a knife to cut his meat during meals.

4.The facility failed to provide Resident #33 with a requested knife to his cut meat during the lunch meals on [DATE] and [DATE].

5. The facility failed to ensure CNA G sat in a chair and remained at eye level with Resident #30 while assisting her with her lunch on [DATE].

These failures could place residents at risk of humiliation, diminished quality of life, loss of dignity and loss of self-worth.

Findings included:

1. Record review of Resident #31's face sheet dated [DATE] indicated Resident #31 was [AGE] year-old and admitted to the facility on [DATE] with diagnoses including acute pulmonary edema (swelling of the lungs), pneumonia (infection of the lungs), urinary tract infection, hypertension (high blood pressure), cognitive communication deficit, weakness, history of falls, heart failure, major depressive disorder (persistent sadness), and anxiety (nervousness).

(continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #31's annual MDS assessment dated [DATE] indicated Resident #31 was understood and understood others. The MDS indicated Resident #31 had a BIMS score of 15 which indicated she was cognitively intact. Resident #31 had fluctuating inattention and disorganized thinking. Resident #31 did not have behavioral symptoms. Resident #31 used a walker and a wheelchair for mobility. Resident #31 was independent with toilet transfers and required partial assistance with toilet hygiene. The MDS indicated Resident #31 was occasionally incontinent of bowel and bladder. Record review of Resident #31's care plan with a revision date of [DATE] indicated Resident #31 had a problem area of compulsively putting wipes and toilet tissue in commode in bathroom after multiple education and notes put by toilet to not put objects in toilet, resident continued to do, so object had even been denied, but was found to have wipes in her wheelchair where she had taken them off the nurse aide cart, which had caused several plumbing issues and bedside commode was placed in the resident's room. Resident #31 had consults due to gastric (stomach) system issues as evidenced by anal fixation and pain. Resident #31 had infatuation with anal area. During an observation and interview on [DATE] at 10:11 AM, Resident #31 was sitting on the side of her bed with her breakfast tray on her bedside table in front of her. Resident #31 said her breakfast was good and she had eaten most of it. Resident #31 had a bedside commode against the wall at the end of her bed. Resident #31's room had a strong smell of bowel movement. Resident #31 said she had to use a bedside commode because her bathroom commode had not worked since [DATE]. Resident #31 said she wished they would fix her commode, because she did not like using the bedside commode. There was a Sorry Out of Order sign on the outside of bathroom door. There was a sign behind the bathroom commode to not put toilet paper or wipes in toilet. During an observation and interview on [DATE] at 8:25 AM, Resident #31 was sitting on the side of her bed with breakfast tray on her bedside table. Resident #31 said she didn't like having to use the bedside commode and wished they would get the bathroom fixed. Resident #31 said it was embarrassing to use the bedside commode and it did not feel private, even with a curtain. During an observation and interview on [DATE] at 12:48 PM, Resident #31 said she asked the DON about getting the commode fixed because she did not like using the bedside commode and he told her he would look into it. Resident #31 said they were trying to blame her for stopping the commode up, but she said she put the toilet paper and wipes in the trash can, so it wasn't her. Resident #31 said using the bedside commode made her feel uncomfortable due to anyone could walk into her room. Resident #31 said they put the curtain up, but it just did not provide the privacy that a door does in a bathroom. Resident #31 said they just really needed to fix her commode. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3:28 PM, the Maintenance Supervisor said they have had to call out the plumbers couple times due to Resident #31 was flushing wipes down the commode and it backed up the entire building septic system. The Maintenance Supervisor said the bathroom toilet in Resident #31's room did work, but they have a sign on the door that it was out of order. The Maintenance Supervisor said Resident #31's bathroom room toilet was fixed approximately a month ago. The Maintenance Supervisor said they have not had an issue with the septic system since they put the bedside commode in Resident #31's room. The Maintenance Supervisor said they were monitoring the situation and there had not been any other issues with the septic system. The Maintenance Supervisor said he did not know what the fix was due to it caused issues with the whole facility's septic system being backed up and residents not being able to flush their toilets. The Maintenance Supervisor said they did not have a specific timeframe to monitor the situation. The Maintenance Supervisor said he knew Resident #31 asked about when her commode would be fixed because the staff told him she asked about it regularly. The Maintenance Supervisor said it was not the ideal situation with an able-bodied person not being able to use their toilet in their room. During an interview on [DATE] at 3:44 PM, CNA A said she had worked at the facility since [DATE] and normally worked the evening and night shifts. CNA A said the kept a plastic bag in Resident #31's bedside commode. CNA A said she would carry Resident #31's bucket of the bedside commode, bag and cover it then transport it to the shower room down the hall and would empty the Resident #31's bedside commode contents in the commode in the shower room. CNA A said she had not heard Resident #31 complain about using the bedside commode. CNA A said if it was her, she would want to go to the bathroom commode with a door. CNA A said she thought they were trying to limit Resident #31's toilet paper, but she was not sure what other interventions they have tried other than bedside commode. During an interview on [DATE] at 01:08 PM, CNA B said she had worked at the facility for approximately 2 years and normally worked the day shift on Resident #31's hall. CNA B said the plumbing had been messed up and Resident 31 had a bedside commode placed in her room. CNA B said she kept a plastic bag in the bedside commode bucket. CNA B said she usually emptied the bedside commode by getting the air out of the plastic bag and tying it up, removed it from the room and then put it in her big trash barrel. CNA B said she did not know if Resident #31's toilet worked, but there was an out of order sign on her bathroom door. CNA B said all the toilets were stopped up at the same time on Resident #31's hall. CNA B said Resident 31 used a lot of toilet paper and sometimes puts it in the trash and sometimes put it in the bedside commode. CNA B said Resident #31 was able to transfer herself and did everything on her own. CNA B said Resident #31 asked for her potty to be fixed almost daily. CNA B said if circumstances warranted the use of a bedside commode, she would be good to use a bedside commode, but if there was a working commode in her room, she would expect to be able to use it. CNA B said Resident #31 did not have a comfortable homelike environment because she had to use a bedside commode and not use the bathroom commode. CNA B said she did not know how it affected Resident #31, but Resident #31 had told her that she did not like having to use the bedside commode. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 1:37 PM, RN C said she had worked at the facility since 2018 and normally worked the day shift. RN C said they started using the bedside commode in Resident #31's room when the toilets stopped up. RN C said she did not remember how long ago that was and she had not tried to flush Resident #31's toilet to see if it worked. RN C said she believed the bedside commode was a short-term situation. RN C said the maintenance director and the ADM were responsible for monitoring the toilet situation. RN C said a homelike environment should be whatever Resident #31 preferred as her homelike environment. RN C said Resident #31 had not mentioned anything to her about her toilet situation. RN C said it would be a dignity issue if someone came in Resident #31's room and saw her using the bedside. During an interview on [DATE] at 2:29 PM, the DON said he did not think it had been that long since Resident #31 started using the bedside commode due to toilet issues. The DON said he was unaware of the plan related to how long Resident #31 would have the bedside commode. The DON said the ADM would make the final determination when/if the bedside commode would be removed from Resident #31's room and when she would be allowed to use the bathroom commode in her room. The DON said he was unaware if Resident #31's bathroom toilet was working, but to the best of his knowledge it was working. The DON said Resident #31 had not asked him to fix her toilet. The DON said he could not speculate on how Resident #31 felt using a bedside commode. The DON said people use bedside commodes all over the world as a useable tool. The DON said he could not speculate as to what would be reasonable to accommodate her. During an interview on [DATE] at 2:55 PM, the ADM said his plan was to get occupational therapy to work with Resident #31 to not use so much toilet paper. The ADM said Resident #31 had a compulsive personality. The ADM said Resident #31 had an anal fixation and would use an abundance of toilet paper and wipes and would flush down the commode and it would stop up the septic system. The ADM said there was one week he had to call the plumber out three times. The ADM said Resident #31's rights were infringing on the rights of others in the facility. The ADM said they have tried multiple interventions with Resident #31. The ADM said they have done education, signs, redirection, and even got Resident #31 bidet commode training with occupational therapy about six months ago. The ADM said Resident #31 was the only resident with a bidet commode in the facility. The ADM said they tried removing wipes from Resident #31's room, but she was found to have taken wipes off the aides' cart. The ADM said he had spoken to occupational therapy about doing some training with Resident #31, but he had not had a chance to see where they were at with it. The ADM said there were situations where a bedside commode was warranted, and he felt he had taken every step he could take with Resident #31 and the next step was to have occupational therapy work with her. 2. Record review of Resident #18's face sheet dated [DATE] indicated Resident #18 was a [AGE] year-old and admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke-damage to brain tissue due to a loss of oxygen to the area), left hemiplegia/hemiparesis (paralysis/weakness to one side of body), major depressive disorder (persistent sadness), dysphagia (difficulty swallowing), memory deficit, and altered mental status. Record review of Resident #18's admission MDS assessment dated [DATE] indicated Resident #18 was usually understood and usually understood others. The MDS indicated Resident #18 had a BIMS score of 8 which indicated she had moderate cognitive impairment. Resident #18 had fluctuating inattention and disorganized thinking. Resident #18 did not have behavioral symptoms. Resident #18 required setup or clean-up assistance with eating. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #18's undated care plan indicated Resident #18 had a problem area related to taking antidepressant medications (used to treat depression) and antianxiety medications (used to treat anxiety). During an observation on [DATE] at PM, the DON took a napkin and reached onto Resident #18's lunch plate and removed an egg roll and said, You can't have that. During an interview on [DATE] at 2:23 PM, Resident #18 said during lunch today ([DATE]), she was served an egg roll on her meal plate. Resident #18 said because she was on a mechanical soft diet, the DON took the egg roll away from her. Resident #18 said he gave her an extra ice cream for it. Resident #18 said the DON got a napkin and took the egg roll off her plate and did not say anything just that she could not have it. Resident #18 said she felt like a bulldog getting their steak taken away. Resident #18 said her meal plate was sitting in front of her and everyone else at the table. Resident #18 said she would have been fine if the DON had asked her first before putting his hand into her plate and just saying you cannot have that as he was doing it. Resident #18 said they seemed to treat her like a little kid and not explain things. During an interview on [DATE] at 01:08 PM, CNA B said if she saw a resident was served something that was not part of their ordered diet, she would explain to the resident the item was not on their ticket and it did not fit into their ordered diet. CNA B said you should explain the situation to the resident before reaching into their plate, because she would not want someone putting their hands into her plate. During an interview on [DATE] at 1:37 PM, RN C said she assisted in the dining room during mealtimes. RN C said she usually stood at the kitchen door where the meal trays were handed out and would check the tickets versus what was placed on the residents' trays. RN C said she would have the dietary staff to fix or remove a wrong item before it was delivered to the resident. RN C said if an item was mistakenly placed on a resident's meal plate and delivered to the resident, she would go to the resident and explain what was going on prior to removing the item from the resident's plate. RN C said you cannot grab anyone's food off their plate without first letting them know why. RN C said it would never be appropriate to take something off a resident's plate without explaining the reason why first. RN C said, imagine if someone stole your food off your plate. RN C said the resident could be upset and not know why staff took their food and not know staff were just trying to protect them from choking. During an interview on [DATE] at 2:29 PM, the DON said he would explain the reason to a resident if he had to take food items from the resident's plate. The DON said he explained to Resident #18 the egg roll was not part of her mechanical soft diet prior to removing her egg roll from her plate. The DON said he offered Resident #18 ice cream and she said she would like some ice cream. The DON said he brought Resident #18 ice cream and replaced the egg roll with bread, which was the substitute for the egg roll and the DON said she was satisfied at the table. The DON said he did not just yank the egg roll from Resident #18 and throw it away. The DON said he offered her ice cream and gave her the substitution of bread. The DON said Resident #18 had an adequate nutritious meal. The DON said he could not speculate of how it made Resident #18 feel, but she was satisfied at the lunch table. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:55 PM, the ADM said he would expect staff to explain to the resident why something was being removed from the meal plate prior to reaching into the resident's meal plate. The ADM said he was sure it would be upsetting for the resident to have a food item removed from their plate by a staff member and not be explained to of why the item was being removed. 3. Record review of Resident #38's face sheet dated [DATE] indicated Resident #38 was 81-years-old and admitted to the facility on [DATE] with diagnoses including senile degeneration of the brain (mental deterioration associated with old age), severe protein-calorie malnutrition (inadequate intake of protein-calorie foods), altered mental status, cognitive communication deficit, nutritional anemia (results from deficiency in either iron, vitamin B-12, or folic acid), adult failure to thrive, and abnormal weight loss. Record review of Resident #38's MDS assessment dated [DATE] indicated Resident #38 had a BIMS score of 6 which indicated he had severe cognitive impairment. Resident #38 had fluctuating inattention and disorganized thinking. Resident #38 was independent with eating. Record review of Resident #38's undated care plan indicated Resident #38 preferred activities that identified with his prior lifestyle. Resident #38 had a problem area of nutritional status with unintended weight loss and potential for malnutrition. During an observation on [DATE] at 12:42 PM, Resident #38 was sitting at the dining table with 2 other male residents. Resident #31 was served a baked chicken breast and struggled for several minutes to try to cut the chicken breast with his fork. Resident #38 then hollered at CNA G to Go get me a knife! How the hell am I supposed to cut this with a fork? I'm sick of this shit. Resident #38 did not receive a knife, but eventually was able to pull the chicken breast apart with his fork and hands and consumed the chicken breast. During an observation on [DATE] at 12:40 PM, Resident #38 was given plastic eating utensils and stated, what am I supposed to do with plastic utensils, when he received his lunch tray. Resident #38 stated I can't cut meat with plastic. I guess I'm going to have to write my congressman to get a real knife in this place. During an interview on [DATE] at 01:08 PM, CNA B said she had not had any residents ask her for a knife at mealtimes. CNA B said she usually asked the resident if she could help cut the resident's meat for them when she delivered the resident's meal tray. During an interview on [DATE] at 1:37 PM, RN C said she assisted in the dining room during mealtimes. RN C said she had not had residents ask her for a knife, but she would ask the residents if they needed help cutting their meat when she delivered their meals. RN C said there was usually staff in the dining area who could assist the residents with any needs. RN C said the staff had worked at the facility long enough to know what the residents' wanted. During an interview on [DATE] at 2:55 PM, the ADM said he assisted in the dining room during mealtimes when he could, and he had not heard residents ask for a knife to cut their meats. The ADM said he offered to help cut the residents meat if needed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.Record review of an undated face sheet revealed Resident #33 was a [AGE] year-old male, admitted to the facility on [DATE] with the diagnoses of dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), depression (mood disorder that causes a persistent feeling of sadness and loss of interest), and diabetes type II (condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). Record review of the quarterly MDS assessment dated [DATE] revealed Resident #33 had a BIMS of 10 which indicated a moderate cognitive impairment. The MDS also indicated Resident #33 required set up/cleanup for eating assistance. Record review of a care plan dated [DATE] revealed Resident #33 had a care plan titled 'Nutritional Status'. The goal for Resident #33 was to gain 1 pound per week to reach his ideal body weight. The care plan intervention revealed to decrease distractions during meals. During an observation and interview of meal service on [DATE] at 12:25 p.m., Resident #33 received a baked chicken breast as the protein for lunch. Resident #33 received a fork and a spoon to eat with and no knife. Resident #33 stated he could not eat the chicken breast because he had no knife and was not going to gnaw it off the bone like a dog. Resident #33 gave his piece of chicken to another resident. He stated he did not want the food to go to waste. During an observation and interview on [DATE] at 12:30 p.m., it was noted Resident #33 received plastic utensils to eat with. Resident #33 said what in the hell am I supposed to do with plastic silverware. Resident #33 said he was sick of not getting the utensils he needed to eat his meal. He stated he never got a knife to cut his meat and no one helped him cut it up. During an interview on [DATE] at 1:45 p.m. CNA G said the kitchen did not pass out knives routinely and it was up to the staff to cut the meat up for the residents. She was not sure how the meat for Residents # 38 and #33 got missed being cut up when their trays were served. CNA G stated if Resident # 38 and Resident #33 were given a knife they could have easily cut up their own meat with no problems. During an interview on [DATE] at 2:00 p.m., the Dietary Manager stated the kitchen never passed out knives with the meal trays. She stated the facility had butter knives, but she stated the residents never asked for a knife that she was aware of. The Dietary Manager stated she could understand how having a knife would make it easier to cut meat. 5.Record review of an undated face sheet revealed Resident # 30 was an 83- year-old female, admitted to the facility on [DATE] with the diagnoses of diabetes type II (condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and anxiety. Record review of a quarterly MDS assessment dated [DATE] revealed Resident #30 had a BIMS of 99, which indicated Resident #30 was unable to complete the interview . The MDS revealed Resident #30 required supervision/ touch assistance with eating. (continued on next page)

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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** 46062 Based on observation, interviews, and record review, the facility failed to provide a safe, clean, sanitary, comfortable, and homelike environment 4 of 15 residents reviewed for environment. (Resident #1, Resident #41, Resident #29, and Resident #31) 1.The facility failed to ensure Resident #1, Resident #29, and Resident #41's bedroom ceiling tiles did not have brown water stains. 2.The facility failed to ensure Resident #31 was allowed to use the working commode in her room. These failures could place residents at risk of an unsafe, unsanitary, uncomfortable environment, embarrassment due to room not appearing homelike, and a decrease in quality of life and self-worth. Findings included: 1. Record review of Resident #1's face sheet printed [DATE] indicated Resident #1 was a [AGE] year-old, male and was admitted on [DATE] with diagnosis including moderate intellectual disabilities (is a term used when there are limits to a person's ability to learn at an expected level and function in daily life), history of acute respiratory disease (occurs when fluid builds up in the tiny, elastic air sacs (alveoli) in your lungs), and non-pressure chronic ulcer of right calf with fat layer exposed (is defined as a defect in the skin below the level of knee persisting for more than six weeks and shows no tendency to heal after three or more months). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 was understood and understood others. The MDS indicated Resident #1 had clear speech, adequate hearing, and adequate vision. The MDS indicated Resident #1 had a BIMS score of 10 which indicated moderate cognitive impairment. During an interview and observation on [DATE] at 10:16 a.m., Resident #1 was sitting on the side of his bed. Above Resident #1's bed, in the corner of the room were three ceiling tiles with brown water mark stains noted. Underneath the brown water mark stains were two buckets sitting on a shelf. In the corner of Resident #1's room near the closet, one ceiling tile with a brown stain and a container underneath it. Resident #1 said the ceiling used to leak but had not leaked in a couple months after the facility fixed the roof. He said sometimes his room had a mildew smell. He said he did not know why the facility had not changed the tiles since the leak was supposed to be fixed. 2. Record review of Resident #41's face sheet printed [DATE] indicate Resident #41 was a [AGE] year-old, male and admitted on [DATE] with diagnosis including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and history of shortness of breath. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Grace Hill Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 215 Fm 161 Business South Hughes Springs, TX 75656	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #41's quarterly MDS assessment dated [DATE]indicated Resident #41 was usually understood and usually understood others. The MDS indicated Resident #41 had clear speech, minimal difficulty hearing, and impaired vision with no corrective lenses. The MDS indicated Resident #41 was unable to complete the BIMS assessment due to being rarely/never understood. The MDS indicated Resident #41 had short-and-long term memory recall problem and severely impaired cognitive skills for daily decision making. During an observation on [DATE] at 10:45 a.m., in Resident #41's room in the corner, near his window were three slightly bowing ceiling tile with brown water stains. Two ceiling tiles above the head of his bed were water stained also. During an interview on [DATE] at 10:20 a.m., the maintenance supervisor said he had been employed at the facility since the end of [DATE]. He said the water-stained ceiling tiles in Resident #1 and Resident 41's room were there when he started in [DATE]. He said the roof was damaged by some storms but was fixed in [DATE]. He said he did not know why the water-stained ceilings were not changed after the roof was fixed. He said he meant to change the ceiling tiles since he started but had not gotten to it. He said he did not know why buckets were underneath the water-stained ceilings. He said he did not place the buckets there. He said the water-stained tiles and bucket were not a homelike environment and was tacky. He said the water buckets were also hazardous. He said if the ceiling tiles were wet, they could potentially collapse. During an interview on [DATE] at 1:43 p.m., the DON said he did not know about the water-stained ceiling tiles in Resident #1 and Resident #41's rooms. He said he expected staff members to put maintenance issues in the maintenance log. He said he expected the maintenance supervisor to fix the issues in timely manner. He said he could not speculate how the water-stained ceiling tiles made the residents feel. He said he could not speculate what risks the water-stained ceiling tiles posed to the residents. During an interview on [DATE] at 2:33 p.m., the ADM said the maintenance director was responsible for the upkeep of the facility. He said staff members had a logbook to place maintenance issues in. He said maintenance issue had priority level decided on by him and the maintenance director. He said he was not aware of Resident #1 and Resident #41's water-stained ceiling tiles in their rooms. He said he imagined the water-stained ceiling tiles in the resident's rooms was unpleasant to look at. 3. Record review of a face sheet dated [DATE] revealed Resident #29 was an [AGE] year-old male, admitted to the facility on [DATE] with the diagnoses of cerebral infarction (damage to tissue in the brain due to lack of oxygen in the area), portal vein thrombosis (a narrowing or blocking of the portal vein by a blood blot), and depression (feelings of sadness, emptiness, and hopelessness). Record review of Resident #29's annual MDS dated [DATE] revealed Resident #29 had a BIMS of 13, which indicated intact cognition. The MDS also indicated Resident #29 was independent for ADL such as mobility and toileting. Record review of a care plan dated [DATE], titled 'Psychological Well Being', indicated Resident #29 had a potential for adjustment to the nursing facility and the intervention was listed to encourage Resident #29 to express his feelings and concerns. (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 log dated [DATE] showed no work order for Resident #29's ceiling tiles. During an observation on [DATE] at 9:45 a.m., the ceiling to the left of the door when entering the room of Resident #29 was noted to have an 18-to-20-inch semicircular brown water stain. During an observation on [DATE] at 2:15 p.m., the stain remained to the ceiling tiles in Resident #29's room. The brown stain was approximately 18-to-20 inches at the widest point. During an interview on [DATE] at 9:47 a.m., Resident #29 stated the water stain on the ceiling had been there for a few months and the ceiling would leak if a hard rain came through. Resident #29 stated it was just a few days prior the ceiling had leaked. Resident #29 stated the leaking ceiling and dirty tile made his anxiety worse because it made him worry about black mold. Resident #29 stated he reported the tiles to the maintenance man several weeks prior, but no one had replaced them. During an interview on [DATE] at 1:20 p.m., the Maintenance Director stated he was aware there were a few rooms that had ceiling tiles that needed to be replaced. He stated he just replaced most of the tiles less than 6 weeks ago. He stated he replaced the ceiling tiles in Resident #29's room around that time. The Maintenance Director stated he did not always make a formal request document or log everything he did. He stated sometimes an issue was reported to him and he just took care of it then. During an interview on [DATE] at 1:30 p.m., the DON stated he could not speculate on how ceiling tiles showing water leakage could impact a resident. During an interview on [DATE] at 2:00 p.m., the Administrator stated it was important for physical health, as well as mental health to have clean and well-kept rooms, including no stained ceiling tiles in the resident's rooms. The Administrator stated he could not speculate on what ill outcomes could occur from a stained ceiling. 4. Record review of Resident #31's face sheet dated [DATE] indicated Resident #31 was [AGE] year-old and admitted to the facility on [DATE] with diagnoses including acute pulmonary edema (swelling of the lungs), pneumonia (infection of the lungs), urinary tract infection, hypertension (high blood pressure), cognitive communication deficit, weakness, history of falls, heart failure, major depressive disorder (persistent sadness), and anxiety (nervousness). Record review of Resident #31's annual MDS assessment dated [DATE] indicated Resident #31 was understood and understood others. The MDS indicated Resident #31 had a BIMS score of 15 which indicated she was cognitively intact. Resident #31 had fluctuating inattention and disorganized thinking. Resident #31 did not have behavioral symptoms. Resident #31 used a walker and a wheelchair for mobility. Resident #31 was independent with toilet transfers and required partial assistance with toilet hygiene. The MDS indicated Resident #31 was occasionally incontinent of bowel and bladder. (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 Resident #31's care plan with a revision date of [DATE] indicated Resident #31 had a problem area of compulsively putting wipes and toilet tissue in commode in bathroom after multiple education and notes put by toilet to not put object in toilet, resident continued to do, so object had even been denied, but was found to have wipes in her wheelchair where she had taken them off the nurse aide cart, which had caused several plumbing issues and bedside commode was placed in the resident's room. Resident #31 had consults due to gastric (stomach) system issues as evidenced by anal fixation and pain. Resident #31 had infatuation with anal area. During an observation and interview on [DATE] at 10:11 AM, Resident #31 was sitting on the side of her bed with her breakfast tray on her bedside table in front of her. Resident #31 said her breakfast was good and she had eaten most of it. Resident #31 had a bedside commode against the wall at the end of her bed. Resident #31's room had a strong smell of bowel movement. Resident #31 said she had to use a bedside commode because her bathroom commode had not worked since [DATE]. Resident #31 said she wished they would fix her commode, because she did not like using the bedside commode. There was a Sorry Out of Order sign on the outside of bathroom door. There was a sign behind the bathroom commode to not put toilet paper or wipes in toilet. During an observation and interview on [DATE] at 8:25 AM, Resident #31 was sitting on the side of her bed with breakfast tray on her bedside table. Resident #31 said she did not like having to use the bedside commode and wished they would get the bathroom fixed. Resident #31 said it was embarrassing to use the bedside commode and it did not feel private, even with a curtain. During an observation and interview on [DATE] at 12:48 PM, Resident #31 said she asked the DON about getting the commode fixed because she did not like using the bedside commode and he told her he would look into it. Resident #31 said they were trying to blame her for stopping the commode up, but she said she put the toilet paper and wipes in the trash can, so it wasn''t her. Resident #31 said using the bedside commode made her feel uncomfortable due to anyone could walk into her room. Resident #31 said they put the curtain up, but it just did not provide the privacy that a door does in a bathroom. Resident #31 said they just really need to fix her commode. During an interview on [DATE] at 3:28 PM, the Maintenance Director said they have had to call out the plumbers couple times due to Resident #31 was flushing wipes down the commode and it backed up the entire building septic system. The Maintenance Director said the bathroom toilet in Resident #31's room did work, but they have a sign on the door that it was out of order. The Maintenance Supervisor said Resident #31's bathroom room toilet was fixed approximately a month ago. The Maintenance Director said they have not had an issue with the septic system since they put the bedside commode in Resident #31's room. The Maintenance Director said they were monitoring the situation and there had not been any other issues with the septic system. The Maintenance Director said he did not know what the fix was due to it caused issues with the whole facility's septic system being backed up and residents not being able to flush their toilets. The Maintenance Director said they did not have a specific timeframe to monitor the situation. The Maintenance Director said he knew Resident #31 asked about when her commode would be fixed because the staff told him she asked about it regularly. The Maintenance Director said it was not the ideal situation with an able-bodied person not being able to use their bathroom toilet in their room. (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 [DATE] at 3:44 PM, CNA A said she had worked at the facility since [DATE] and normally worked the evening and night shifts. CNA A said the kept a plastic bag in Resident #31's bedside commode. CNA A said she would carry Resident #31's bucket of the bedside commode, bag and cover it then transport it to the shower room down the hall and would empty the Resident #31's bedside commode contents in the commode in the shower room. CNA A said she had not heard Resident #31 complain about using the bedside commode. CNA A said if it was her, she would want to go to the bathroom commode with a door. CNA A said she thought they were trying to limit Resident #31's toilet paper, but she was not sure what other interventions they have tried other than the bedside commode. During an interview on [DATE] at 01:08 PM, CNA B said she had worked at the facility for approximately 2 years and normally worked the day shift on Resident #31's hall. CNA B said the plumbing had been messed up and Resident #31 had a bedside commode placed in her room. CNA B said she kept a plastic bag in the bedside commode bucket. CNA B said she usually emptied the bedside commode by getting the air out of the plastic bag and tying it up, removed it from the room and then put it in her big trash barrel. CNA B said she did not know if Resident #31's toilet worked, but there was an out of order sign on her bathroom door. CNA B said all the toilets were stopped up at the same time on Resident #31's hall. CNA B said Resident 31 used a lot of toilet paper and sometimes puts it in the trash and sometimes put it in the bedside commode. CNA B said Resident #31 was able to transfer herself and did everything on her own. CNA B said Resident #31 asked for her potty to be fixed almost daily. CNA B said if circumstances warranted the use of a bedside commode, she would be good to use a bedside commode, but if there was a working commode in her room, she would expect to be able to use it. CNA B said Resident #31 did not have a comfortable homelike environment because she had to use a bedside commode and not use the bathroom commode. CNA B said she did not know how it affected Resident #31, but Resident #31 had told her that she did not like having to use the bedside commode. During an interview on [DATE] at 1:37 PM, RN C said she had worked at the facility since 2018 and normally worked the day shift. RN C said they started using the bedside commode in Resident #31's room when the toilets stopped up. RN C said she did not remember how long ago that was and she had not tried the Resident #31's toilet to see if it worked. RN C said she believed the bedside commode was a short-term situation. RN C said the maintenance director and the ADM were responsible for monitoring the toilet situation. RN C said a homelike environment should be whatever Resident #31 preferred as her homelike environment. RN C said Resident #31 had not mentioned anything to her about her toilet situation. During an interview on [DATE] at 2:29 PM, the DON said he did not think it had been that long since Resident #31 started using the bedside commode due to toilet issues. The DON said he was unaware of the plan related to how long Resident #31 would have the bedside commode. The DON said the ADM would make the final determination when/if the bedside commode would be removed from Resident #31's room and when she would be allowed to use the bathroom commode in her room. The DON said he was unaware if Resident #31's bathroom toilet was working, but to the best of his knowledge it was working. The DON said Resident #31 had not asked him to fix her toilet. The DON said he could not speculate on how Resident #31 felt using a bedside commode. The DON said people use bedside commodes all over the world as a useable tool. The DON said he could not speculate as to what would be reasonable to accommodate her. (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 [DATE] at 2:55 PM, the ADM said his plan was to get occupational therapy to work with Resident #31 to not use so much toilet paper. The ADM said Resident #31 had a compulsive personality. The ADM said Resident #31 had an anal fixation and would use an abundance of toilet paper and wipes and would flush down the commode and it would stop up the septic system. The ADM said there was one week he had to call the plumber out three times. The ADM said Resident #31's rights were infringing on the rights of others in the facility. The ADM said they have tried multiple interventions with Resident #31. The ADM said they have done education, signs, redirection, and even got Resident #31 bidet commode training with occupational therapy about six months ago. The ADM said Resident #31 was the only resident with a bidet commode in the facility. The ADM said they tried removing wipes from Resident #31's room, but she was found to have taken wipes off the aides' cart. The ADM said he had spoken to occupational therapy about doing some training with Resident #31, but he had not had a chance to see where they were at with it. The ADM said there were situations where a bedside commode was warranted, and he felt he had taken every step he could take with Resident #31 and the next step was to have occupational therapy work with her. On [DATE] at 11:00 AM, a policy on Safe, Comfortable Home like environment was requested and the ADM said they did not have a policy related to Safe, Comfortable, Home-like environment. 44933 44596

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interviews and record review, the facility failed to ensure assessments accurately reflected the status for 1 of 5 residents reviewed for assessments. (Resident #1) The facility failed to ensure Resident #1's MDS assessment did not improperly code Cilostazol (in a class of medications called platelet-aggregation inhibitors (antiplatelet medications)) as an anticoagulant instead of an antiplatelet. This failure could place residents at risk of not having individual needs met. Findings included: Record review of Resident #1's face sheet printed 03/20/24 indicated Resident #1 was a [AGE] year-old, male and was admitted on [DATE] with diagnosis including peripheral vascular disease (is a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel), acute embolism (a blood clot or a foreign body enters the bloodstream and obstructs blood flow) and thrombosis (a blood clot forms in blood vessels and partially or completely blocks blood flow) of unspecified deep vein of right lower extremity, and non-pressure chronic ulcer of right calf with fat layer exposed (is defined as a defect in the skin below the level of knee persisting for more than six weeks and shows no tendency to heal after three or more months). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 was understood and understood others. The MDS indicated Resident #1 had clear speech, adequate hearing, and adequate vision. The MDS indicated Resident #1 had a BIMS score of 10 which indicated moderate cognitive impairment. The MDS indicated Resident #1 was independent for toilet hygiene and dressing, setup or clean-up assistance for oral and personal hygiene and eating. The MDS indicated Resident #1 had taken an anticoagulant during the last 7 days of the assessment period. Record review of Resident #1's care plan dated 05/28/19, edited 04/20/23 indicated Resident #1 took Plavix and Eliquis for embolism, he was at risk for bruising easily. Intervention included administer medication per MD orders. Record review of Resident #1's consolidated physician orders dated 01/01/24-01/31/24 indicated an order for Cilostazol, 50 mg, 1 tablet, oral, Diagnosis: acute embolism and thrombosis of unspecified deep vein of right lower extremities, twice a day. Start date 11/03/23- open ended. The consolidated physician orders did not indicate a current order for Plavix or Eliquis. Record review of Resident #1's MAR dated 01/01/24-01/31/24 indicated Cilostazol, 50 mg, 1 tablet, oral, twice a day, Diagnosis: acute embolism and thrombosis of unspecified deep vein of right lower extremities. Start date 11/03/23- open ended. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/20/23 at 10:45 a.m., the MDS Coordinator said she was responsible for MDSs. She said Resident #1 was on a blood thinner and it was antiplatelet. She said she must have marked the wrong button when she did Resident #1's MDS. She said she did not have someone to monitor the MDS she submitted. She said she had a consultation she contacted for questions or guidance. She said she reviewed the list of MDS triggered problems monthly, orders, and other parts of the chart to complete the MDS. She said the MDS needed to be accurate because it affected the facility's funding. She said the MDS reflected the care the resident received, individualized resident status, what area or problem the resident needed care provided for them. During an interview on 03/20/24 at 1:43 p.m., the DON said the MDS Coordinator was responsible for completion of MDSs, and he signed the MDS to signify it was completed correctly. He said he expected the MDS coordinator to complete the MDS accurately to the best of her knowledge. He said the MDS coordinator had a consultation to monitor her but did not know if the consultation did audits. He said the MDS should be correct to reflect the resident's status and it is a payment source for the facility. He said an incorrect MDS should not negatively affect the resident because the resident would still get the care they needed. During an interview on 03/20/23 at 2:33 p.m., the ADM said the MDS coordinator was responsible for the accuracy of resident's MDSs. He said a consultation did a percentage of audits, quarterly. He said MDS needed to be accurate because any assessment needed to be correct to provide proper care. The ADM said the facility did not have a policy on accuracy of assessment but followed the RAI guidelines.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interviews and record review, the facility failed to ensure individuals with mental health disorders were provided an accurate Preadmission Screening and Resident Review (PASRR) Screening for 1 of 3 residents (Resident #2) reviewed for resident assessments. The facility failed to review Resident #2's PASRR level 1 assessment for accuracy. Resident #2 was diagnosed with Bipolar, and the mental health question was answered no. This failure could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs. Findings included: Record review of Resident #2's face sheet printed 03/18/24 indicated Resident #2 was a [AGE] year-old, male and admitted on [DATE] with diagnosis including other bipolar disorder (is a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) without behavioral disturbance , and other recurrent depressive disorders (involves a depressed mood or loss of pleasure or interest in activities for long periods of time). Record review of Resident #2's MDS assessment dated [DATE] indicated Resident #2 was usually understood by other and usually understood others. The MDS indicated Resident #2 had a BIMS score of 10 which indicated moderate cognitive impairment. The MDS indicated Resident #2 had inattention and disorganized thinking that fluctuated. The MDS indicated Resident #2 required partial/moderate assistance for oral, personal, and toilet hygiene, shower/bathe self and lower body dressing. The MDS indicated Resident #2 had an active diagnosis of bipolar disorder and depression. Record review of Resident #2's care plan dated 03/10/23 indicated Resident #2 was at risk for social isolation/loneliness related to little interest/pleasure in doing things at times. Interventions included assess for verbal/nonverbal indicators of social isolation/loneliness. Record review of Resident #2's PASRR Level 1 Screening dated 01/18/23 indicated .Mental illness .Is there evidence or an indicator this is an individual that has a Mental Illness .No . During an interview on 03/20/24 at 10:45 a.m., the MDS Coordinator said she was responsible for PASRRs. She said she input the referring entity's referral paperwork in the system. She said she was aware Resident #2 had a bipolar disorder diagnosis but since he had dementia, she did not think he was PASRR positive. She said when PASRRs were not correct, residents risked not receiving outside services, therapy, outpatient and inhouse mental health therapy, specialized wheelchairs, and trainings. She said the facility had initiated audits, after Resident #2's PASRR was brought to their attention, with the IDT for resident with new and current residents with diagnosis of mental illness to ensure PASRR screenings were completed correctly. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/20/24 at 1:43 p.m., the DON said he only knew the MDS coordinator was responsible for PASRRs with some assistance by social services. He said he was not knowledgeable enough on the process to answer other questions. During an interview on 03/20/24 at 2:33 p.m., the ADM said the MDS coordinator submitted PASRRs, and he reviewed them before accepting new residents. He said the referring entity was responsible for the PASRR that came with the residents on admission. He said there was no process to ensure the referring entity referrals was accurate until Resident #2's PASRR incident. He said now the facility had a process in place to review the referral before it was submitted in the portal. He said when PASRRs were not completed accurately, resident did not receive PASRR services. The ADM said the facility did not create a PASRR policy until 03/20/24.

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NAME OF PROVIDER OR SUPPLIER Grace Hill Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 215 Fm 161 Business South Hughes Springs, TX 75656	

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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	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** 44933 Based on interviews and record review, the facility failed to ensure each resident's person-centered comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 2 of 13 residents (Residents #1 and Resident #11) reviewed for care plans. 1. The facility failed to revise and update Resident #1's comprehensive care plan for the type of blood thinner, Cilostazol (is in a class of medications called platelet-aggregation inhibitors (antiplatelet medications)), he was prescribed instead of Plavix (is an antiplatelet drug you can take to prevent blood clots) and Eliquis (is a blood thinner medicine that reduces blood clotting.). 2. The facility failed to revise and update Resident #11's comprehensive care plan for his diet, fluid restriction, and increase protein need for dialysis. These deficient practices could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. Findings included: 1. Record review of Resident #1's face sheet printed 03/20/24 indicated Resident #1 was a [AGE] year-old, male and was admitted on [DATE] with diagnosis including peripheral vascular disease (is a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel), acute embolism (a blood clot or a foreign body enters the bloodstream and obstructs blood flow) and thrombosis (a blood clot forms in blood vessels and partially or completely blocks blood flow) of unspecified deep vein of right lower extremity, and non-pressure chronic ulcer of right calf with fat layer exposed (is defined as a defect in the skin below the level of knee persisting for more than six weeks and shows no tendency to heal after three or more months). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 was understood and understood others. The MDS indicated Resident #1 had clear speech, adequate hearing, and adequate vision. The MDS indicated Resident #1 had a BIMS score of 10 which indicated moderate cognitive impairment. The MDS indicated Resident #1 was independent for toilet hygiene and dressing, setup or clean-up assistance for oral and personal hygiene and eating. The MDS indicated Resident #1 had taken an anticoagulant during the last 7 days of the assessment period. Record review of Resident #1 care plan dated 05/28/19, edited 04/20/23, indicated Resident #1 took Plavix and Eliquis for embolism, and he was at risk for bruising easily. An intervention included administer medication per MD orders. The care plan did not indicate use of Cilostazol. Record review of Resident #1's consolidated physician orders dated 01/01/24-01/31/24 indicated an order for Cilostazol, 50 mg, 1 tablet, oral, Diagnosis: acute embolism and thrombosis of unspecified deep vein of right lower extremities, twice a day. Start date 11/03/23- open ended. The consolidated physician orders did not indicate a current order for Plavix or Eliquis. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #11's face sheet printed 03/18/24 indicated Resident #11 was a [AGE] year-old, male and admitted on [DATE] with diagnoses including end stage renal disease (is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), cerebral infarction (stroke), acute kidney failure (occurs when your kidneys suddenly become unable to filter waste products from your blood), hypotension of hemodialysis (occurs because a large volume of blood water and solutes are removed over a short period of time), and arteriovenous fistula (is an irregular connection between an artery and a vein). Record review of Resident #11's quarterly MDS assessment dated [DATE] indicated Resident #11 had clear speech, minimal difficult hearing, and impaired vision with corrective lenses. The MDS indicated Resident #11 was usually understood and understood others. The MDS indicated Resident #11 had a BIMS score of 15 which indicated intact cognition. The MDS indicated Resident #11 required partial/moderate assistance for shower/bathe self, dressing, and putting on footwear, supervision for toileting and personal hygiene, and setup for oral hygiene. The MDS indicated Resident #11 was on a mechanically altered diet and dialysis. Record review of Resident #11's care plan dated 03/15/22, edited 01/05/23, indicated Resident #11 had experienced weight loss related to being on dialysis on Monday, Wednesday, and Friday. Intervention included renal diet. The care plan did not indicate mechanical soft diet with chopped meats, double protein portions with each meal, and increase protein intake by 15 grams a day with extra protein portions or supplements. Record review of Resident #11's consolidated physician's orders dated 03/01/24-03/20/24 indicated orders for the following: *Mechanical soft diet with chopped meats, double protein portions with each meal, start date 03/25/23, no end date. *Increase protein intake by 15 grams a day with extra protein portions or supplement, start date 01/19/24, no end date. *Liberal fluid restriction 1200 milliliters a day, start date 02/24/23, no end date. Record review of Resident #11's care plan dated 03/15/22, edited 01/05/23, indicated Resident #11 had dialysis related to renal failure. Intervention included assist resident in preparing for transport to dialysis. The care plan did not indicate liberal fluid restriction of 1200 milliliters a day. During an interview on 03/20/24 at 10:45 a.m., the MDS Coordinator said social services, the DON, and herself worked on care plans. She said the care plans were reviewed and revised during care plan meetings with the IDT. She said during the quarterly care plan meetings, new orders over the last 3 months were reviewed and reflected on the care plan. She said it was herself and social services' responsibility to make sure care plans were current. She said she did not make sure changes were made to resident's care plans after care plan meetings. She said Resident #11's diet order should have been updated and fluid restriction added to his care plan. She said Resident #1's blood thinner medication should have been updated to his current care plan. She said the care plan needed to be updated or revised because they reflected the individual needs of the residents. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/20/24 at 1:33 p.m., the social service representative said she took notes during the care plan meetings. She said meetings were done quarterly. She said she reviewed the care plan with issues regarding behaviors. She said if she was not directly told to update a problem on a care plan during the meeting, it could get missed. During an interview on 03/20/24 at 1:43 p.m., the DON said the MDS coordinator was responsible for updating care plans. He said care plans were revised with the IDT quarterly, as needed, and at care plan meetings. He said the care plans should be revised to accurately reflect the resident and it guided the resident's care. He said the MDS coordinator should be monitoring if care plans are revised and updated. He said the facility had a consultant that assisted the MDS coordinator, but he did not know her involvement in care plans. He said he could not speculate how not having an updated or revised care plan affected the resident. During an interview on 03/20/24 at 2:33 p.m., the ADM said care plans were generated after quarterly assessment CAAS from the MDS and out of cycle done by the IDT. He said physician orders were reviewed during IDT meetings for updates. He said Resident #11's diet order should have reflected what his current physician order stated. He said monitoring of care plan revision happened during IDT meetings. Record review of a facility's Care Area Assessment policy revised 05/2011 indicated .care area assessment will be used .to develop individualized care plans .link between assessment and care planning .review the triggered CAAs .history taking, physical assessments, gathering of relevant information .sequencing of clinically significant events .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interviews and record review, the facility failed to ensure dialysis service were provided consistently with professional standards of practice for 1 of 1 resident reviewed for dialysis services. (Resident #11) The facility failed to document vital signs and an assessment of the access site after Resident #11 returned from dialysis. This failure could place residents who received dialysis at risk for complications and not receiving proper care and treatment to meet their needs. Findings included: Record review of Resident #11's face sheet printed 03/18/24 indicated Resident #11 was a [AGE] year-old, male and admitted on [DATE] with diagnoses including end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), cerebral infarction (stroke), acute kidney failure (occurs when your kidneys suddenly become unable to filter waste products from your blood), hypotension of hemodialysis (occurs because a large volume of blood water and solutes are removed over a short period of time), and arteriovenous fistula (is an irregular connection between an artery and a vein). Record review of Resident #11's quarterly MDS assessment dated [DATE] indicated Resident #11 had clear speech, minimal difficult hearing, and impaired vision with corrective lenses. The MDS indicated Resident #11 was usually understood and understood others. The MDS indicated Resident #11 had a BIMS score of 15 which indicated intact cognition. The MDS indicated Resident #11 required partial/moderate assistance for shower/bathe self, dressing, and putting on footwear, supervision for toileting and personal hygiene, and setup for oral hygiene. The MDS indicated Resident #11 was on dialysis. Record review of Resident #11's care plan dated 03/15/22, edited 01/05/23, indicated Resident #11 had dialysis related to renal failure. Interventions included assist resident in preparing for transport to dialysis, listen for bruit (a sound heard over an artery or vascular channel, reflecting turbulence of flow) over shunt site every shift, monitor access site every shift, and palpate shunt for thrill (An abnormal vibration that is felt on the skin overlying a loud cardiac murmur or an arteriovenous fistula) site every shift. Record review of an undated, blank facility's dialysis communication form indicated .day of dialysis (pre dialysis) .Resp .Temp .examine shunt site .Dialysis .BP .Pulse .Resp .Temp . The facility's dialysis communication form did not indicate post dialysis vital signs and assessment of access site. Record review of Resident #11's dialysis communication form dated 03/18/24, 03/15/24, 03/13/24, 03/11/24, 03/09/24, 02/23/24, 02/26/24, and 02/23/24 did not indicate post dialysis vital signs and assessment of access site. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #11's progress notes dated 12/05/23-03/18/24 did not reveal post dialysis assessment documentation. Record review of Resident #11's vital report dated 03/04/24-03/18/24 indicated blood pressure and pulse at the beginning of each shift. During an interview on 03/18/24 at 2:30 p.m., Resident #11 said he went to dialysis three times a week. He said when he returned from dialysis, nursing staff did not check his blood pressure or pulse. During an interview on 03/20/24 at 1:18 p.m., RN C said the nurse was responsible for filling out the dialysis form when the resident went to dialysis. She said before dialysis, the nurse checked the resident's vital signs and thrill and bruit of the shunt. She said when the resident returned from dialysis, a bandage was over the site and left on for a couple hours before its removed. She said the nurse normally documented post dialysis vital signs in the vital signs section or progress notes. She said it was important to do a post dialysis assessment to make sure there was no abnormal bleeding, monitor vital signs, and make sure the resident tolerated dialysis. She said if a post dialysis assessment was not done, bleeding could be missed, fistula malfunction could occur, or miss the resident having problems. She said the facility did not have a guideline to specify where to document the post dialysis assessment done at the facility. During an interview on 03/20/24 at 1:43 p.m., the DON said the facility used a dialysis communication form to document vital signs and thrill and bruit. He said the nursing staff should review the documentation from the dialysis center when the resident returned. He said he did not know if nursing staff had to check vital signs after the resident returned from dialysis. He said he had to review the dialysis form and policy. He said the post dialysis assessment was important to ensure the patient was stable. He said he could not speculate how not obtaining the post dialysis assessment affected the resident. He said if staff documented post dialysis assessments, a progress note, or vital signs section would be adequate. Record review of https://www.mayoclinic.org/tests-procedures/hemodialysis/about/pac-20384824 dated 08/05/23 and accessed on 04/04/24 indicated .hemodialysis treatment can be efficient at replacing some lost kidney function, you may experience some of the related conditions .low blood pressure .muscle cramps . sleep problems .anemia .high/low potassium levels .access site complications .it's extremely important to take care of your access site to reduce the possibility of infection and other complications . Record review of the facility's Outpatient Dialysis Service Agreement effective date 02/06/23 which indicated . whereas, the provision of hemodialysis services to ESRD Residents deemed appropriate for such care is consistent with ESRD Residents' rights, community standards of care, public policy, and the efficient and economic delivery of care . Record review of a facility's End-Stage Renal Disease, Care of a Resident with policy dated 09/10 indicated . residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interviews and record review, the facility failed to ensure each residents' drug regimen was free from unnecessary psychotropic drugs (without adequate behavior monitoring) for 4 (Resident # 2, Resident # 11, Resident # 16, and Resident # 41) of 13 residents whose medications were reviewed in that: 1.The facility failed to ensure Resident #2 had behavior monitoring for his prescribed Zoloft (is an antidepressant used to treat major depression). 2.The facility failed to ensure Resident #11 had behavior monitoring for his prescribed Lexapro (is an antidepressant used to treat depression). 3.The facility failed to ensure Resident #16 had behavior monitoring for his prescribed Ativan (is used to treat anxiety), Buspirone (is used to treat anxiety disorders) and Lexapro (is an antidepressant used to treat depression). 4.The facility failed to ensure Resident #41 had behavior monitoring for his prescribed Depakote (is used to treat seizure disorders, certain psychiatric conditions (manic phase of bipolar disorder), and to prevent migraine headaches) and Sertraline (is an antidepressant used to treat major depression). This deficient practice could place residents at risk of not receiving the intended therapeutic benefits of their psychotropic medications. Findings included: 1. Record review of Resident #2's face sheet printed 03/18/24 indicated Resident #2 was a [AGE] year-old, male and admitted on [DATE] with diagnosis including other bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) without behavioral disturbance, and other recurrent depressive disorders (a depressed mood or loss of pleasure or interest in activities for long periods of time). Record review of Resident #2's MDS assessment dated [DATE] indicated Resident #2 usually understood and usually understood others. The MDS indicated Resident #2 had a BIMS score of 10 which indicated moderate cognitive impairment. The MDS indicated Resident #2 had inattention and disorganized thinking that fluctuated. The MDS indicated Resident #2 required partial/moderate assistance for oral, personal, and toilet hygiene, shower/bathe self and lower body dressing. The MDS indicated Resident #2 had an active diagnosis of bipolar disorder and depression. The MDS indicated Resident #2 had received an antidepressant during the 7 days assessment period. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's care plan dated 02/08/23 indicated Resident #2 was at risk for adverse consequence related to receiving Zoloft for diagnosis of depressive disorder. Intervention included monitor resident's behavior and response to medication. Record review of Resident #2's consolidated physician order dated 03/01/24-03/20/24 indicated an order for Zoloft (Sertraline), 100 mg, 1 tablet, oral, DX: other recurrent depressive disorders, at bedtime, start date 01/24/23, no end date. No order for behavior monitoring noted. Record review of Resident #2's Side Effects/Behavior Administration history dated 03/01/24-03/20/24 indicated Anti-depressant Medication Use, observe resident closely for significant side effects, every shift, start date 09/26/23, no end date. No administration record for behavior monitoring noted. 2. Record review of Resident #11's face sheet printed 03/18/24 indicated Resident #11 was a [AGE] year-old, male and admitted on [DATE] with diagnosis including other history of recurrent depressive disorders. Record review of Resident #11's quarterly MDS assessment dated [DATE] indicated Resident #11 had clear speech, minimal difficult hearing, and impaired vision with corrective lenses. The MDS indicated Resident #11 was usually understood and understood others. The MDS indicated Resident #11 had a BIMS score of 15 which indicated intact cognition. The MDS indicated Resident #11 required partial/moderate assistance for shower/bathe self, dressing, and putting on footwear, supervision for toileting and personal hygiene, and setup for oral hygiene. The MDS indicated Resident #11 had received an antidepressant during the 7 days assessment period. Record review of Resident #11's care plan dated 03/15/22, edited 01/05/23 indicated Resident #11 was at risk for adverse consequences related to receiving Lexapro 10mg an antidepressant for depression. Intervention included monitor resident's behavior and response to medication. Record review of Resident #11's consolidated physician order dated 03/01/24-03/20/24 indicated an order for Lexapro, 10mg, 1 tablet, oral, DX: other recurrent depressive disorders, once a day. Start date 05/22/23, no end date. No order for behavior monitoring noted. Record review of Resident #11's Side Effects/Behavior Administration history dated 03/01/24-03/20/24 indicated Anti-depressant Medication Use, observe resident closely for significant side effects, twice a day, start date 07/25/23, no end date. No administration record for behavior monitoring noted. 3. Record review of Resident #16's face sheet printed 03/18/24 indicated Resident #16 was a [AGE] year-old, male and admitted on [DATE] and 04/20/22 with diagnoses including depression (is a common and serious medical illness that negatively affects how you feel, the way you think and how you act), alcohol abuse with alcohol-induced anxiety disorder, generalized anxiety disorder (a constant state of worry, fear, and dread), and other recurrent depressive disorders (depression). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #16's quarterly MDS assessment dated [DATE] indicated Resident #16 was understood and understood others. The MDS indicated Resident #16 had a BIMS score of 15 which indicated intact cognition. The MDS indicated Resident #16 required supervision for shower/bathe self and personal hygiene, setup for oral hygiene, independent for toileting hygiene, dressing, and putting on footwear. The MDS indicated Resident #16 an antidepressant and antianxiety during the 7 days assessment period. Record review of Resident #16's care plan dated 09/27/28, edited 02/08/23 indicated Resident #16 received antidepressant medication related to major depressive and disorder and insomnia. Intervention included monitor resident's behavior and response to medication. Record review of Resident #16's care plan dated 11/23/20, edited 02/08/23 indicated Resident #16 received antianxiety medication related to anxiety, Lorazepam. Intervention included monitor resident's mood and response to medication. Record review of Resident #16's consolidated physician order dated 03/01/24-03/2024 indicated an order for: *Lorazepam, 0.5mg, 1 tab, oral, twice a day, DX: Generalized anxiety disorder. Start date 04/14/23, no end date. *Lexapro, 10mg, 1 tablet, oral, DX: Depression, once a day. Start date 05/11/23, no end date. *Buspirone, 5mg, 1 tablet, oral, DX: Generalized anxiety disorder, twice a day. Start date 10/25/23, no end date. No order for behavior monitoring noted. Record review of Resident #11's Side Effects/Behavior Administration history dated 03/01/24-03/20/24 indicated: * Anti-depressant Medication Use, observe resident closely for significant side effects, every shift, start date 02/06/23, no end date. *Anti-anxiety Medication Use, observe resident closely for significant side effects, twice a day, start date 07/25/23, no end date. *Target Behavior: (Angry). At the end of each shift mark frequency, intervention, and effectiveness, twice a day, start date 05/23/22, no end date. No administration record for behavior monitoring noted. 4. Record review of Resident #41's face sheet printed 03/20/23 indicate Resident #41 was a [AGE] year-old, male and admitted on [DATE] with diagnosis including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dementia, moderate, with anxiety (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and depression (is a common and serious medical illness that negatively affects how you feel, the way you think and how you act). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #41's quarterly MDS assessment dated [DATE]indicated Resident #41 was usually understood and usually understood others. The MDS indicated Resident #41 had clear speech, minimal difficulty hearing, and impaired vision with no corrective lenses. The MDS indicated Resident #41 was unable to complete the BIMS assessment due to being rarely/never understood. The MDS indicated Resident #41 had short-and-long term memory recall problem and severely impaired cognitive skills for daily decision making. The MDS indicated Resident #41 an antidepressant and antianxiety during the 7 days assessment period. Record review of Resident #41's care plan dated 11/15/23 indicated Resident #41 received antidepressant medication. Intervention included monitor resident's mood and response to medication. Record review of Resident #41's consolidated physician order dated 03/01/24-03/2024 indicated order for the following: *Depakote Sprinkle capsules, 125mg, 1 tablet, oral, DX: Dementia in other diseases classified elsewhere, severe, with other behavioral disturbance, twice a day. Start date 11/02/23, no end date. *Sertraline, 25mg, 1/2 tablet, oral, DX: Depression, unspecified, once a day. Start date 02/28/24, no end date. No order for behavior monitoring noted. Record review of Resident #41's Side Effects/Behavior Administration history dated 03/01/24-03/20/24 indicated: * Anti-depressant Medication Use, observe resident closely for significant side effects, every shift, start date 11/03/23, no end date. *Anti-anxiety Medication Use, observe resident closely for significant side effects, every shift, start date 11/03/23, no end date. *Anticonvulsant Medication Use, observe resident closely for significant side effects, every shift, start date 11/03/23, no end date. *Target Behavior: Increase anxiety, restlessness, panic attacks, At the end of each shift mark frequency, intervention, and effectiveness, every shift, start date 11/03/22, no end date. No administration record for behavior monitoring noted. During an interview on 03/20/24 at 12:50 p.m., the ADON said she had been employed at the facility since July 2023. She said target behavior was to monitor the behaviors the resident received the medication for. She said only antipsychotic and antianxiety medications needed behavior monitoring. She said she believed the state only required those two drug classes. She said all psychotropic medication needed side effect monitoring. She said resident did not need orders for behavior monitoring for it to be done. She said using nursing judgement let you know to look for behaviors on all residents. She said she did not feel like the behavior monitoring done by nurses needed to always be documented because you always did not see what the previous nurse charted. She said if a nurse wanted to document behaviors, a progress note, report between nurse, and the 24-hour report was sufficient. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/20/24 at 1:18 p.m., RN C said she had been employed at the facility since 2018. She said the behavior monitoring was under the side effects area. She said behaviors were increased agitation, confusion, or sleepiness. She said behavior monitoring should include intensity, intervention, and effectiveness of intervention. She said behavior monitoring was important to know if the medication was not working and if it needed to be changed. She said if behavior monitoring was not done, residents could hurt themselves or other residents, fall, elope, and wander. During an interview on 03/20/24 at 1:43 p.m., the DON said behavior monitoring was in the side effects/behaviors administration. He said behavior monitoring was to monitor if the resident had behaviors related to what the medication was prescribed to treat. He said behavior monitoring was not the side effects of taking the medication. He said he thought the side effects area had a frequency and intervention section for behavior monitoring. During a phone interview on 03/20/24 at 3:10 p.m., the pharmacy consultant said the facility was not required to do behavior monitoring on antidepressants or anticonvulsants. She said this was per the State. At that time, a request was made to the pharmacy consultant to email the DON the information from the State stating behavior monitoring was not required for certain drug classifications. No information received before or after exit. Record review of an undated facility's Medical Utilization and Prescribing policy indicated .the physician and staff will adjust existing medication based on their efficacy and the continued presence of relevant conditions and risk .monitoring .the staff and physician will periodically re-evaluate the conditions and symptoms for which each resident is receiving medications to ensure that the medication and dosage are still relevant and are not causing undesired complications .this may be reviewed in care plan or other routine assessments .

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NAME OF PROVIDER OR SUPPLIER: Grace Hill Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 215 Fm 161 Business South Hughes Springs, TX 75656	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observation, interviews, and record review, the facility failed to ensure that drugs and biologicals used in the facility were secured properly for one of four nurse medication carts (Hall 100 nurse medication cart). 1. The facility failed to ensure LVN D did not leave 2 Insulin pens on top of nursing cart unsupervised. 2. The facility failed to ensure LVN D's medication cart was not left unlocked and supervised. These deficient practices placed residents at risk of drug diversion and having access to medications not prescribed for them which could result in injury and hospitalization . The findings include: Observation on 03/19/2024 at 12:00 PM revealed the nurse in charge of the cart, LVN D left 2 insulin pens on top of nursing cart unsupervised and parked in the hall in front of room [ROOM NUMBER], while going into resident room to check resident's blood glucose. Observation on 03/19/2024 at 12:06 PM after LVN D checked resident blood glucose she grabbed the 2 insulin pens and left the cart unlocked with the keys in the cart unsupervised. On 03/20/2024 at 12:45 PM attempted to call LVN D, no answer and left message for a returned call. 03/20/2024 at 3:07 PM attempted to call LVN D, no answer and left message for a returned call. During an interview on 03/20/24 12:55 PM CMA F stated in the nurse cart there were several taken as needed medications, Nebulizer treatments, inhalers, diabetic medications and insulins. CMA F said she honestly did not know everything that was kept in the nursing cart. CMA F said the first thing should be done prior to walking away from medication carts was to make sure the cart was locked, and the screen was closed, before the cart was left. CMA F said it was important to keep the nursing cart locked because anyone can get into the cart. CMA F said residents could get things they did not need and the facility would be in trouble. During an interview on 03/20/2024 at 1:10 PM RN C said the facility had a lot of stuff on the nursing cart like as needed medications for every resident, Nitroglycerin, Diabetic testing strips, insulins, breathing treatments, bandages and stir strips on the nursing cart. RN C said the first thing should have been done before walking away from the nursing cart was to make sure everything was cleaned off the top of the cart, wipe down items had been used from the cart, make sure the cart was locked and log off the computer. RN C said the cart should be locked, because it had items on the cart the facility did not want random people, other staff or residents to get ahold to. When RN C was asked what could happen if a resident got into the cart RN C replied, It will not happen, because the carts should be locked at all times. RN C said as needed medications and insulins could make resident's blood sugar drop. RN C said residents could get into the inhalers; anything could happen. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/20/24 at 1:17 PM LVN E said the nursing cart had breathing treatments, Insulins, alcohol swabs, creams, purple top wipes, as needed medications and Narcotics box of medications. LVN E said before walking away from the nursing cart the drawers should be closed and locked. LVN E said it was important to keep the nursing cart locked, because of the Narcotics (a drug that relieves pain and induces drowsiness, stupor, or insensibility). LVN E said no one should have access to the nurse cart, except for the nurse. LVN E said if a resident got ahold to some of the medications on the nurse cart it could be very dangerous. LVN E said most of the items on the cart could be a hazard and danger to an unsupervised resident. During an interview on 03/20/24 at 1:36 PM the DON said there were medications on the Nursing cart. The DON said the first thing should be done was to follow the standards set for the storage of medications. When asked why it was important to keep the nursing cart locked, the DON responded, I do not speculate. After the question was rephrased, the DON still replied I do not speculate. When asked what could happen if a resident got into the nursing cart, the DON replied, I do not speculate. After the question was rephrased, the DON still replied I do not speculate. During an interview on 03/20/24 at 1:56 PM the Administrator said there were medications on the nurse cart, but he was not sure exactly what all would be on the cart. The Administrator said the first thing before walking away from the nurse cart was lock it. The Administrator said the reason the cart should be locked was because it should have limited access. When asked what could happen to a resident if got into the nurse cart the Administrator said the facility would have a problem. The Administrator said, he could not speculate on that. Record review of the facility policy titled Medication Storage revised on 07/14/2017 read in part: Policy statement Medications must only be accessible to authorized staff and locked when not under the direct observation of authorized staff. The medication cart should always be locked unless it is in direct view of the Nurse or medication aide. No medications should be left unattended: on medication carts. Controlled medications must be stored in a manner to limit access and to facilitate reconciliation in accordance with the facility policies.

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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. 46062 Based on observation, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements. The facility failed to ensure the ceiling was in good repair in the kitchen. This failure could place residents at risk of foodborne illness and food contamination. Findings included: During initial tour observations in the kitchen on 3/18/24 beginning at 9:08 AM, there was brown staining to approximately six ceiling tiles above to area of the tea maker machine, juice machine, and the food processor (used to make puree and chopped foods). One of the ceiling tiles had a rounded dropped appearance and had loose ceiling tile particles hanging from it directly above the tea maker where there were two uncovered tea filter holders sitting on top of the tea maker and the food processor was beside the tea maker. There was an approximate 1-inch gap in the ceiling tile around half of the fire sprinkler head located above the juice machine. One ceiling tile located directly in front of the tea maker, juice machine and the food processor had a rounded dropped appearance with an approximate 3/4 to 1-inch crack/separation in the ceiling tile on both sides of the air vent, and the air vent was dropped approximately 3/4 of an inch from the ceiling. During an observation on 3/19/24 beginning at 11:26 AM, the DM used the food processor located beside the tea machine and below the damaged ceiling tiles to puree (thick liquid suspension made from cooked food) pork loin, green beans, and black-eyed peas. During an interview on 3/19/24 at 3:11 PM, the DM said the ceiling tiles in the kitchen above the area of the food processor, tea, and juice machines, had been like that since around the first of year or a little before. The DM said the maintenance supervisor had been trying to fix it from leaking. The DM said the maintenance supervisor had put tar on the roof trying to fix the leak. The DM said the area in the kitchen would leak if they had a hard rain, but it did not leak when it rained last month. The DM said it made her a little nervous working in the area where the ceiling tile damage was due to the electrical wiring and ducts. The DM said there could be cross-contamination from the particles hanging from the ceiling tile and/or open areas in the ceiling tiles, but they made sure they washed things down before they used the tea machine, tea filter containers, juice machine, or food processor and kept it as clean as possible. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/19/24 at 3:28 PM, the Maintenance Supervisor said the damaged ceiling tiles in the kitchen had been that way since before he started at the facility in June 2023. The Maintenance Supervisor said he had been on the roof of the building and in the attic trying to patch things and it still leaked when it rained heavy. The Maintenance Supervisor said he did replace the damaged ceiling tiles in the kitchen around the beginning of March, but after the last big rain it was back like it was again. The Maintenance Supervisor said he did not have the repairs documented in his log. The Maintenance Supervisor said he had the ceiling tiles to repair the ceiling in the kitchen, but he had not been able to fix them yet because he would need to schedule the repair when the kitchen was not in use. The Maintenance Supervisor said he had reported the issue to the ADM. The Maintenance Supervisor said the damaged ceiling tiles in the kitchen did not look nice and attic dust and/or insulation could potentially get into the drinks or food with the juicing and tea machines and the food processor being located in the same area. During an interview on 3/20/24 at 2:55 PM, the ADM said he had seen the damaged kitchen tiles and they had been dealing with a leak. The ADM said they had repaired it and sometimes it would leak and sometimes it did not leak. The ADM said he was waiting on a repair quote from a roofing company. The ADM said it seemed like it would be a sanitation issue with the cracks in the ceiling tiles and particles hanging from the ceiling. Record review of the facility's policy titled Food Safety and Sanitation Plan dated revised on 11/28/2017 indicated . it was the policy of the facility to follow an effective, proactive food safety program that was based on preventing food safety hazards before they occurred . residents risk serious complications from foodborne illness as a result of their compromised health status . sanitary conditions must be present in health care food service settings to promote safe food handling .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interviews, 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 1 of 3 residents reviewed for infection control during wound care. (Resident #1) The facility failed to ensure WCN practiced infection control measures by using hand gel or washing hands after the removal of gloves. This failure could place residents at risk for cross-contamination and at an increased risk of infection. Findings included: Record review of Resident #1's face sheet printed 03/20/24 indicated Resident #1 was a [AGE] year-old, male and was admitted on [DATE] with diagnosis including peripheral vascular disease (is a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel), acute embolism (a blood clot or a foreign body enters the bloodstream and obstructs blood flow) and thrombosis (a blood clot forms in blood vessels and partially or completely blocks blood flow) of unspecified deep vein of right lower extremity, and non-pressure chronic ulcer of right calf with fat layer exposed (is defined as a defect in the skin below the level of knee persisting for more than six weeks and shows no tendency to heal after three or more months). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 was understood and understood others. The MDS indicated Resident #1 had clear speech, adequate hearing, and adequate vision. The MDS indicated Resident #1 had a BIMS score of 10 which indicated moderate cognitive impairment. The MDS indicated Resident #1 was independent for toilet hygiene and dressing, setup or clean-up assistance for oral and personal hygiene and eating. The MDS indicated Resident #1 had one venous and arterial ulcers present. The MDS indicated Resident #1 received application of nonsurgical dressings other than to feet and ointments/medications. Record review of Resident #1's care plan dated 03/18/21, edited 02/15/24 indicated Resident #1 had chronic venous ulcer wound to right lower medial leg. An intervention included complete ordered treatment daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 03/19/24 at 11:30 a.m., the WCN performed a wound care dressing change on Resident #1. The WCN placed wound care supplies on the bedside cart on top of wax paper. The WCN washed her hands then placed gloves on her hands. The WCN placed a pad on Resident #1's bed and Resident #1 placed his leg on the pad. The WCN grabbed a pair of scissors and proceeded to cut the outer layer dressing off. She removed the outer layer dressing then removed her gloves and placed new ones on without using hand gel or washing her hands. The WCN then removed moderately saturated inner dressing from Resident #1's leg. The WCN removed her gloves then placed new gloves on without hand gel or washing her hands. The WCN removed the old pad from underneath Resident #1 then placed a new pad down. The WCN cleaned the wound bed with gauze and ordered solution. The WCN removed her gloves, went to Resident #1's bedroom door where the treatment cart was to get more gloves and gauze without hand gel or washing her hands. The WCN returned to bedside with gloves already on. Unable to determine if the WCN use hand gel before putting on new gloves because of Resident #1's bedroom door blocking view. The WCN resumed cleaning Resident #1's wound bed. The WCN said I should be washing my hands or using gel after I take my gloves off! During an interview on 03/20/24 at 10:10 a.m., the WCN said she could not fully remember step by step how she did Resident #1's dressing change for yesterday (03/19/24). She said she normally washed her hands, sanitized the scissors, placed a pad on the resident's bed, place sheets of wax paper down and set up table with supplies, pulled the resident's curtain, cut the bandage, cleaned the scissors, changed gloves, cleaned site with ordered solution, let the solution dry, placed moisture barrier around site, changed gloves, placed absorbent pads over the site, wrapped the leg in kerlix and Coban tape, then disposed of dressing in biohazard room. She said she washed her hands twice during the dressing change. She said she washed before she started the wound care and after cleaning the gloves in Resident #1's sink. She said she had hand gel on her treatment cart, but it was not in the room with her during the dressing change. She said she did recall saying she should have been washing her hands or using hand gel before putting on new gloves. She said not doing that placed resident at risk for infections. She said resident could get an infection and get sick or septic. She said the resident then could require hospitalization or death. During an interview on 03/20/24 at 1:43 p.m., the DON said it depended on the circumstances if hand gel or hand washing was needed after glove removal. He said Resident #1's dressing change was a clean procedure not a sterile procedure. He said hand washing or gel needed to be used after glove removal for soiled gloves or sterile procedures. He said when the WCN removed Resident #1's inner soiled dressing, she should have washed her hands after she removed her gloves. He said washing hands or using hand gel after glove removal was important to prevent the spread of contaminates. Record review of a facility's Wound Care policy revised 10/2010 indicated .put on exam glove .loosen tape and remove dressing .pull glove over dressing and discard .wash and dry your hands thoroughly .put on gloves . Record review of a facility's Work Practices policy revised 08/2008 indicated .employee shall wash their hands as soon as possible after removing contaminated gloves or other personal protective equipment and after contact with blood or other potentially infectious materials .