STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676176	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crowley Nursing and Rehabilitation	920 E Fm 1187 Crowley, TX 76036

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required for 1 of 9 residents (Resident #1) reviewed for care plans. The facility failed to develop a comprehensive care plan which addressed and included measurable objectives and timeframes related to Resident #1's indwelling urinary catheter (a thin, hollow tube inserted through the urethra into the urinary bladder to drain urine), which he had from approximately 01/29/25 until 04/09/25. This failure placed residents with indwelling urinary catheters at risk of experiencing urethral/bladder/kidney injury, pain, and possible infection. Findings include: Record review of Resident #1's face sheet dated 04/11/25 reflected the resident was a [AGE] year-old male who was initially admitted to the facility on [DATE] and most recently re-admitted on [DATE]. He was diagnosed with infection and inflammatory reaction due to indwelling urethral catheter, type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), chronic kidney disease, stage 4 (significant decline in kidney function, nearing kidney failure), hypertensive heart disease with heart failure (when prolonged high blood pressure weakens the heart muscle, eventually leading to the heart's inability to pump blood effectively), and cognitive communication deficit (difficulties with communication caused by problems with underlying cognitive processes). Record review of Resident #1's significant change MDS dated [DATE] reflected he had a BIMS score of 4 (severe cognitive impairment); Resident #1 used a walker and manual wheelchair for ambulation; Resident #1 was dependent on staff for toileting; Resident #1 had an indwelling catheter; Resident #1 was frequently incontinent of bowel; Resident #1 was diagnosed with renal insufficiency (also called renal failure - when the kidneys lose the ability to remove waste and balance fluids)/renal failure/ or end-stage renal disease (see renal failure); and Resident #1 had been diagnosed with a UTI (an infection that can affect any part of the urinary system) within the previous 30 days. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's baseline care plan dated 03/17/25 reflected, . 3. Health Conditions . C. Bowel and Bladder. 1. Urinary continence - Always continent . 4. Bowel and bladder appliances - Indwelling catheter . Record review of Resident #1's physician's orders for February 25 - April 25 reflected the following: - Flush [catheter] with 60cc's NS every day, PRN, every shift. Start date: 02/01/25. End date: 02/11/25. - [Catheter] care: Output Q shift every day and night shift. Start date: 02/01/25. End date 02/11/25. - Change [Catheter] and drainage bag PRN for obstruction or when closed system is compromised as needed. Start date: 02/25/25. End date: 03/07/25. - Flush [catheter] with 60cc's NS every day, PRN, as needed. Start date: 02/26/25. End date: 03/07/25. - Flush [catheter] with 60cc's NS every day, PRN, every shift. Start date: 03/18/25. End date: 04/11/25. - [Catheter] care: Output Q shift every day and night shift. Start date: 03/17/25. End date 04/09/25. Reason: [Catheter] discontinued. - Remove [catheter], if not voided in 8 hours, replace [catheter] one time only for 1 day, remove at 3:00 PM Order date 04/09/25. End date: 04/10/25. Record review of Resident #1's comprehensive care plan, revised 04/09/25 reflected the following care areas: - [Resident #1] has acute renal failure. Goal included: [Resident #1] will have no s/sx of complications related to fluid deficit (dehydration - when the body loses more fluid than it takes in). Interventions included: Give medications as ordered by physician. Monitor changes in mental status. Monitor for s/sx of infection, UTI. Monitor lab reports of electrolytes and report to physician. - [Resident #1] has incontinence and limited mobility due to his multiple comorbidities putting him at risk for skin breakdown. Goal included: The resident will maintain or develop clean and intact skin. Interventions included: Encourage good nutrition and hydration. Keep skin clean and dry. - [Resident #1] has urinary incontinence putting him at risk for having a UTI. Goal included: Resident #1's risk for septicemia (blood poisoning - a bloodstream infection where bacteria and their toxins are carried throughout the body) will be minimized/prevented via prompt recognition and treatment of symptoms of UTI. Interventions included: Clean peri-area with each incontinence episode. Encourage fluids during the day to promote prompted voiding responses. Ensure the resident has an unobstructed path to the bathroom. Incontinent: Check every 2 hours and as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- [Resident #1] is at risk for renal insufficiency due to him having chronic kidney disease stage 4. Goal included: Resident #1 will have no s/sx of complications related to fluid deficit. Interventions included: Monitor/document/report PRN any s/sx of acute renal failure. Further review of Resident #1's comprehensive care plan reflected no care area to address his indwelling urinary catheter. Record review of Resident #1's nursing progress notes for January 25 - April 25 reflected the following: - On 01/29/25 at 6:00 AM, an unidentified staff member wrote, admission details: Arrived by: ambulance. admission mode: stretcher . - On 01/30/25 at 4:14 PM, RN C wrote, Re-admit day 2/3 (Resident #1 was readmitted to the facility on [DATE]. There was no documentation about a catheter before this date). Resident is alert and oriented to self and situation . Resident's [catheter] is patent and draining clear, yellow urine. No color noted . - On 02/09/25 at 1:01 AM, LVN B wrote, . Genitourinary (urinary and genital organs): Catheter character: Patent (open or unobstructed). Catheter in place due to urinary retention (the inability to completely empty the bladder when urinating). Catheter size: 16 . - On 04/09/25 at 4:55 AM, LVN A wrote, Late Entry. Resident [catheter] discontinued per RP request and NP orders and tolerated well. Will monitor urine output through night per orders to reinsert if output not sufficient. Observation and interview with Resident #1 on 04/11/25 at 1:05 PM revealed he was alert and spoke Spanish. Through an interpreter with the HHSC approved language line, Resident #1 provided his name and birthdate. He did not have a catheter at that time. In an interview with the DON on 04/15/25 at 10:45 AM, she stated Resident #1 had a catheter at one time, but it was removed last week. She said she could not recall why Resident #1's catheter was removed, but she did not think he had it for a long time. In a follow-up interview with the DON on 04/15/25 at 12:58 PM, she stated Resident #1 may have returned from the hospital with the catheter on 3/17/25. She said Resident #1's catheter should have been listed as a care area on his care plan to inform staff how to care for it and to communicate what was going on with him. She said she was surprised to hear that Resident #1's catheter was not mentioned on his care plan. She stated the MDS Nurse was responsible for updating care plans and she was going to ask the MDS Nurse why there was no care area related to Resident #1's catheter. In an interview with Resident #1's Physician on 04/15/25 at 1:28 PM, she stated her records indicated Resident #1 first had the catheter around 02/08/25 due to urinary retention. She said the purpose of a care plan was to ensure staff knew what to do regarding the care areas, like Resident #1's catheter. She said staff never contacted her about any issues with Resident #1's catheter. She said as far as she knew, Resident #1's family requested to remove the catheter because they were taking him home. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the MDS Nurse on 04/15/25 at 2:30 PM, she stated she was responsible for updating residents' care plans. She said she and her assistant received information from morning staff meetings and the DON gave them lists of residents with feeding tubes, catheters, and tracheostomy tubes (a surgical procedure that creates an opening in the neck to insert a tube directly into the trachea). She said if any resident had a change in condition, she or her assistant would update their care plan. The MDS Nurse initially stated her assistant resolved (removed from the care plan) Resident #1's catheter information on 04/11/25. She said Resident #1 was readmitted on dialysis on 03/17/25, so she and her assistant completed a significant change assessment (completed a significant change MDS). She stated any resolved care area on a care plan would still be visible in their computer system. After reviewing Resident #1's comprehensive care plan on her computer, the MDS Nurse stated she did not see any care area related to Resident #1's catheter. She stated she was on leave when Resident #1 readmitted , but she heard the team (the nursing staff) talk about Resident #1 when she returned to work. The MDS Nurse stated she did not see any care area related to Resident #1's catheter which would have resolved from the care plan. She said Resident #1's catheter was addressed on his MDS and baseline care plan, but it did not carry over to his comprehensive care plan. She said the purpose of the care plan was to ensure all the staff knew each residents' plan of care and what interventions were in place. She said the care plan was also for new staff who were not familiar with the residents. She stated there were no negative effects related to Resident #1's catheter not being addressed on his care plan, but a negative effect would be that staff would not know information, like when to change him or how to care for him, and that could lead to infection. In an interview with the DON on 04/15/25 at 3:00 PM, she said Resident #1 had the catheter in February 2025. She said Resident #1 was discharged to the hospital and returned with the catheter. She stated Resident #1 did not experience any negative effects from not having the catheter addressed on his care plan because the staff followed orders from his physician. She said a negative effect would be infection. Record review of the facility's Care Plans, Comprehensive Person-Centered policy, revised March 2022, reflected: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation . 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .c. includes the resident's stated goals upon admission and desired outcomes .e. Reflects currently recognized standards of practice for problem areas and conditions .11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition .c. when the resident has been readmitted to the facility from a hospital stay .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #75) reviewed for accidents. The facility failed to remove Resident #75's fall mat, next to her bed, when she would take a few steps to her bedside commode, which posed a trip hazard. This failure could place residents at risk for serious injury or harm, decline in health, and decreased quality of life. Findings included: Record review of Resident #75's MDS dated [DATE] reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included stroke, non-Alzheimer's dementia and muscle weakness. Resident #75 had a BIMS of 8 indicating her cognition was moderately impaired. The MDS further reflected the resident required substantial/maximal assistance for bed to chair and toiler transfers and she was not coded as having recent falls. Record review of Resident #75's care plan initiated on 01/10/25 reflected she was at risk for falls related to a history of falls due to unsteady gait, and poor safety awareness. Interventions included to provide a safe environment such as even floors free from spills and/or clutter. Observation and interview on 06/03/25 at 11:21 AM of Resident #75 revealed she was in her room sitting on the side of her bed and she was on continuous oxygen. Next to the bed there was a bedside commode and next to that was a wheelchair. There was a fall mat noted on the floor and three wheels of the resident's bedside table were on the fall mat. Resident #75 stated she was able to independently self-transfer/walk to the bedside commode and to her wheelchair but she was afraid she would trip on the fall mat. The resident stated it was difficult for her to move her bedside table out of the way when she would transfer herself to the bedside commode because the wheels would get stuck on the mat. Resident #75 said her family had tried to remove the mat but the staff said it needed to stay in place because she was a high fall risk. Interview on 06/03/25 at 11:26 PM with Resident #75's family revealed they did not like the fall mat on the floor next to the resident's bed because they felt like the resident would trip on it going to her bedside commode. The family further stated they had asked the staff to remove it but they told them the fall mat was being used to help the resident during a fall. Interview on 06/04/25 at 1:44 PM with LVN B revealed Resident #75 was able to self-transfer to the bedside commode in her room and to her wheelchair. LVN B said the resident had not had any recent falls and the fall mat stayed on the floor at all times as a fall prevention. She said the family had tried to remove it but the staff would put it back on the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/04/25 with CNA D at 1:53 PM revealed Resident #75 was able to transfer herself to the bedside commode and did not have any recent falls. The CNA said the fall mat stayed on the floor next to the resident's bed as a fall prevention. CNA D further stated had noted the bedside table was leaning a bit because it was sitting on the curvature of the fall mat. Interview on 06/04/25 at 2:03 PM with CNA E revealed the Resident #75 required limited supervision with ADLs and was able to transfer herself to the bedside commode. CNA E said the fall mats were in place to protect her in case they resident fell, and the resident had never complained to her about the mat being a trip hazard. Interview on 06/09/2025 at 2:12 PM with the Physical Therapist revealed the nursing staff were responsible for the fall mats and deciding which residents had one. It was her professional opinion that if a resident was mobile or ambulatory, a fall mat should only be in place when they are lying in bed and picked up throughout the day because the fall mat could be a trip hazard making it unstable to walk on and could cause a resident to fall on it. Interview on 06/05/25 with the ADON revealed Resident #75 required a fall mat day and night as a fall prevention because she was in bed most of the time. The ADON said if the fall mat was placed correctly, it should not have been a trip hazard. The ADON further stated she had spoken to the resident the day prior (06/04/25) and the resident had said she was afraid she would fall on the fall mat as she transferred to and from her commode chair. Interview on 06/05/25 at 1:40 PM with the DON revealed Resident #75's fall mat did not need to be in picked up because it was not a trip hazard of they were positioned properly and wheelchairs could be maneuvered over it. Record review of the facility's Falls - Clinical Protocol policy, revised April 2007, reflected the following: .a. Risk factors for subsequent falling include lightheadedness or dizziness, multiple medications, musculoskeletal abnormalities, peripheral neuropathy, gait and balance disorders, cognitive impairment, weakness, environment hazards

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding for 1 of 6 residents (Resident #76) reviewed for enteral feeding. The facility failed to have a physician's order for an abdominal binder that was being used to secure/protect the resident from pulling out her g-tube. This failure could place residents at risk for diminished quality of care. Findings included: Record review of Resident #76's MDS dated [DATE] reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. She had a diagnosis of gastrostomy status (refers to the presence or absence of a gastrostomy tube or a percutaneous endoscopic gastrostomy (PEG) tube). Resident #76 had a BIMS of 0 which indicated her cognition was severely impaired. The MDS further reflected the resident was dependent with all ADLs with the assistance 2 or more staff members and she was on a feeding tube. Record review of Resident #76's care plan revised on 07/24/25 reflected she required a tube feeding related to a swallowing problem. Interventions included to check for tube placement per protocol and document. Record review of Resident #76's monthly physician orders for June 2025 reflected the resident to give Nestle Nova source Renal at 35 ml/hr per GT X 22 hours every shift. Further review reflected there were no orders for an abdominal binder. Record review of Resident #76's progress notes reflected the following: 03/17/25 - nurse notified by aide that while giving resident a bed bath resident pulled out G-Tube. Nurse immediately assessed resident. Physician notified Non-emergency transport contacted to transport to [hospital] to replace tube. 04/26/25 - the aide taking care of resident notified this nurse that the resident pulled out her G-Tube. MD notified, and ordered that resident be transferred to the ER for a G-Tube replacement Observation 06/05/25 at 9:17 AM of Resident #76 revealed Resident #76 was in bed with her eyes open and was not able to carry a conversation due to her impaired cognition. The aide pulled up the resident's gown and an abdominal binder was noted to be in place covering the g-tube site. Interview on 06/04/25 at 1:33 PM with LVN B revealed Resident #76 had pulled out her g-tube out a couple of times because she was very mobile during care and would fidget with her hands and if she got agitated she would pull out her tube. LVN B said they kept the dressing at the g-tube site and an abdominal binder in place to help prevent it from being pulled out. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/04/25 at 1:47 PM with LVN D revealed Resident #76 had pulled out her g-tube while she was giving her a bed bath. LVN D said the resident was very mobile and would try to grab her g-tube during care. Resident #76 now had an abdominal binder in place and they had not had any incidents where the resident had pulled her g-tube out. Interview on 06/04/25 at 1:59 PM with CNA E revealed Resident #76 had not pulled out her g-tube since they placed the abdominal binder on the resident. Interview on 06/05/25 at 1:32 PM with the DON revealed resident's did not require a physician order for an abdominal binder because it was not a treatment and only being used for protection. Interview on 06/05/25 at 3:36 PM with the Physician revealed he would expect the resident to have an order for an abdominal binder as part of their care. Record review of the facility's policy titled Enteral Nutrition revised January 2014 reflected the following: Adequate nutritional support through enteral feeding will be provided to residents as ordered

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain medical records that were complete and accurately documented for 15 of 15 residents (Residents #7, #25, #31, #36, #38, #41, #74, #85, #90, #92, #201, #204, #205, #206, and #208) reviewed for medical record accuracy. 1. CNA F documented her care for Residents #7, #25, #31, #36, #38, #41, #74, #85, #90, #92, #201, #204, #205, #206, and #208 under LVN C's computer credentials on 06/03/25 and 06/04/25 2. CNA G documented her care for Resident's #7, #25, #31, #36, #38, #41, #74, #85, #90, #92, #201, #204, #205, #206, and #208 under CNA D's computer credentials on 06/03/25. These failures could place the residents at risk of inaccurate documentation of care. Findings included: Record review on 06/04/25 of Resident #90's Tasks reflected LVN H had documented personal care completed on 06/03/25 at 7:39 AM and again on 06/04/25 at 9:35 AM. Review of facility staffing schedule indicated LVN H had not worked on 06/03/25 or 06/04/25. His last shift was on 05/30/25 from 10:00 PM-6:00 AM. Resident #90 would have been cared for by CNA F from 6:00 AM-2:00 PM on 06/03/25 and 06/04/25, and by CNA G from 2:00 PM-10:00 PM on 06/03/25 according to the schedule. In an interview on 06/04/25 at 11:00 AM, ADON A stated staff are not allowed to share their log-in credentials for the facility's EHR system with each other, each staff member has their own unique log-in. She stated the only way for someone to document under someone else's credentials would be for the person to share their credentials, or to have not logged off a computer when they walked away from it. ADON A checked the computers at the nurse's station and discovered LVN H had saved his log-in credentials to the computer. Anyone clicking on the log-in would have automatically logged in as LVN H. In an interview on 06/04/25 at 11:05 AM, CNA F stated she had provided personal hygiene to Resident #90 on 06/03/25 and 06/04/25. She stated she had documented her cares in the EHR under LVN H's credentials because she was busy, and her credentials were not working, and she did not have time to ask the DON to fix it. She stated when she clicked on the log-in, LVN H was logged in and she did her documentation. CNA F stated she knew she was not allowed to document under someone else's credentials. She stated she did not know it was considered false documentation. In an interview on 06/04/25 at 11:17 AM, the DON and Administrator both stated it was not accepted practice to share credentials with other staff, or to document under someone else's credentials. The DON stated it was also not acceptable to save your log-in credentials on a computer so that someone else could document as you. The Administrator stated he did not know if there was a policy addressing using another person's login as it was just common sense not to share your credentials with others. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 06/04/25 from 11:30 AM-11:50 AM of resident cares documentation for all residents cared for by CNA F reflected on 06/03/25 and 06/04/25 she had documented personal hygiene, bathing, incontinent care, oral care, and positioning as LVN H for Residents #7, #25, #31, #36, #38, #41, #74, #85, #90, #92, #201, #204, #205, #206, and #208. It was also discovered CNA G had also documented personal hygiene, oral care, positionig, and incontinent care on the 2:00 PM-10:00 PM shift on 06/03/24 using CNA I's credentials In a phone interview on 06/04/25 at 12:35 PM, CNA G stated she had documented her cares under CNA I's credentials because her credentials were not working, and she was too busy to go to the DON to have them reset. She stated she asked CNA I for her credentials. She stated she knew she was not supposed to use someone else's credentials to chart, but she stated she did not know it was considered false documentation to do so. In a phone interview on 06/04/25 at 12:53 PM, LVN H stated he worked at the facility PRN, and he worked at multiple facilities, so he saves his EHR log-in to the computers, so he did not have to remember multiple log-in credentials. He stated he did not know someone else could or would log-in as him and document in the chart. In a phone interview on 06/04/25 at 1:05 PM, CNA I she stated she had not shared her credentials with anyone. She stated she must have no logged out of a computer when she was done. She stated her last shift at the facility was on 06/01/25. Follow-up interview on 06/04/25 at 1:20 PM, ADON A she stated CNA I's credentials had been saved to a computer on the 200 Hall, the same as LVN H had done. Record review of the facility's Charting and Documentation policy, dated July 2017, reflected: .3. Documentation in the medical record will be objective, complete, and accurate .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676176	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crowley Nursing and Rehabilitation	920 E Fm 1187 Crowley, TX 76036

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure the quality assessment and assurance committee (QAA) met at least quarterly and consisted of the required members for 11 of 11 quarterly QAA meetings. The facility failed to ensure the Medical Director, or his/her designee, attended 11 QAA committee meetings held on 06/11/24, 07/15/24, 08/08/24, 09/12/24, 10/10/24, 12/13/24, 01/07/25, 02/11/25, 03/10/25, 04/10/25, and 05/13/25. This failure could place residents at risk for quality deficiencies being unidentified and with no appropriate guidance developed or implemented. Findings included: Record review of the QAA meeting sign in sheets revealed the Medical Director or his/her designee did not attend on the following dates: 06/11/24, 07/15/24, 08/08/24, 09/12/24, 10/10/24, 12/13/24, 01/07/25, 02/11/25, 03/10/25, 04/10/25, and 05/13/25. Interview with the Administrator on 06/05/25 at 2:22 PM revealed the facility Medical Director rarely attended the QAA meetings. The Administrator stated the Medical Director was notified of the date and time of the QAA meetings by the Chairperson of the QAA committee. The Administrator said it was his responsibility to follow up with the Medical Director to ensure that he attended the QAA meetings. The Administrator revealed when the Medical Director did not attend the QAA meetings there was a communication breakdown about the residents' care and the long-term plans about the facility and future residents. Interview with the Medical Director on 06/05/25 at 2:47 PM revealed he had not been invited to any QAA meetings by the facility and had not attended any QAA meetings. Record review of facility's QAA Policy, dated 11/28/17, revealed the QAA Committee consisted of at a minimum the Committee Chairperson, Administrator, Director of Nursing, and the Medical Director.