STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676186	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Ltc Partners Inc	1621 Butler Dimmitt, TX 79027

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** 46534 Based on observation, interview, and record review the facility failed to ensure the resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States for 11 (Resident #2, Resident # 3, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10, Resident #11, Resident #12, and Resident #13) of 54 residents reviewed for resident rights. The facility failed to ensure 11 residents (Resident #2, Resident # 3, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10, Resident #11, Resident #12, and Resident #13) were able to vote in the election of 2024. This failure could place residents at risk of feeling unheard and devalued. Findings Included: 1. Record review of Resident #2's admission record dated 11/06/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, hemiplegia (partial paralysis) affecting right dominant side, muscle weakness, and repeated falls. Record review of Resident #2's quarterly MDS completed on 10/03/24 revealed a BIMS of 12 which indicated moderately impaired cognition. Record review of Resident #2's care plan revealed a completion date of 10/23/24 . 2. Record review of Resident #3's admission record dated 11/06/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, neuroleptic induced Parkinsonism (difficulty initiating movements), schizoaffective disorder bi-polar type (mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder), and post-traumatic stress disorder (mental health condition caused by a traumatic event that affects your ability to function normally). Record review of Resident #3's quarterly MDS completed on 09/10/24 revealed a BIMS of 12 which indicated moderately impaired cognition. (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 #3's care plan revealed a completion date of 10/02/24. The DNR section of the care plan noted, I am capable of making my own healthcare decisions and giving informed consent. 3. Record review of Resident #5's admission record dated 11/06/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), alcohol dependance, and major depressive disorder (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities). Record review of Resident #5's quarterly MDS completed on 11/05/24 revealed a BIMS of 15 which indicated intact cognition. Record review of Resident #5's care plan revealed a completion date of 10/27/24. The care plan noted, I am capable of making my own healthcare decisions and giving informed consent. Under the focus area of activities an intervention was, Assist with arranging community activities. Arrange transportation. 4. Record review of Resident #6's admission record dated 11/06/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, alcohol dependence in remission and major depressive disorder (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities). Record review of Resident #6's quarterly MDS completed on 10/16/24 revealed a BIMS of 12 which indicated moderately impaired cognition. Record review of Resident #6's care plan revealed a completion date of 10/27/24. Under the focus area of activities an intervention was, Assist with arranging community activities. Arrange transportation. 5. Record review of Resident #7's admission record dated 11/25/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, anxiety disorder (mental disorder characterized by significant and uncontrollable feelings of anxiety and fear), major depressive disorder (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities), bipolar disorder (serious mental illness characterized by extreme mood swings such as extreme excitement or extreme depressive feelings), and Wernicke's encephalopathy (degenerative brain disorder caused by the lack of vitamin B1). Record review of Resident #7's quarterly MDS completed on 10/24/24 revealed a BIMS of 12 which indicated moderately impaired cognition. Record review of Resident #7's care plan revealed a completion date of 10/23/24. 6. Record review of Resident #8's admission record dated 11/25/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning), intermittent explosive disorder (repeated sudden outbursts of anger), and Parkinson's disease (chronic and progressive movement disorder that initially causes tremors in one hand and stiffness or slowing of movement). (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 #8's quarterly MDS completed on 09/11/24 revealed a BIMS of 00 which indicated severely impaired cognition. Record review of Resident #8's care plan revealed a completion date of 10/27/24. 7. Record review of Resident #9's admission record dated 11/25/24 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning), type 2 diabetes (insufficient production of insulin, causing high blood sugar), and epilepsy (disorder that causes abnormal brain function, seizures). Record review of Resident #9's admission MDS completed on 10/02/24 revealed a BIMS of 2 which indicated severely impaired cognition. Record review of Resident #9's care plan revealed a completion date of 10/27/24. 8. Record review of Resident #10's admission record dated 11/25/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, hemiplegia (partial paralysis) affecting left nondominant side, psychotic disorder with hallucinations (severe mental illness including seeing things that are not there), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it, stroke), and type 2 diabetes (insufficient production of insulin, causing high blood sugar). Record review of Resident #10's quarterly MDS completed on 10/08/24 revealed a BIMS of 14 which indicated intact cognition. Record review of Resident #10's care plan revealed a completion date of 10/27/24. 9. Record review of Resident #11's admission record dated 11/25/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, type 2 diabetes (insufficient production of insulin, causing high blood sugar), cellulitis (common bacterial skin infection that causes redness, swelling, and pain) of trunk, and necrotizing fasciitis (serious bacterial issue affecting tissue under the skin). Record review of Resident #11's annual MDS completed on 09/24/24 revealed a BIMS of 15 which indicated intact cognition. Record review of Resident #11's care plan completed on 10/08/24 revealed the following: . I am capable of making my own healthcare decisions and giving informed consent. 10. Record review of Resident #12's admission record dated 11/25/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, dementia (a group of thinking and social symptoms that interferes with daily functioning), type 2 diabetes (insufficient production of insulin, causing high blood sugar), and paranoid schizophrenia (a mental illness characterized by episodes of psychosis including hallucinations, delusions, and disorganized thinking). (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 #12's quarterly MDS completed on 09/11/24 revealed a BIMS of 13 which indicated intact cognition. Record review of Resident #12's care plan completed on 09/24/24 revealed the following: . I am capable of making my own healthcare decisions and giving informed consent. 11. Record review of Resident #13's admission record dated 11/25/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, bipolar disorder (serious mental illness characterized by extreme mood swings such as extreme excitement or extreme depressive feelings), major depressive disorder (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities), and anxiety disorder (serious mental illness characterized by extreme mood swings such as extreme excitement or extreme depressive feelings). Record review of Resident #13's quarterly MDS completed on 11/04/24 revealed a BIMS of 14 which indicated intact cognition. Record review of Resident #13's care plan revealed it was initiated on 10/16/24. During an interview on 11/06/24 at 09:57 AM ADM was asked for copies of any in-services regarding residents' right to vote. During an observation and interview on 11/06/24 at 10:05 AM Resident #13 stated she wanted to vote but did not get to as her ID was missing. She stated she thought her ID was left at her facility. Resident #13 stated no one asked her if she wanted to vote or offered to help her get an ID. During an interview on 11/06/24 at 10:19 AM OMB stated in August of 2024 she began talking with residents about voting in the 2024 election. She stated in September of 2024 she began talking to ADM and AD about getting residents prepared to vote in the 2024 election. OMB stated in October 2024 she sent emails to ADM regarding residents' voting rights and deadlines to register to vote in person and by mail. During an observation and interview on 11/06/24 at 10:33 AM Resident #2 and Resident #3 were in their room. Resident #3 stated no one asked him if he wanted to vote in the 2024 election. He stated he was registered to vote and would have like to vote. Resident #3 stated, They did not take us out to vote. Resident #2 stated no one asked him if he wanted to vote. He stated, It was like we didn't matter. During an observation and interview on 11/06/24 at 11:34 AM Resident #6 stated he had been in the facility for a year. Resident #6 stated he was registered to vote and wanted to vote but no one spoke to him about voting in the 2024 election. During an observation and interview on 11/06/24 at 12:11 PM Resident #5 asked if facility staff assisted her in voting in the 2024 election she stated, No! And I am very upset about that! I was told nobody got a card (to vote by mail). No one in here (facility) voted except the people who work here. When asked if she told staff she wanted to vote she stated, No, I just assumed I would get to because I am registered to vote. (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 11/06/24 at 03:40 PM ADM was asked for copies of any in-services regarding residents' right to vote. She stated she would ask DON and ADON if there were any in-services on that subject. During an interview on 11/07/24 at 10:58 AM SW stated she did not remember OMB speaking to her about residents voting rights. She stated, I am not in charge of voting. SW stated ADM did not speak to her about residents voting rights. She stated she did not know what the facility policy on resident's voting rights contained. SW stated she thought AD oversaw helping residents vote. She stated a possible negative outcome of residents not being assisted to vote was possible because it is a citizen right. It is a duty and right people should have the option to exercise. During an interview on 11/07/24 at 11:03 AM LVN C stated she was not talked to by anyone in administration regarding residents' right to vote. She stated, I think they (residents) should be able to vote if they want to or choose to. During an interview on 11/07/24 at 11:48 AM AD stated OMB did not speak to her about residents' right to vote. She stated ADM spoke to her about getting residents ready to vote. She stated she was not aware the facility had a policy that addressed residents' right to vote. AD stated, I truly believe it is very important for them (residents) to vote if they choose to vote. She stated on 10/07/24 she was told by ADM to talk to residents about voting so we did that as like an activity. AD stated the facility only had one resident who was registered to vote in the facility's county and that resident chose not to go vote when the day came. AD did not have an answer to what she did to assist other interested residents in registering to vote in the facility's county. When asked if residents who were registered to vote in other counties were assisted to register in the facility's county AD stated, They chose not to. When asked if she received an email regarding voter registration deadlines, AD stated, Yes, and they chose not to. She stated zero residents voted in the 2024 election. She stated she could see how not being assisted to vote in the 2024 election could have negatively affected residents. AD stated she spoke to Resident #6, and he told her he wanted to vote but chose not to. She stated she spoke to Resident #5 about voting but Resident #5 did not have any ID as her purse was misplaced at the last nursing home. AD stated she did not attempt to contact the previous nursing home or help Resident #5 apply for a new ID so she could register to vote in the facility's county. She stated she did not speak to Resident #3 about voting in the 2024 election. She did not give a reason for not speaking to Resident #3. AD stated she did not speak to Resident #4 about voting because Resident #4 was not feeling well on 10/07/24 when AD held the activity to talk to residents about voting. During an interview on 11/07/24 at 12:11 PM OMB stated the facility was responsible to assist residents who were not registered in the facility's county to register in that county in time to cast their vote in the 2024 election. During an interview on 11/07/24 at 01:02 PM ADON stated she did not receive any emails, directives, or trainings regarding assisting residents to vote in the 2024 election. She stated a possible negative outcome of residents not exercising their right to vote was, You don't get the president you want. (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 11/07/24 at 1:08 PM DON stated she did not have any training on assisting residents to vote. She stated she did receive an email regarding residents voting rights and deadlines to register to vote. She searched on her computer and stated the email was sent to AD and SW and the business office manager. DON stated she was copied on the email. She stated the email was sent on 10/04/24. DON stated she was not sure if zero or 1 resident from the facility voted in the 2024 election. During an interview on 11/07/24 at 1:20 PM ADM stated she could not remember if OMB spoke to her about residents' voting rights because usually when she calls or comes in, she has a lot to tell me. She stated she did remember receiving an email from OMB about residents' voting rights and deadlines to register to vote. ADM stated OMB sent her the email on 10/03/24. ADM stated the negative outcome of residents not being assisted to vote was, They didn't get to exercise that right. During an observation and interview on 11/25/24 at 09:50 AM Resident #10 stated no one asked her if she wanted to vote. She stated she did want to vote. Resident #10 said of not being assisted to vote, It sorta hurt my feelings. I was hoping to. During an observation and interview on 11/25/24 at 10:01 AM Resident #9 stated he wanted to vote and not one asked him if he needed help voting or registering to vote. During an observation and interview on 11/25/24 at 10:05 AM Resident #3 stated of voting, I wanted to, why didn't I get to? Of not voting, he stated, It felt bad. During an observation and interview on 11/25/24 at 10:11 AM Resident #7 stated he wanted to vote and no one asked him about voting. When asked how he felt about not being assisted to vote, he stated, Just part of the deal I guess. During an observation and interview on 11/25/24 at 10:15 AM Resident #8 stated he was going to (vote), but it didn't happen. He stated, It didn't feel good. I was going to vote for the woman. During an observation and interview on 11/25/24 at 10:22 AM Resident #11 stated he wanted to vote but, I don't live here. He stated staff did not ask him if he wanted to vote or wanted assistance registering to vote in the facility's county. During an interview on 11/25/24 at 11:09 AM ADM stated the only documentation AD had of her meeting with residents regarding voting was the written statement already provided. When asked if there was a list of residents who attended the meeting, ADM stated AD told her it would be in the Resident Council minutes. ADM provided Resident Council minutes dated 09/03/24 and 10/01/24. During an observation and interview on 11/25/24 at 11:53 AM Resident #12 stated she wanted to vote. She stated no one asked her if she wanted to vote or needed help doing so. During an interview on 11/25/24 at 12:45 PM ADM and VPC were on speaker phone with AD. VPC said to AD regarding residents voting, We usually try to start in August or September to at least show that we are trying and documenting the trying. VPC stated every resident must be interviewed about interest in voting regardless of BIMS and their responses must be documented. (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 11/25/24 at 12:50 PM VPC stated AD did not document speaking with residents about voting. She stated AD did not document residents declining to vote. She stated she would begin interview each resident and document their responses today. Record review of Resident Council minutes dated 09/03/24 revealed no mention of voting. Record review of Resident Council minutes dated 10/01/24 revealed no mention of voting. Record review of written statement provided by AD to the State Surveyor revealed the following: On October 7, 2024, I ([first name of AD] Activity Director) asked all residents with a BIMS score of 10 or higher if they would like to vote. Of the residents that I asked only 1 was registered in [facility's county]. However, she was not feeling well and chose to NOT go vote. The others that I asked are not registered in [facility's county] and they all declined to go vote citing a disinterest in voting period. The first week of December we will follow up with those residents to see if they would like to get registered here in [facility's county] in case they want to participate in future elections. Record review of facility policy titled Resident Rights and dated 2024 revealed the following: . The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 1. Exercise of rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. a. The resident has the right . to be supported by the facility in the exercise of his or her rights. Record review of facility policy titled Resident Right to Vote and dated 2024 revealed the following: .It is the policy of this facility to support residents in exercising their right to vote, as a resident of the facility and as a citizen or resident of the United States. 2. All residents should have access to timely information about upcoming elections. 4. The social worker, social service designee, or assigned staff member should be familiar with the voting requirements of that district, as it relates to voter registration, absentee ballots, and voting facilities. 6. Prior to an election, the social worker, social service designee or assigned staff member should identify the residents who choose to vote, and identify the residents who need to register. 7. Prior to an election, the social worker, social service designee, or assigned staff member should obtain forms and assist residents with registration, as needed. 8. Prior to an election, the social worker, social service designee, or assigned staff member should obtain absentee ballots for residents unable to go to the voting facility, as provided by the voting district. 13. The social worker, social service designee, or assigned staff member should document the method by which the resident voted, . If the resident refuses to vote, the refusal should be documented.

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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** 46534 Based on observation, interview, and record review the facility failed to ensure each resident had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 2 (Resident #1 and Resident #4) of 6 residents and 3 (Room A2, Room A7, and Room A9) of 8 rooms on the locked unit reviewed for environment. 1. The facility failed to ensure Resident #1 had a sink in his bathroom for approximately a week. 2. The facility failed to ensure Resident #4 had a sink in her bathroom for an undetermined period of time. 3. The facility failed to ensure the sinks in the bathrooms of Room A2, Room A7, and Room A9 were securely attached to the wall. These failures could place residents at risk of injury, infection, and feeling ill at ease in their living environment. Findings Included: 1. Record review of Resident #1's admission record dated 11/06/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), impulse disorder (lack of ability to control self), prostate cancer, and anxiety disorder (mental disorder characterized by significant and uncontrollable feelings of anxiety and fear). Record review of Resident #1's MDS tab in his EHR revealed his admission MDS was in progress. Record review of Resident #1's in progress admission MDS revealed section C was complete. Resident #1 had a BIMS of 1 which indicated severely impaired cognition. Record review of Resident #1's care plan, initiated on 10/27/24, revealed Resident #1 required staff participation to use the toilet, get dressed, and bathe. Record review of Resident #4's admission record dated 11/06/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, diffuse traumatic brain injury with loss of consciousness of unspecified duration (a severe type of traumatic brain injury that occurs when the brain rapidly shifts inside the skull), epilepsy (disorder that causes abnormal brain function, seizures), and cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning). Record review of Resident #4's annual MDS completed on 11/05/24 revealed the following: Section C: Resident #4 had a BIMS score of 13 which indicated intact cognition. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section E: Resident #4 exhibited no behaviors. Section GG: Resident #4 had no impairment of upper or lower extremities and used a w/c for mobility. Resident #4 was independent or required set up or clean up assistance across all ADLs except for oral hygiene, tub/shower/toilet transfer, and walking 10 feet where she required supervision or partial/moderate assistance. Section H: Resident #4 was frequently incontinent of bladder and occasionally incontinent of bowel. Record review of Resident #4's care plan completed 08/31/24 revealed Resident #4 was to be encouraged to do what he/she is capable of doing for (her)self in relation to ADLs. Resident #4 was PASRR positive for intellectual disability and developmental disability. She required staff assistance with personal hygiene. Record review of Resident #4's progress notes from 09/06/24 to 10/07/24 revealed the following note written on 10/06/24 by LVN C: was alerted per staff CNA resident was washing her hands in to actual toilet basin, states her sink is broken and she needs to wash her hands somewhere; staff CNA showed resident where a common bathroom is so that she could wash her hands; . During an observation and interview on 11/06/24 at 10:09 AM MS was unwrapping a new sink from cardboard. He stated he was replacing a resident's sink so the resident would have a sink with a cabinet underneath to make it sturdy. He stated a resident on the locked unit was without a sink for a week. I had to order it (the sink). MS stated the sink the resident on the locked unit had prior to the new one he ordered was pulled off the wall by the resident and broke on the floor. Hs said, We are starting to put these in (sinks with cabinets underneath) because that way when they (residents) pull on it, it has support. During an observation and interview on 11/06/24 at 10:26 AM Resident #4 was asked if staff helped her wash her hands she stated, No, they expect us to do that on our own. When asked if she had always had a sink in her bathroom she stated, No. The sink was weak and I am very strong, and it fell on the floor and broke to pieces. Resident #4 stated she has a new sink with a cabinet underneath it in her bathroom now. Resident #4 stated she was not sure how long she was without a sink and added, They didn't replace it quickly. It took a long time to have a sink in there. I was washing my hands in the commode water, you know, the clean water, after you flush it, and it fills up with clean water? She stated the sink was out of her bathroom for more than a week and possibly more than a month. During an observation and interview on 11/06/24 at 11:45 AM Resident #1's family member stated Resident #1's bathroom did not have a sink for a few days. She stated, Where was he supposed to wash his hands. I mean he has Alzheimer's. It is hard for him to remember on a good day when there is a sink. Resident #1's bathroom, on the locked unit, had a new sink with a cabinet underneath the sink. 2. During an observation on 11/06/24 at 11:51 AM the sink in Room A2 of the locked unit was loosely attached to the wall. There was a line of whitish caulking along the top back edge of the sink. Between this line of caulking and the wall was a space of approximately 1/8th of an inch. When the sink was touched under the front edge it was easily moved up and down. One resident resided in Room A2. (continued on next page)

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Cambridge Ltc Partners Inc	1621 Butler Dimmitt, TX 79027

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/06/24 at 11:52 AM the sink in Room A7 of the locked unit was loosely attached to the wall with a space between the top back edge of the sink and wall that measured approximately 1/8th of an inch. When the sink was touched under the front edge it was easily moved up and down. One resident resided in Room A7. During an observation on 11/06/24 at 11:52 AM the sink in Room A9 of the locked unit was loosely attached to the wall with a space between the top back edge of the sink and wall that measured approximately 1/8th of an inch. When the sink was touched under the front edge it was easily moved up and down. One resident resided in Room A9. Observations on 11/06/24 from 11:53 AM to 12:03 PM of the other 4 rooms on the locked unit revealed one room with a pedestal sink and three rooms with sinks that were firmly attached to the wall and when touched under the front edge were not moveable up or down. During an interview on 11/06/24 at 12:10 AM DON stated the facility did not have a policy addressing resident's hand hygiene and the role staff played in said. She stated, No facility has that. It is just standard precautions that when they have soiled hands, we wash their hands. During an interview on 11/07/24 at 11:03 AM LVN C stated she could not remember which CNA told her Resident #4 was washing her hands in the toilet bowl. She stated Resident #4 did not have a sink that day because her sink had just fallen off and broken on the floor. LVN C stated a resident not having a sink in their bathroom could be detrimental especially if the resident did not really understand what good hand hygiene was or had Alzheimer's or dementia. She stated Resident #4's sink was replaced the following day. She stated she had no knowledge of any other resident being without a sink in their bathroom. LVN C stated if a resident's sink was not securely fastened to the wall it could fall off the wall. During an interview on 11/07/24 at 11:19 AM MS stated the only resident room that had been without a sink for more than a few hours was A4 on the locked unit. He stated Resident #4 had broken two sinks, at different times, in her bathroom by grabbing them and causing them to fall on the floor. MS stated that was the reason for replacing her sink with one with a cabinet underneath. He stated she was without a sink for one evening before he installed the new sink. MS stated, I don't really see it (a resident not having a sink in their bathroom) being negative. It is just our concern to make sure they get what they need as quick as possible. They (residents) might see if differently depending on the day they were having. MS stated he had not noticed any sinks on the locked unit being loosely attached to the wall. He said he could not think of a negative outcome for residents if sinks were loosely attached to the wall. During an interview on 11/07/24 at 11:25 MS stated he had looked at the sinks in the locked unit. He stated, I see what you are saying (about some of the sinks being loose). He stated the sinks were made to slide into a bracket and would, therefore, always be loose. He stated he would have to put a pedestal under the sinks to keep them from being loose. He stated he was not sure why some sinks were loose, and others were not. (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 11/07/24 at 01:02 PM ADON stated she knew some residents' sinks were loose because the residents used the sinks to pull themselves up to standing. She stated loose sinks could result in residents hurting themselves. She stated when a sink is broken it is a process to order a new sink and get it installed. She stated that process would probably take a couple days. She stated not having a functional sink in their bathrooms could affect residents negatively, Because they need to wash hands after they use the bathroom. During an interview on 11/07/24 at 01:08 PM DON stated she knew of one resident who did not have a sink in their room for a few days. She named Resident #1's roommate. She stated she did not know how long Resident #1's bathroom was without a sink. She stated she could not think of a negative outcome for a resident not having a sink in their bathroom because, There are other sinks available where we can take them to wash their hands. DON stated she had not noticed any residents' sinks being loosely attached to the wall. She stated she could not think of a negative outcome of a sink loosely attached to the wall as long as there is working water. During an interview on 11/07/24 at 01:20 PM ADM stated she did not see a negative outcome for residents not having sinks in their bathrooms because, We have the shower room. She stated since she had been employed with the facility (her hire date was 07/15/24) she knew of 2 sinks that had fallen off the wall. She stated a negative outcome to residents of loosely attached sinks was They (sinks) could fall off. Record review of facility policy titled Resident Rights and dated 2024 revealed the following: . The resident has the right to a dignified existence . The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences . The resident has the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Record review of facility policy titled Safe and Homelike Environment and dated 2024 revealed the following: . In accordance with resident rights, the facility will provide a safe, clean, comfortable and homelike environment . This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independent and does not pose a safety risk. Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms . Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in the completion of the activities of daily living.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on observation, interview, and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 (Resident #1) of 6 residents reviewed for abuse and neglect. The facility failed to report to the State Survey Agency Resident #1's black eye within 24 hours of discovery of the injury. This failure could place residents at risk of continued and/or unrecognized abuse or neglect. Findings Included: Record review of Resident #1's admission record dated 11/06/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), impulse disorder (lack of ability to control self), prostate cancer, and anxiety disorder (mental disorder characterized by significant and uncontrollable feelings of anxiety and fear). Record review of Resident #1's MDS tab in his EHR revealed his admission MDS was in progress. Record review of Resident #1's in progress admission MDS revealed section C was complete. Resident #1 had a BIMS of 1 which indicated severely impaired cognition. Record review of Resident #1's care plan, initiated on 10/27/24, revealed a focus area initiated on 11/06/24 which noted he had a bruise to his left eye. The care plan revealed, resident hit self with phone to chin area and left eye while on phone. Another focus area initiated on 11/06/24 revealed, I am prone to skin tears and bruising of unknown origin related to fragile skin. The interventions for this focus area did not mention notifying state survey agency. Record review of Resident #1's progress notes revealed the following notes: A note written by LVN G on 10/27/24 at 06:58 PM entered as LATE ENTRY This nurse when entering unit to do medication pass, resident sitting in chair in common area and this nurse noted dark purple bruising to left eye. No s/s of pain or discomfort noted. Resident unable to state what occurred. DON notified . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A note written by LVN D on 10/28/24 at 11:19 AM Notified [family members of Resident #1] that resident has a black eye. [first name of DON] DON et [first name of ADON] ADON investigating. [first name of ADM] Administrator . notified. The note continued to address Resident #1's family member being upset, requesting to speak to management, and the call being transferred to management. A note written by LVN G on 10/28/24 at 10:04 PM Notified DON, [first name of ADM], NP and [family member of Resident #1] of received X-ray results. No evidence of acute fracture. No significant soft tissue abnormality. A note written by LVN G on 10/28/24 at 10:56 PM . Continues with black left eye and no pain or discomfort noted. A note written by ADON on 10/29/24 at 02:29 PM received message to have resident call [family member] back. X1 assist with cna from secured unit to phone at nurse's desk. Writer at nurse's desk placed call and phone given to resident. At this time resident grabs phone cord and tries to unravel cord and hits self with receiver part of phone underneath left eye states ouch asked if he was ok while he is still waiting for daughter to answer phone continues to unravel cord and hits self again of receiver part of the phone to left lateral chin area asked resident to give writer the phone. redialed number and held phone until daughter answered and handed resident phone. noted small area with purple discoloration to left lateral chin. bruising underneath left eye has no change. notified daughter after phone callcompleted [sic] with resident of x 2 hits to self with phone. verbalized understanding. called and left message with [first name of receptionist] from [name of hospice] to have nurse call back. call back pending. [first name of ADM] admin notified; [first name of DON] RN DON notified. resident declined he was in pain. no facial grimacing noted or guarding of face. A note written by ADON on 10/29/24 at 04:50 PM received call back from nurse from [name of hospice]. called this am at 1136am call back at 1650 (04:50 PM) stated message just received. explained bruising has increased to left eye and incident that happened this am from resident hitting self with phone to chin area and left eye while on phone. [Name of hospice] nurse concerns of cameras available in lobby. explained to [name of hospice] nurse cameras are only in secured unit and resident was at nurses' desk in front of writer when incident happened. did explainthat [sic] we will monitor bruising r/t dx of prostate cancer may have increase bruising. Record review of Resident #1's Weekly Skin Assessment updated completed on 10/24/24 at 11:28 AM by LVN D revealed Resident #1 had no bruises. Record review of an untitled, three-page document provided by DON and dated 10/27/24 revealed a heading of #2030 Skin Alteration Date 10/27/24 18:35 (06:35 PM) Resident: [first and last name of Resident #1] Incident Location: Hallway Person Preparing Report: [first and last name of LVN G] across the top of all three pages. A section titled Incident Description noted This nurse when entering unit to do mediation pass, resident sitting in chair in common area and this nurse noted dark purple bruising to left eye. No s/s of pain or discomfort noted. Resident unable to state what occurred. Resident unable to give description. A section titled Notes and written by DON revealed, in part: 10/27/24 Received a message at 1847 (06:47 PM) from [first name of LVN G]/LVN of fresh bruise noted to residents left side of face. Unable to return call to nurse until 2120 (09:20 PM). Notified [first name of ADM]/administrator at 2130 (09:30 PM) . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Weekly Skin Assessment updated completed on 10/28/24 at 07:50 AM by ADON revealed a bruise 4cm x1 cm light maroon color underneath left eye. Record review of Resident #1's Weekly Skin Assessment updated completed on 10/29/24 at 11:26 PM by ADON revealed bruising increased underneath left eye from previous injury bruising pea sz (size) to left lateral chin area. During an observation and interview on 11/06/24 at 11:40 AM Resident #1 was seated in a chair in the common area of the locked unit. He had a purple spot the size of a quarter down and to the left of his left eye. He was able to shake hands and introduce himself. When asked how the bruise happened, Resident #1 smiled and said he did not know. During an interview on 11/06/24 at 11:40 AM Resident #1's family member stated the family was concerned about him having a black eye and bruising to his face. During an interview on 11/07/24 at 11:03 AM LVN C stated the protocol when a resident had an injury of unknown origin was to first of all report it to everybody, DON, ADON, doctor, family, and then investigate to figure out what happened. She stated she did not really know anything about Resident #1's black eye except that after he had the original black eye, she witnessed him accidently hit himself in the face with the phone receiver in the lobby area. She stated she and the ADON were present during that incident. LVN C stated an injury of unknown origin was to be reported immediately. During an interview on 11/07/24 at 11:28 AM CNA E and CNA F stated they noticed Resident #1's bruise at the same time LVN G noticed the bruise. They stated an injury of unknown origin was to be reported immediately to the nurse. During an interview on 11/07/24 at 01:02 PM ADON stated injuries of unknown origin are to be reported immediately. She said if an injury of unknown origin was not reported immediately it could get worse. ADON stated she and DON did an investigation into Resident #1's black eye and they were unable to determine how it happened. She stated she saw Resident #1 hit himself in the face with the phone receiver two days after he got the black eye. During an interview on 11/07/24 at 01:08 PM DON stated LVN G notified her about Resident #1's black eye via a voicemail message at 06:47 PM on 10/27/24. DON stated she was taking a nap and did not listen to the message until 09:20 PM the same day and she called ADM at 09:30 PM to notify her of the injury. DON stated staff were to report injuries of unknown origin immediately to administration and administration was to report them to state within 24 hours. When asked why Resident #1's injury of unknown origin was not reported within 24 hours to state, DON stated, Because we were conducting our investigation. She stated she could not think of a possible negative outcome of not reporting to state timely because he was not in any immediate harm. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/07/24 at 01:20 PM ADM stated she was notified by DON via text message on 10/27/24 of Resident #1 black eye. She stated the injury was not reported to state within 24 hours because, When it first happened the working idea was that him picking up that phone with his left hand and they observed him hitting himself in the face. I was investigating and had a working probability but with daughter not feeling comfortable with that I decided to self-report it. She stated she did not think there was a possible negative outcome of not reporting timely because Resident #1 was safe, no falls, no incidents with residents or staff and we had him on neuro (neurological) checks and x-ray. During an interview on 11/07/24 at 03:12 PM LVN G stated she reported Resident #1's black eye to DON right away after I assessed him. She stated injuries of unknown origin were to be reported right away. She stated a resident might be abused or neglected if an injury was not reported timely. Record review of Incidents by Incident Type report for August 2024 to October 2024 revealed Resident #1 under the Skin Alteration Incidents on 10/27/24 at 06:35 PM and under the Self Inflicted Injury Incidents on 10/29/24 at 11:30 AM. Record review of facility staff in-services on abuse, neglect, and exploitation from 08/06/24 to 11/06/24 revealed one training offered to staff over three days from 10/30/24 to 11/01/23. Record review of facility policy titled Incidents and Accidents and dated February 2023 revealed the following: . The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. Meeting regulatory requirements for analysis and reporting of incidents and accidents. Incidents that rise to the level of abuse, misappropriation, or neglect, will be managed and reported according to the facility's abuse prevention policy. The following incidents/accidents require an incident/accident report but are not limited to: . Self-inflicted injuries . Unobserved injuries . Record review of facility policy titled Abuse, Neglect and Exploitation and dated August 2024 revealed the following: . Possible indicators of abuse include, but are not limited to: . Physical marks such as bruises . on a resident's body Physical injury of a resident, of unknown source . The facility will have written procedures that include: Reporting all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies . within specified timeframes: Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.