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	04/09/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on interview, and record review, the facility failed to ensure all residents had the right to formulate an advanced directive for 1 (Resident #21) of 13 residents reviewed for advanced directives. Resident #21 had a DNR in his record that was missing information in the Two Witness's Section. The facility's failure to ensure the accuracy of a residents advanced directive such as a DNR (Do Not Resuscitate), recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care could place residents a risk for not receiving healthcare as per their or their legal representatives wishes. Findings included: Record review of Resident #21's face sheet printed [DATE] revealed he was a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), intermittent explosive disorder(repeated sudden outbursts of anger), diabetes(a chronic condition that affects the way the body processes blood sugar (glucose), psychoactive substance abuse (a strong desire or sense of compulsion to take the substance), hypertension (a condition in which the force of the blood against the artery walls is too high), and cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). Resident #21's last MDS was a quarterly assessment completed [DATE] listing him with a BIMS of 6 indicating he was severely cognitively impaired, and he had a functionality of requiring substantial to maximal assistance with most of his activities of daily living. Under the section Advanced Directives Resident #21 was listed as a DNR. Record review of Resident #21's care plan revealed the following: Focus: CODE STATUS: .DNR Date Initiated: [DATE] Revision on: [DATE]. Goal: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	My Advance Directives are in effect, and they will be carried out in accordance with my wishes on an ongoing basis through next review date. Date Initiated: [DATE] Target Date: [DATE]. Interventions: - Ensure staff aware of DNR status Date Initiated: [DATE] Revision on: [DATE] - Ensure that a copy of my Advance Directive is on my medical record and accessible. Date Initiated: [DATE]. - I understand that an Advance Directive can be revoked or changed if I, or my appointed health care representative, change our mind about the medical care we want delivered. Date Initiated: [DATE]. Record review of the clinical record for Resident #21 revealed an Order Summary with active orders as of [DATE] with the following order: DNR (with an order date of [DATE]) Record review of the clinical record for Resident #21 revealed a DNR dated [DATE] (signed by the physician) with the following: Section-Two Witnesses-There was no information or signatures provided. Section-Directive by two physicians-There was a notary stamp with no signature provided on or for the stamp. Section-All persons who have singed above must sign below, acknowledging that this document has been properly completed. -This is the only section that has the notary signature. During an interview on [DATE] at 02:00 PM ADON A verified that she was the nurse responsible for Resident #21 this shift. ADON A verified that Resident #21 was currently a DNR and that if he coded which meant he was discovered without a heartbeat or respirations she would not code him (not start CPR) and she would notify the doctor, the DON, and the family. When asked to review Resident #21's DNR in his electronic record ADON A reported that the DNR form was not correctly filled out and therefore was not valid or current so she (ADON A) would have to start CPR if Resident #21 coded. ADON A reported that due to the invalid DNR Resident #21 was currently considered a full code. ADON A reported that if the DNR process was not completed correctly then the residents wishes, and care would be affected. She stated that a staff member will do a full code on a resident that does not wish to have CPR. ADON A also reported that the family's wishes would not be followed if they had to ignore the DNR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:13 AM the DON reported that the DON was the ultimate responsible person for ensuring that the DNR was completed and accurate. The DON reported that she was currently the interim DON until a permanent DON can be hired. The DON reported that the DNR process was started upon admission, then goes to the DON to ensure it was correct, that the DON was the final piece. The DON reported that if the DNR process is not completed correctly then they are not following resident wishes, they are violating resident rights. Record review of the facility provided policy titled Resident Rights Regarding Treatment and Advanced Directives date implemented [DATE], revealed the following: Policy: It is the policy of this facility to support and facilitate a resident right to request, refuse, and/or discontinue medical or surgical treatment and to formulate an advanced directive. Definitions: Advance Directive-is a written instruction .recognized under State Law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Record review of the OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER-TEXAS DEPARTMENT OF STATE HEALTH SERVICES, undated revealed the following: -The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professional

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39813 48161 Based on observation, interview, and record review, the facility failed to provide a comfortable environment for 4 of 10 anonymous residents reviewed for environment and a homelike environment for 9 (Resident #2, #4, #21, #22, #27, #34, #36, #41, and #96) of 19 residents reviewed for environment. The facility failed to ensure during dining times that residents had comfortable sound levels that encouraged interactions. The facility failed to provide any furnishings to promote a homelike environment for 9 residents residing in the locked unit. This failure could place residents at risk for increased stress and affecting residents overall wellbeing. This failure could place residents at risk for diminished quality of life due to the lack of a well-kept environment. Findings included for comfortable sound levels: Record review of Resident #23's face sheet printed on 04/8/2024 revealed at [AGE] year-old resident admitted to the facility on [DATE] with diagnoses to include schizoaffective disorder (mental disorder), anxiety disorder, cognitive communication deficit (problems with communication), dysarthria (difficulty in speech due to weakness of speech muscles), anarthria (inability to produce clear speech), and pseudobulbar affect (inappropriate involuntary laughing or crying). Record review of Resident #23's quarterly MDS dated [DATE] revealed the resident had a BIMS score of 03 which indicated that she had severe impairment. The MDS also revealed that Resident #23 was rarely/never understood but related to ability to understand others, responds adequately to simple, direct communication. Record review of Resident #23's care plan dated 01/19/2024 revealed the following: Focus: Communication: Resident #23 had a communication deficit and had difficulty making self-understood. Goal: Encourage resident to continue stating thoughts even if resident had difficulty. Focus on a word or phrase that made sense or responded to the feeling resident tried to express. (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 #28's face sheet printed on 04/08/2024 revealed a [AGE] year-old resident admitted to the facility on [DATE] with diagnoses to include Cerebral Palsy, schizoaffective disorder(delusions), bipolar type (episodes of mood swings), anxiety disorder, unspecified, intermittent explosive disorder, down syndrome, need for assistance with personal care, cognitive communication deficit, and pseudobulbar affect (uncontrollable crying or laughing). Record review of Resident #28's quarterly MDS dated [DATE] revealed resident had a BIMS score of 04 which indicated that she had severe impairment. Section B0100 revealed that Resident #28 had difficulty communicating some words or finish thoughts but was able if prompted or given time. Record review of Resident #28's care plan dated 01/26/2024 revealed the following: Focus: Communication: Resident #28 had a communication problem related to making self-understood. Goal: Be conscious of resident position when in groups, activities, dining room to promote proper communication with others. During an observation on 04/07/2024 at 12:18 PM Resident #23 was sitting in her wheelchair at a dining room table, during lunch time, trying to communicate with staff in the dining room yelling in frustration. During an observation on 04/07/2024 at 12:25 PM Resident #28 was sitting in her wheelchair at a dining room table waiting for lunch to be served. Resident #28 started yelling in the dining room trying to get staff's attention. Staff attended to Resident #28. Observation of Resident #28 content while staff assisted her. During on observation on 04/08/2024 at 8:00 AM Resident #28 was sitting in her wheelchair at a dining room table waiting for breakfast to be served. Resident #28 was yelling. An anonymous resident put his finger up to his lips telling her to shhh and another anonymous resident told her to be quiet. Staff attended to Resident #28. Observation of Resident #28 content while staff assisted her. During an anonymous interview on 04/08/2024 at 11:00 AM with 10 residents, 4 of those residents stated that they do not like eating in the dining room due to the noise level of some of the residents yelling. During an interview on 04/09/2024 at 03:00 PM the SW stated that when Resident #28 and #23 yell it disrupts other residents in the facility. During an interview on 04-09-2024 at 08:45 AM CNA D stated she has worked at the facility for [AGE] years and stated that it was a normal occurrence for Resident #28 and #23 to yell in the dining room. During an interview on 04/09/2024 at 8:59 AM the ADM stated that the noise level in the dining room was disruptive to other residents trying to eat. The ADM stated that the past administration had tried interventions such as serving the residents that were disruptive first and stated she would be looking into new interventions for those specific residents. Findings for furnishings included: Resident #2 (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 #2's face sheet printed 4-8-2024 revealed he was an [AGE] year-old male resident admitted to the facility originally on 1-24-2024 and readmitted on [DATE] with diagnoses to include cardiac arrythmia (a condition in which the heart beats with an irregular or abnormal rhythm), psychotic disorder with hallucination (severe mental illness including seeing things that are not there), major depressive disorder(a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), intermittent explosive disorder(repeated sudden outbursts of anger, Alzheimer's (a progressive disease that destroys memory and other important mental functions), and diabetes(a chronic condition that affects the way the body processes blood sugar (glucose). His last MDS was a quarterly completed on 3-6-2024 listing him with a BIMS of 3 indicating he was severely cognitively impaired, and he had a functionality of partial to moderate assistance with most of his activities of daily living. Record review of Resident #2's care plan revealed the following: Focus: Activities: Resident #2 is dependent on staff for activities, cognitive stimulation, social interaction. Residents wish to participate in 1:1 activities at this time. Hand Massages, reading newspaper, watching TV. Date Initiated: 03/01/2024 Revision on: 04/08/2024 Goal: The resident will maintain involvement in cognitive stimulation, social activities as desired through review date: Date Initiated: 03/29/2024 Revision on: 03/29/2024 Target Date: 05/30/2024. During an observation and interview on 04-07-2024 at 09:29 AM Resident #2 was not in his room. There were no furnishings in the room other that Resident #2's bed and a small dresser. No TV, no personal belongings, nothing hanging on the wall other than a March 2024 activity calendar that was hanging on the wall. Resident was observed in the main room in the locked unit sleeping in a recliner. He did not wake to introduction or questions. Resident #4 (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 #4's face sheet printed 4-8-2024 revealed he was a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include dementia(a group of thinking and social symptoms that interferes with daily functioning), anxiety(a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), psychotic disorder with hallucination(severe mental illness including seeing things that are not there), major depressive disorder(a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), intermittent explosive disorder(repeated sudden outbursts of anger), diabetes(a chronic condition that affects the way the body processes blood sugar (glucose), and hypertension(a condition in which the force of the blood against the artery walls is too high). His last MDS was a quarterly completed on 2-23-2024 listing him with a BIMS that required staff assessment due to his memory impairment, and he had a functionality of partial to moderate assistance with showering and toileting and touch assistance with most of his other activities of daily living. Record review of Resident #4's care plan revealed the following: Focus: Activities: Resident #4 is dependent on staff for activities, cognitive stimulation, social interaction r/t Cognitive deficits. Date Initiated: 01/26/2024 Revision on: 01/26/2024 Goal: The resident will maintain involvement in cognitive stimulation, social activities as desired through review date. Date Initiated: 01/26/2024 Revision on: 03/14/2024 Target Date: 06/27/2024 During an observation and interview on 04-07-2024 at 09:33 AM Resident #4 was in his room lying on top of his bed with his head under his sheet. He did not respond to knocking or introduction. He did appear to be awake with movement of his head. His room was clean but had no furnishing or personal belongings other that a bed and a small dresser. There was nothing hanging on his walls and no TV present. Resident #21 Record review of Resident #21's face sheet printed 4-8-2024 revealed he was a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), intermittent explosive disorder(repeated sudden outbursts of anger), diabetes(a chronic condition that affects the way the body processes blood sugar (glucose), psychoactive substance abuse (a strong desire or sense of compulsion to take the substance), hypertension(a condition in which the force of the blood against the artery walls is too high), and cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). His last MDS was a quarterly completed 3-1-2024 listing him with a BIMS of 6 indicating he was severely cognitively impaired, and he had a functionality of requiring substantial to maximal assistance with most of his activities of daily living. Record review of Resident #21's care plan revealed the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus: Activities: Resident #21 is dependent on staff for activities, cognitive stimulation, social interaction r/t cognitive impairments. Date Initiated: 03/14/2024 Revision on: 03/27/2024 Goal: The resident will maintain involvement in cognitive stimulation, social activities as desired through review date. Date Initiated: 03/14/2024 Revision on: 03/27/2024 Target Date: 06/19/2024 During an observation and interview on 4-7-2024 at 09:21 AM Resident #21 was in his room, in his bed, under his covers. He appeared in good condition but did not wake to knocking or introduction. Resident #21's room was clean but did not have any furnishings other that his bed and small dresser. He had nothing on his walls, no pictures, calendars, etc. Resident #22 Record review of Resident #22's face sheet printed 4-8-2024 revealed he was a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interferes with daily functioning), psychotic disorder with delusion (severe mental illness including distorted beliefs), diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), major depression, (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), hypertension(a condition in which the force of the blood against the artery walls is too high), atrial fibrillation(an irregular, often rapid heart rate that commonly causes poor blood flow), cerebral infraction(occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), and altered mental status. His last MDS was a quarterly completed on 2-13-2024 listing him with a BIMS of 8 indicating he was moderately cognitively impaired, and he had a functionality of substantial to maximal assistance with most of his activities of daily living. Record review of Resident #22's care plan revealed the following: Focus: Secure unit: Resident #22 is at risk for feeling of isolation d/t being on facility secured unit r/t (high risk elopement) r/t exit seeking behaviors and poor safety awareness. Date Initiated: 01/30/2024 Revision on: 01/30/2024 Goal: Resident will not have feelings of isolation and will feel safe and secure in the care received while on the secured unit. Date Initiated: 01/30/2024 Target Date: 05/13/2024 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4-7-2024 at 09:18 AM Resident #22 was in his room sleeping in his bed under his covers. Resident #22 did wake to knocking and stated very good but had no other response to questions. The only furnishing present in the room were his bed and small dresser. Resident #22 had a March 2024 activity calendar hanging on his wall and nothing else such as pictures, family photos, or a TV. During an interview on 04-09-2024 at 08:49 AM Resident #22 (with staff member LVN C translating) when questioned if he would like to have personal belonging such as family photos in his room stated, Why, I wouldn't remember anyways and all my family is growing and changing, Resident #27 Record review of Resident #27's face sheet printed 4-8-2024 revealed he was a [AGE] year-old resident admitted to the facility on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interferes with daily functioning), cerebral infarction(occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), psychotic disorder with delusion(severe mental illness including distorted beliefs), personality change(a personality disorder characterized by sever mood swings, impulsive behavior, and difficulty forming stable personal relationships), bipolar disorder(a disorder associated with episode of mood swings ranging from depressive lows to manic highs), chronic viral hepatitis, (inflammation of the liver) Mood disorder (marked disruptions in emotions), and hypertension (a condition in which the force of the blood against the artery walls is too high). His last MDS was a quarterly completed on 1-5-2024 listing him with a BIMS that required staff assessment due to his memory impairment, and he had a functionality of requiring substantial to maximal assistance with most of his activities of daily living. Record review of Resident #27's care plan revealed the following: Focus: Activities: Resident #27 is dependent on staff for activities, cognitive stimulation, social interaction r/t Cognitive deficits. Date Initiated: 11/11/2020 Revision on: 11/10/2021 Goal: Resident #27 will maintain involvement in cognitive stimulation, social activities as desired through review date. Date Initiated: 11/11/2020 Revision on: 12/02/2023 Target Date: 06/27/2024 During an observation on 04-07-2024 at 09:23 AM Resident #27 was not in his room. There was no furnishing in the room other that Resident #27's bed and a small dresser. There was a March 2024 activity calendar hanging on the wall and no other furnishings, no personal items, no pictures, no decorations, and no TV. During an observation and interview on 04-07-2024 at 09:31 AM Resident #27 was in the main room of the locked unit sitting at a table in his wheelchair. Resident #27 shook his head yes to good care and no issues and then started talking incoherently and randomly concerning different subjects and did not address any further questions. Resident #34 (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 #34's face sheet printed 4-8-2024 revealed he was a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include Alzheimer's (a progressive disease that destroys memory and other important mental functions), major depressive disorder(a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), intermittent explosive disorder(repeated sudden outbursts of anger), anxiety(a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), impulse disorder (a disorder characterized by urges and behaviors that are excessive), diabetes(a chronic condition that affects the way the body processes blood sugar (glucose), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and hypertension(a condition in which the force of the blood against the artery walls is too high). His last MDS was a significant change of condition completed on 2-27-2024 listing him with a BIMS of 6 indicating he was severely cognitively impaired, and he had a functionality of requiring supervision to touch assistance with most of his activities of daily living. Record review of Resident #34's care plan revealed the following: Focus: Activities: Resident #34 is dependent on staff for activities, cognitive stimulation, social interaction r/t Alzheimer's Disease. Date Initiated: 10/24/2023 Revision on: 10/24/2023 Goal: The resident will maintain involvement in cognitive stimulation, social activities as desired through review date. Date Initiated: 10/24/2023 Revision on: 04/07/2024 Target Date: 04/27/2024 During and observation and interview on 4-7-2024 at 09:15 AM Resident #34 was in his room sleeping in his bed under his covers. Resident #34 did not wake to knocking or introduction. Resident #34 was sleeping on his back and snoring softly. The only furnishing present in the room were his bed and small dresser. Resident #34 had a March 2024 event calendar hanging on his wall and nothing else such as pictures, family photos, or calendars. No TV was present in the room. Resident #36 (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 #36's face sheet printed 4-8-2024 revealed he was a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include psychotic disturbance (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), dementia(a group of thinking and social symptoms that interferes with daily functioning), psychotic disorder with delusions (severe mental illness including distorted beliefs), major depressive disorder(a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), anxiety(a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), and hypertension(a condition in which the force of the blood against the artery walls is too high). His last MDS was a quarterly completed on 2-9-2024 listing him with a BIMS that required staff assessment due to his memory impairment, and he had a functionality of being dependent of staff for most of his activities of daily living. Record review of Resident #36's care plan revealed the following: Focus: Activities: Resident #36 is dependent on staff for activities, cognitive stimulation, social interaction r/t Cognitive impairments r/t Dementia. Date Initiated: 12/29/2022 Revision on: 01/12/2023 Goal: The resident will maintain involvement in cognitive stimulation, social activities as desired through review date. Date Initiated: 12/29/2022 Revision on: 12/02/2023 Target Date: 05/08/2024 During an observation and interview 04/07/24 at 09:25 AM Resident #36 was not in his room. Resident #36 had no furnishings in the room other that his bed and a small dresser. Noted was a March 2024 activity calendar hanging on the wall. Resident #36 was observed in the main room in the locked unit sleeping in a recliner. Resident 36 did not wake to knocking or introduction. Resident #41 Record review of Resident #41's face sheet printed 4-8-2024 revealed he was a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include Alzheimer's (a progressive disease that destroys memory and other important mental functions), psychotic disorder with hallucinations (severe mental illness including seeing things that are not there), pain, psychotic disorder with delusion(severe mental illness including distorted beliefs), dementia(a group of thinking and social symptoms that interferes with daily functioning), major depressive disorder(a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and delusional disorder (a type of [NAME] health condition in which a person can't tell what's real from what's imagined). His last MDS was a quarterly completed on 3-18-2024 listing him with a BIMS of 0 due to he was rarely/never understood, and he had a functionality of requiring substantial/maximal assistance with most of his activities of daily living. Record review of Resident #41's care plan revealed the following: (continued on next page)

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	676186	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Focus: The resident is dependent on staff for activities, cognitive stimulation, social interaction r/t Cognitive deficits. Date Initiated: 12/07/2023 Goals: The resident will maintain involvement in cognitive stimulation, social activities as desired through review period. Date Initiated: 12/07/2023 Revision on: 02/23/2024 Target Date: 06/16/2024 During an observation and interview on 04-07-2024 at 09:24 AM Resident #41 was not in his room. Resident #41 had no furnishings in his room other than his bed, a small dresser, and a March activity calendar. Resident #41was observed in the main room in the locked unit in a wheelchair leaning forward next to the nurse's desk with a staff member present for observation. The staff member was observed helping Resident #41 to position himself. Resident #41 did not respond to introduction or questions, just stared blankly. Resident #96 Record review of Resident #96's face sheet printed 4-8-2024 revealed he was an [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include diabetes(a chronic condition that affects the way the body processes blood sugar (glucose), Alzheimer's(a progressive disease that destroys memory and other important mental functions), anxiety(a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), osteoarthritis(a type of arthritis that occurs when flexible tissue at the ends of bones wears down)Intermittent explosive disorder(repeated sudden outbursts of anger), delirium (a disturbed state of mind or consciousness), and major depressive disorder(a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). His last MDS was an annual completed on 3-8-2024 listing him with a BIMS that required staff assessment due to his memory impairment, and he had a functionality of requiring substantial/maximal assistance with most of his activities of daily living. Record review of Resident #96's care plan revealed the following: Focus: Activities Resident #96 is dependent on staff for activities, cognitive stimulation, social interaction r/t. Date Initiated: 05/25/2023 Revision on: 05/27/2023. Goals: Resident #96 will maintain involvement in cognitive stimulation, social activities as desired through review date. Date Initiated: 05/27/2023 Revision on: 03/26/2024 Target Date: 06/08/2024 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 04-07-2024 at 09:22 AM Resident #96 was not in his room. There was no furnishing in the room other that Resident #96's bed and a small dresser. No personal belongings, no noted pictures hanging on the walls, and no TV. During an interview on 04-09-2024 08:46 AM LVN C (the nurse for the locked unit this shift) observed Resident #22's room and verified that no personal items were provided for Resident #22. LVN C reported that all the resident rooms in the locked unit were that same as Resident #22's. LVN C reported that residents care and condition would be better if the residents had things provided in their rooms that they were familiar with. During an interview on 04-09-2024 at 08:59 AM the Administrator reported that she was aware that some resident rooms were light on personal furnishings especially the locked unit which made them appears institutionalized, not homelike. The Administrator stated that this created an uncomfortable condition for the residents and that overall, it would affect the resident's condition negatively, that they would need something to stimulated them or they could have an increase in their depression and boredom. The Administrator verified that the Activity Director was responsible for assisting the residents in developing a homelike environment and that the current Activity Director resigned with her last day being 3-6-2024 and a new Activity Director started 4-8-2024 and was currently completing orientation. During an interview on 04-09-2024 at 10:20 AM the DON reported that the residents in the locked unit needed to be educated on what they could put on the walls. That the current situation in the locked unit is not a homelike environment. The DON reported that not having a homelike environment like they currently have in the locked unit can affect the residents and the staff by affecting their lively hood. The DON agreed with the administrator that it can increase a resident's depression and boredom if the resident does not have an environment that is homelike. During and observation and interview on 04-09-2024 at 11:03 AM Resident #96 was observed on the locked unit in the main area sitting in his wheelchair dressed well for the day in a hat, light coat, jeans, socks, and shoes. Resident #96 appeared lethargic and stared at this surveyor for introduction and questions but did not offer any response. Record review of the facility provided policy titled Safe and Homelike Environment date implemented 9-1-2023 revealed the following: Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Definitions: Environment refers to any environment in the facility that is frequented by resident including (but is not limited to) the residents' rooms . (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A homelike environment is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment. Comfortable sound levels means levels that do not interfere with the resident's hearing, levels that enhance privacy when privacy is desired, and levels that encourage interaction when social participation is desired. Policy Explanation and Compliance Guidelines: -The facility will create and maintain, to the extent possible, a homelike environment that de-emphasized the institutional character of the setting. -The facility will allow resident to use their personal belongings, including furnishing and clothing (as space permits) to assist in creating and maintain a homelike environment.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813 Based on interview, and record review the facility failed to conduct a comprehensive and accurate assessment of each resident using the resident assessment instrument (RAI) specified by CMS for 1 (Resident #40) of 13 residents whose records were reviewed for assessments. Resident #40 was not listed as using tobacco on his 11-14-2023 admission MDS. This failure to ensure comprehensive and accurate assessments could affect residents by placing them at risk for inaccurate and incomplete MDS assessment which could result in residents not receiving correct care and services. Finding included: Record review of Resident #40's face sheet dated 4-8-2024 revealed a [AGE] year-old male resident admitted to the facility originally on 11-2-2023 and readmitted on [DATE] with diagnoses to include neuroleptic induced parkinsonism (a disorder of the central nervous system that affects movements to include tremors), hypertension (a condition in which the force of the blood against the artery walls is too high), stimulant dependence (the continued use of stimulants despite harm to the user), Schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), anxiety (a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), and muscle weakness. Record review of the clinical record for Resident #40 revealed his last MDS completed was a quarterly completed 2-27-2024 listing him with a BIMS of 11 indicating he was moderately cognitively impaired, and he had a functionality of requiring substantial/maximal assistance with activities of daily living. The quarterly assessment does not require tobacco use to be assessed. Record review of the clinical record for Resident #40 revealed an admission MDS completed 11-14-2023 with Section J-Health Conditions with the following: J1300-Current Tobacco Use-Resident #40 is marked 0-No. Record review of Resident #40's Baseline Care Plan completed 11-9-2023 revealed the following: Care Plan Summary: .Resident is a smoker. Showed him the smoking section and explained smoking policy . Record review of Resident #40's clinical record revealed a Safe Smoking Assessment with effective date of 11-2-2023 and signed 11-9-2023 revealing the following: Summary (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. This resident is safe to smoke unsupervised, at this time: 4. All smoking materials will be kept at the nurses? station 5. Care Plan up to date or updated 6. The evaluation has been discussed with the resident. Record review of Resident #40's care plan revealed the following: Focus: Smoker: I smoke cigarettes, vape, and dip per my choice. Date Initiated: 11/09/2023 Revision on: 12/01/2023. Goal: Resident will safely smoke cigarettes without injury. Date Initiated: 11/09/2023 Revision on: 12/02/2023 Target Date: 05/22/2024. During an interview on 04-09-2024 at 09:41 AM the MDS Coordinator verified that Resident #40 did not have tobacco use marked on his 11-14-2023 admission MDS and it should have been according to his admission paperwork. The MDS Coordinated stated, I just missed it, and I will get it corrected right now. The MDS Coordinator reported that since the smoking was care planned, she did not feel the error on the MDS affected the resident in any way, that the error did not affect the reimbursement, and therefore would not affect resident care either. The MDS Coordinator reported that the policy followed to assess residents needs and completed the MDS is the RAI manual. During an interview on 04-09-2024 at 10:11 AM the DON verified that Resident #40 has always been a smoker and has a history of drug addiction. The DON reported that if a residents MDS does not accurately assess the residents needs it can affect the facility's reimbursement but since Resident #40's smoking was care planned his care was not affected. The DON reported that if a resident's care was care planned then the residents care will not be affected by an inaccurate MDS, only the facility's reimbursement. Record review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1. 18.11, dated October 2023 revealed the following: Section J Health Patterns- J1300: Current Tobacco Use Item Rationale Health-related Quality of Life (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o The negative effects of smoking can shorten life expectancy and create health problems that interfere with daily activities and adversely affect quality of life. Coding Instructions o Code 0, no: if there are no indications that the resident used any form of tobacco. o Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48161 Based on observations, interviews, and record review, the facility failed to provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish based on the comprehensive assessment and consistent with the resident's needs and choices for 1 of 12 residents (Resident # 23) reviewed for activities of daily living. The facility failed to assess Resident # 23's needs for a communication board to assist her to effectively communicate with staff. This failure could place residents at risk of not receiving services/care and decreased quality of life. Findings included: Record review of Resident #23's face sheet printed on 04/8/2024 revealed at [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include Schizoaffective disorder (mental disorder), anxiety disorder, cognitive communication deficit (problems with communication), Dysarthria(difficulty in speech due to weakness of speech muscles), anarthria (inability to produce clear speech), and Pseudobulbar affect (inappropriate involuntary laughing or crying). Record review of Resident #23's quarterly MDS dated [DATE] revealed resident had a BIMS score of 03 which indicated that she had severe impairment. The MDS also revealed that Resident #23 was rarely/never understood but was able to respond adequately to simple, direct communication. Record review of Resident #23's care plan dated 01/19/2024 revealed the following: Focus: Communication: Resident #23 had a communication deficit and had difficulty making self-understood. Goal: Encourage resident to continue stating thoughts even if resident had difficulty. Focus on a word or phrase that mad sense or responded to the feeling resident tried to express. Observation on 04/07/2024 at 12:25 PM Resident #23 was sitting in her wheelchair in the dining room trying to communicate with the DON., The DON was saying words to Resident #23 such as Dr. Pepper, Room, Coke trying to help with Resident #23's needs. -Resident #23 was moving her hands in the air trying to communicate her needs to the DON. Observation of staff taking resident to her room. Staff instructed Resident #23 to put her feet up and Resident #23 put her feet up as they left the dining room., Resident #23 was observed understanding direction and lifted her feet. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/08/2024 at 3:00 PM the SW stated that she had worked for the facility for a few months. The SW stated that Resident #23 had a hard time communicating her needs with staff due to being nonverbal. The SW stated that she was told that the past administration tried using a communication board with Resident #23, but since she has worked in the facility, they have not tried any type of communication board with Resident #23. The SW stated that Resident #23 knew what channel she liked to watch on tv, how to use her cell phone, and that a communication board would be beneficial for Resident #23. In an interview on 04/08/2024 at 3:30 PM the SW stated she printed off a piece a paper with a sad face and a happy face on it along with other pictures. The SW said that she showed the paper to Resident #23 and asked Resident #23 if she was happy or sad and pointed to the pictures. The SW stated that Resident #23 pointed to the sad face. The SW said again she thought a communication device would help with Resident #23's communication deficit. In an observation on 04/09/2024 at 8:30 AM Resident #23 was in the common area with a staff member, she was moving her arms in the air trying to communicate with staff. In an interview on 04/09/2024 at 2:36 PM the DON stated that Resident #23 would absolutely benefit from a communication device. The DON stated that Resident #23 knew what channel she liked to watch on tv, she loved the Dallas Cowboys and Friends, and a communication device would help her communicate her needs and wants. Accommodation of Needs Policy implemented on 09/01/2023 revealed the following: The facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preferences of a resident. Policy explanation and Compliance Guidelines Based on individual needs, the facility will assist the resident in maintaining or/or achieving independent functioning, dignity, and wellbeing to the extent possible.

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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** 39813 Based on observations, interviews, and record review, the facility failed to ensure the resident environment remained as free of accident hazards and each resident received adequate supervision as is possible for 2 of 12 residents (Resident #33 and Resident #40) reviewed for accidents and hazards. 1. The facility failed to ensure that a space heater was not being utilized in Resident #33's room. 2. The facility failed to ensure that Resident #33 did not have a lighter in his room. 3. The facility failed to ensure that Resident #40 did not have a Vape pen in his room. This failure could affect residents at the facility by placing them at risk for fire related injuries or ingesting unknown liquids from the Vape Pen. The findings were: Record review of Resident #33's face sheet dated 04/07/2024 revealed, a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, heart failure, intermittent explosive disorder, difficulty in walking, muscle weakness, and unsteadiness on feet. Record review of Resident #33's Admission MDS assessment dated [DATE] revealed Resident #33 had a BIMS score of 10 which indicated that Resident #33 had moderately impaired cognitive impairment. Record review of Resident #33's care plan dated 03/31/2024 revealed that Resident #33 was a smoker with interventions and tasks that included to instruct resident about the facility policy on smoking: locations, times, safety concern. The care plan also identified Resident #33 as a fall risk that included interventions such as a safe environment, free from clutter. Record review of Resident #40's face sheet printed 04/08/2024 revealed he was a [AGE] year-old male admitted to the facility originally on 11-2-2023 and readmitted on [DATE] with diagnoses to include neuroleptic induced parkinsonism (a disorder of the central nervous system that affects movements to include tremors), hypertension (a condition in which the force of the blood against the artery walls is too high), stimulant dependence (a dependence on stimulant drugs that can be psychological, physical, or both), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), anxiety (a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), and polyneuropathy (malfunction of many peripheral nerves throughout the body). His last quarterly MDS was completed on 2-27-2024 and listed him with a BIMS score of 11 indicating he was moderately cognitively impaired, and he had a functionality of requiring substantial/maximal assistance with most of his activities of daily living. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During on observation and interview on 04/07/2024 at 9:36AM revealed a small space heater in Resident #33's room near the television and a cigarette lighter located on the resident's bed. The space heater was on and producing heat. Resident #33 was sitting in his recliner. Resident #33 stated that a family member brought the space heater for his room because he was cold. Resident #33 stated that he was an independent smoker and was allowed to have his lighter with him. During an observation on 04/07/2024 at 10:07 AM Resident #40 was not in his room, the room appeared generally disheveled but clean with no odor. Noted was a Vape machine and a carton of cigarettes (with 10 packs of cigarettes present) on top his bed side dresser within view of the hallway. During an observation and interview on 04/08/2024 at 8:11 AM, Resident #33 yelled at writer stating it was her fault that his space heater was removed from his room. Observation of Resident #33's room revealed no space heater or cigarette lighter in room. During an interview on 04/09/2024 at 8:45 AM, CNA D stated that residents were not allowed to have space heaters or lighters in their room. CNA H stated that if an item like that was in a room it would need to be removed. The negative outcome for having a space heater or lighter in a resident's room would be that it could cause a fire in the facility. During an interview on 04/09/2024 at 08:55 AM the ADM reported that Resident #40's Vape should be handled the same as a resident leaving out a cigarette lighter in his room., The ADM stated that a confused or none confused resident could pick up the Vape and use it, and you never know what is in a Vape that any resident could be using inadvertently . During an interview on 04/09/2024 at 8:58 AM, the ADM stated that a resident should not have a lighter or space heater in their room and that a negative outcome for having those items would be that a resident could cause a fire in the facility, or they could burn themselves or burn another resident. During an interview on 04/09/2024 at 10:11 AM the DON verified that Resident #40 has always been a smoker and has a history of drug addiction. The DON reported that a resident keeping a Vape pen in his room was an issue and that any other resident could have picked the Vape pen up and used it, that it could have resulted in a resident injury. During an interview on 04/09/2024 at 2:36 PM, the DON said that a family member must have brought up the space heater as he was a new admit. The DON also stated that a negative outcome for having a space heater or lighter in a resident's room would be that the resident could possibly catch the facility on fire . Record Review of Accidents and Supervision Policy implement on 09/01/2024 revealed the following: The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: Identifying hazards and risks. Hazards refers to elements of the resident environment that have the potential to cause injury or illness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Supervision/Adequate Supervision [NAME] to intervention and means of mitigating risk of an accident. 48161

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48161 Based on interviews, and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 1 (02/11/2024) of the last 90 days reviewed. The facility did not have an RN working in the facility for 1 (02/11/2024) of the last 90 days reviewed. This deficient practice had the potential to affect residents in the facility by leaving staff without supervisory coverage for coordination of events such as hospice care, emergency care and disasters such as with flooding, power outage, tornado, fire, etc. Findings included: Record review of the facility's last 90 days (11/26/2023-04/07/2024) of RN coverage provided by the Administrator revealed the facility had no RN working in the facility for the following date: 02/11/2024. During an interview on 04/08/2024 at 3:17PM the DON verified that the facility did not have an RN working in the facility for 1 out of the last 90 days. The DON stated that on 02/11/2024 there was bad weather and that was the cause of not having a RN on shift that day as the RN that was supposed to be on duty called in. The DON stated she had no excuse and looked through all staff scheduling, even agency scheduled, and could not find an RN to cover the shift on 02/11/2024. During an interview on 04/09/2024 at 8:45 AM, CNA D stated that a possible negative outcome for not having a registered nursed during working hours would be that something bad could have happened to a resident and a nurse would not be at the facility to help. During an interview on 04/09/2024 at 8:58 AM, the ADM stated that she was aware that there was no RN coverage on 02/11/2024 and stated that a possible negative outcome for not having a registered nurse would be that there would be no facility oversight for the nursing team. Record Review of Nursing Services-Registered Nurse Policy dated implemented 09/01/2023 revealed the following: It is the intent of the facility to comply with Registered Nurse staffing requirements. Policy Explanation and compliance Guidelines: The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day 7 days per week.

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	676186	A. Building B. Wing	04/09/2024

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

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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. 39813 Based on observation, interview, and record review; the facility failed to ensure medications were stored in accordance with currently accepted professional principles for 1 (the medication room) of 2 medication storage areas reviewed for medication storage. The medication room refrigerator had medications that had been stored out of recommended storage temperatures. The facility's failure to ensure medications were stored in accordance with currently accepted professional principles could result in a resident receiving the incorrect medication or a medication that would be ineffective for their treatment resulting in exacerbation of the resident's condition and disease processes. Findings included: Record review of the medication room (the facility had one medication storage room) refrigerator log for April 2024 revealed the following documented temperatures: (-per merriam-webster.com: freezing point of water is 32 degrees Fahrenheit.) 4-1-2024-no temperature was noted. 4-2-2024- no temperature was noted. 4-3-2024-32 degrees Fahrenheit 4-4-2024-33 degrees Fahrenheit 4-5-2024-30 degrees Fahrenheit Record review of the medication room refrigerator log for March 2024 revealed the documented temperatures from 3-1-2024 to 3-31-2024 to be between 36 to 39 degrees Fahrenheit. During an observation on 4-7-2024 at 2:24 PM the following was noted in the medication room refrigerator: -3 Novolin R insulins. (Manufacturer instructions: Do not freeze. Do not us if it has been Frozen) -10 Lantus insulins. (Manufacturer instructions: Store unused Lantus Insulin vials in the refrigerator between 36 F to 46 F degrees. Do not freeze.) -3 Novolin N insulins. (Manufacturer instructions: Keep all unopened Novolin Insulin in the refrigerator between 36 F to 46 F degrees. Do not freeze.) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-4 Humulin insulins. (Manufacturer instructions: Humulin hat is unopened and not currently being used should be stored in the refrigerator at 36 F to 46 F degrees, but not frozen.) -1 box of Acetaminophen suppositories. Manufacturer instructions to store between 68-77-degree Fahrenheit.) During an interview on 4-7-2024 at 2:36 PM ADON A verified that for a medication temperature to be freezing it had to be at 32 degrees or below. ADON A reviewed the April refrigerator temperatures log for the medication room and reported that the temperature on 4-3-2024 was listed at 32 degrees and on 4-5-2024 was listed at 30 degrees which meant the medications in the refrigerator were freezing on two days. ADON A also reported that the temperature log form gave specific instructions on what to do if the temperature was out of acceptable range for the medications to be stored at. ADON A reported that if a medication was stored outside of what was listed then that medication is not any good anymore. ADON A reported that if a medication was improperly stored then it will not be effective for the resident, and it will not have its intended strength and will not be good to use. The ADON reported that the night shift staff monitor the temperatures in the medication room and would not be available due to working the previous night. The ADON did report that all staff will be educated on proper temperature monitoring to include the night shift when available. During an interview on 04-09-2024 at 10:26 AM the DON reported that if a medication was not stored properly then that medications effectiveness will be affected, if a staff member were to administer the medication that has been improperly stored then the resident's condition will be affected in a negative way. Record review of the instruction printed on the 4-2024 Medication Room Refrigerator log revealed the following: Temperature Between 36 and 46 Degrees Monitored for temperature and appropriate content .If the temperature is not between 36 and 46 degrees readjust temp and recheck in 10-15 minutes. Record review of the instruction printed on the 3-2024 Medication Storage Monthly Temperature Log revealed the following: Refrigerator Temperature-Acceptable Ranged 36F-46F Record review of the facility provided polity titled, Medication Storage/Storage of Medication dated 1-2024, revealed the following: Policy: Medications and biologicals are stored properly, following manufacturer or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. 11. Medications requiring refrigeration: or temperatures between (36F) and (46F) are kept in a refrigerator with at thermometer to allow temperature monitoring .A temperature log or tracking mechanism is maintained to verify that temperature has remained withing accepted limits. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. Insulin products should be stored in the refrigerator until opened .Do not freeze insulin. If insulin had been frozen, do not use.

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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. 48209 Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure stored food was properly labeled and dated. This failure could put place Residents at risk for foodborne illness. Findings Included: Observation of shelved/refrigerated foods on 4/7/2024 at am revealed the following: 1. Observation of freezer 1 on 4/7/24 at 9:16 am revealed 1 bag of meat with no label or date. 2. Observation of freezer 1 on 4/7/24 at 9:18 am revealed 1 bag of squash in a plastic bag with no label or date. 3. Observation of freezer 1 on 4/7/24 at 9:18 am revealed 1 bag of green beans with no label or date. 4. Observation of refrigerator 1 on 4/7/24 at 9:25 am revealed 1 block of butter in a plastic bag with no label or date. 5. Observation of refrigerator 1 on 4/7/24 at 9:25 am revealed 1 cup of cream with no label or date. 6. Observation of kitchen counter on 4/7/24 at 9:26 am revealed 1open bag of corn flakes on counter with no date. 7. Observation of condiment cart on 4/7/24 at 9:26 am revealed no label or date. 8. Observation of pantry 2 on 4/7/24 at 9:34 am revealed 2 bags of pasta with no date. 9. Observation of refrigerator 1 on 4/7/24 at 9:34 am revealed 1 bag of hoagie bread with no label or date. 10. Observation of pantry 2 on 4/7/24 at 9:41 am revealed 2 bags of sugar frosted flakes with no date. 11. Observation of pantry 2 refrigerator 1 on 4/7/24 at 9:43 am revealed 1 bag of tater tots with no label or date. 12. Observation of refrigerator 1 on 4/7/24 at 9:43 am revealed 5 bags of zucchini with no date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	13. Observation of freezer 1 on 4/7/24 at 9:46 am revealed 1 bag of scrambled eggs with no date. 14. Observation of Freezer 2 on 4/7/24 at 9:47 am revealed of meat patties with no label or date. 15. Observation of freezer 2 on 4/7/24 at 9:50 am revealed 10 Bags of spinach with no date. An interview on 4/8/2024 at 2:30pm with the ADM, she stated that all kitchen staff were responsible for safe food storage per their policy. The ADM stated that the negative outcome for not practicing food storage would be contamination. An interview on 4/9/24 at 9:31 am with cook E, she stated that kitchen staff were to follow facility policy for proper food storage. She said that a negative outcome for Residents would be contamination. An interview with FSA F on 4/9/24 at 9:35 am she said that all kitchen staff were responsible for food storage per their policy. She said a negative outcome would be that residents could get sick. An interview on 4/9/24 at 9:37 am with FSA G he said that all dietary staff are responsible for food storage per facility policy. He said that a negative outcome would be food poisoning. Record review of in-service dated 3/16/23 at 3: 40 PM, training contained proper labeling and storage. Record review of Food and Drug Administration on, dated 1/18/23, stated in section 5-305.11 food storage should be at least 15cm (6 inches) above the floor. Record Review of Policy: Food Storage Revised on 6/1/2019 Procedure: Dry Storage Room To ensure freshness, store opened and bulk items in tightly covered containers. All containers must be labeled and dated. Procedure: Refrigerators Date, label and tightly seal all refrierated foods using clean , nonabsorbent, covered containers that are approved for food storage. Procedure: Freezers Store frozen foods in moisture-proof wrap or containers that are labeled and dated.