STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676187	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House of Marshall Health & Rehabilitation	5915 Elysian Fields Road Marshall, TX 75672

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 49019 Based on interview and record review the facility failed to consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident and life in the facility and be able to demonstrate their response and rationale for the response for 7 of 7 anonymous residents (AR) reviewed for grievances. (AR#1-AR#7) The facility failed to follow-up and monitor previous grievances to resolve resident concerns for AR#1-AR#7. This failure could place residents at risk of not having the right to voice their concerns and grievances to be followed-up on in a timely manner. Findings include: Record review of the Resident Council Minutes, dated 3/1/2024, reflected .ice passes are not consistent . aids standing in hallway talking about personal matters .staff have been in-serviced Record review of the Resident Council Minutes, dated 5/1/2024, reflected .only get shower on Tuesdays . states aids will enter room, turn off the call light say they will be back and never return . Findings reflected . No concerns voiced. During a confidential resident group interview the residents in attendance voiced multiple grievances that were previously addressed and continue to occur within the facility related to voiced concerns of staff not filling their water and ice but one time a week and residents were required to get their own water, ice, and bedtime snacks. The confidential attendees said they would push their call light and staff would not answer for hours later or ask want you want and never return with the request. The confidential group said residents depended on each other for assistance. During a confidential interview with 7 of 7 resident attendees, the attendees voiced staff not filling up water and ice, staff not responding timely to call lights, staff not returning to room, and staff on phone during resident care. During an interview on 6/26/2024 at 2:12 PM, CNA V said she had not heard anyone complain of loud noises at night and snacks were offered and the staff would bring snacks to resident rooms. CNA V said the snacks were located at the front of nurse's station when dietary would set it out at night. (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/26/2024 at 3:04 PM, the SW said the ADM was the grievance coordinator. The SW said if a resident had a complaint, they would come to her and discuss the issue and file a formal grievance. The SW said the facility followed up in the investigation. The SW said she had complaints of call lights not being answered timely and the facility in-serviced and talked with staff about the concerns. During an interview on 6/26/2024 at 2:30 PM, LVN M said if a resident complained about abuse, staff immediately notified the ADM. LVN M said if it was something else, the staff tried to take care of it. LVN M said he had not had any recent complaints about loud noises at night and he expected the staff to answer call lights immediately in case a resident had an emergency or had fallen. During an interview on 6/26/2024 at 2:40 PM, the ADON said she could initiate a grievance and would report immediately to the ADM of any abuse. The ADON said the charge nurse would contact the ADON, DON and ADM to report a grievance. The ADON said she heard of a resident staying up at night listening to loud music. The ADON said residents were able to have bedtime snacks due to some residents having weight loss requiring snacks. The ADON said she had not heard of other staff telling residents to get their ice, water, or snacks. The ADON said ice and water should be passed on every shift. During an interview on 6/26/2024 at 3:40 PM, the DON said the SW was responsible for grievances. The DON said the SW talked to the residents about loud music at night. The DON said the residents were not responsible for getting their own bedtime snacks and staff should pass them out. The DON said residents complained in the past about staff being on their phone and the facility in-serviced staff on customer service . During an interview on 6/26/2024 at 4:37 PM, the ADM said she expected the grievances to be documented, recorded, and investigated by the grievance officer. The ADM said the facility was addressing staff on phones and not answering call lights on the night shift and in-services were completed. The ADM said she expected care to be provided to one-on-one without phone calls and said the residents should not have to wait to receive care. The ADM said staff should offer snacks to the residents in the evening and the snacks should be delivered to them. During record review on 7/2/2024 of grievances and in-services, the facility had multiple complaints regarding the call lights not being answered and were voiced in the confidential resident group interview. The confidential grievances were documented and in-serviced by nursing administration. Record review of the facility policy, dated 11/2/2024, titled Grievances reflected .the resident has a right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear off discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which had not been furnished, the behavior of staff and of other residents; and other concerns regarding their long-term care facility stay. The resident has the right to, and the facility must make prompt efforts by the facility to resolve grievances the resident may have. 1. The facility will notify the residents on how to file a grievance orally, in writing or anonymously with posting in prominent locations. 2. The grievance official of this facility is the administrator or their designee. 3. The grievance official will . oversee the grievance process .receive and track grievances to their conclusion, lead and necessary investigations by the facility, maintain the confidentiality of all information associated with grievances, issue written grievance decisions to the residents

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review the facility failed to ensure each resident was informed before, or at the time of admission, and periodically during the residents stay, of services available in the facility and of charges for those services, which included charges for services not covered under Medicare/Medicaid or by the facility's per diem rate for 2 of 3 residents (Resident #31 and Resident #212) reviewed for Medicare/Medicaid coverage. 1. The facility failed to ensure Resident #31 and Resident #212 were given a NOMNC (is a notice that indicates when your care is set to end from a home health agency, skilled nursing facility, comprehensive outpatient rehabilitation facility, or hospice) when discharged from skilled services prior to his covered days being exhausted. 2. The facility failed to ensure Resident #31 and Resident #212 were given a SNF ABN (is document that informs a Medicare beneficiary that Medicare will no longer pay for skilled services) when discharged from skilled services at the facility prior to covered days being exhausted. These failures could place residents at risk for not being aware of changes to provided services. Findings include: 1. Record review of Resident #31's face sheet, dated 06/25/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #31 had diagnoses which included congestive heart failure (occurs when the heart muscle doesn't pump blood as well as it should) and Type 2 diabetes (is a chronic medical condition in which the levels of sugar, or glucose, build up in your bloodstream). Record review of Resident #31's quarterly MDS, dated [DATE], reflected Resident #31 was understood and understood others. Resident #31 had a BIMS score of 15, which indicated her cognition was intact. Record review of the SNF Beneficiary Notification Review reflected Resident #31 received Medicare Part A skilled services on 01/24/24 and last covered day of Part A was 03/22/24 prior to using up her 100 days of skilled services. The SNF Beneficiary Notification Review reflected the facility/provider initiated the discharge from Medicare Part A Services when benefits days were not exhausted. Resident #31 was not provided a SNF ABN or a NOMNC form due to the SW failed to deliver the forms to the resident. 2. Record review of Resident #212's face sheet, dated 06/24/24, reflected Resident #212 was a [AGE] year-old, female who was admitted to the facility on [DATE] and readmitted on [DATE], and 05/25/24. Resident #212 had diagnoses which included pulmonary embolism (is a sudden blockage in your pulmonary arteries, the blood vessels that send blood to your lungs), Type 2 diabetes (is a chronic medical condition in which the levels of sugar, or glucose, build up in your bloodstream), and chronic kidney disease, stage 4 (severe loss of kidney function). (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #212's quarterly MDS, dated [DATE], reflected Resident #212 was understood and understood others. Resident #212's BIMS score was not indicated on her MDS, dated [DATE]. Record review Resident #212's quarterly MDS, dated [DATE], reflected a BIMS score of 15, which indicated her cognition was intact. Record review of the SNF Beneficiary Notification Review reflected Resident #212 received Medicare Part A skilled services on 11/22/23 and last covered day of Part A service was 03/01/24. The SNF Beneficiary Notification Review reflected Resident #212 Part A services was terminated/discharged due to insurance issued a NOMNC. A SNF ABN and a NOMNC were not provided to Resident #212 due to the SW failed to complete the forms. During an interview on 06/26/24 at 2:53 p.m., the SW said with the old company she was responsible for the ABN and NOMNC forms. She said the current company, she was only going to be responsible for the NOMNCs and the MDS coordinator would do the ABNs. She said the ABN letters should be given when the NOMNC was delivered to the resident. She said NOMNC had to be delivered 48 hours prior to the resident being discharged from insurance or facility-initiated discharges. She said when doing ABNs and NOMNC, she notified the resident or RP in person or by phone. She said a copy of the ABN and/or NOMNC letter was given to the resident and placed in the resident's medical records. She said she delivered Resident #212's March 2024 ABN and NOMNC letters to her but could not find a copy in her medical records. She said Resident #212 would not remember if she received the letters since it happened it March 2024. She said Resident #31 had transferred from Medicare to LTC Medicaid and giving the resident her ABN and NOMNC letters was overlooked. She said delivering the resident's ABN and NOMNC letters were important so the resident could make an informed decision about their healthcare, it was part of the discharge process, and it made them aware of their plan of care. She said it was always important to provide the resident with ABNs and NOMNC letters timely because there was an appeal process that was time sensitive. She said when the ABN and NOMNC were not delivered before services were discontinued, it took the residents by surprise, caused a feeling of helplessness and out of the loop, or their voices not being heard. During an interview on 06/26/24 at 4:45 p.m., the ADM said with the old company the SW was responsible for the ABN and NOMNC forms. She said the new company, the MDS coordinator would be responsible. She said the ABN and NOMNC letters had to be delivered to the resident three days prior of when their 100 days ended. She said it was important to give the resident ABN and NOMNC letters, to ensure a plan of care for home was known and if the resident changed to LTC services. Record review of the facility's Advanced Beneficiary Notice NOMNC policy and procedure, revised 05/2024, reflected .a Medicare provider or health plan .must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing .the NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of services if care is not being provided daily (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Advanced Beneficiary Notice ABN policy and procedure, revised 05/2024, reflected, . the ABN is a notice given to beneficiaries in original Medicare to convey that Medicare is not likely to provide coverage in s specific case .the ABN must be reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed .the ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice .in all cases, the notifier must retain a copy of the ABN delivered to the beneficiary on file

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review the facility failed to ensure within 14 days after a facility completed a resident's assessment, a facility must transmit encoded, accurate, and complete MDS data, to the CMS System for 16 of 46 residents (Residents #25, #53, #162, #113, #5, #212, #115, # 20, # 117, #9, # 12, # 31, # 52, # 114, #112, and # 10) records reviewed for transmitted MDS records. The facility failed to ensure the MDS assessments were electronically transmitted as required for: Resident #25's discharge assessment dated [DATE] and entry record dated 05/28/2024. Resident #53's comprehensive assessment dated [DATE]. Resident # 162's discharge assessment dated [DATE] and entry record dated 06/04/2024. Resident #113's entry record dated 06/04/2024. Resident #5's quarterly assessment dated [DATE]. Resident #212's discharge assessment dated [DATE]. Resident #115's entry record dated 06/06/2024. Resident #20's comprehensive assessment dated [DATE]. Resident #117's discharge assessment dated [DATE]. Resident # 9's quarterly assessment dated [DATE]. Resident #12's quarterly assessment dated [DATE]. Resident #31's quarterly assessment dated [DATE]. Resident # 52's quarterly assessment dated [DATE]. Resident #114's entry record dated 06/10/2024. Resident # 112's entry record dated 06/11/2024. Resident #10's discharge assessment dated [DATE]. This failure could place residents at risk of the facility not providing complete and specific information for payment and quality of measure purposes. Finding include: (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Record review of a document titled export ready list, dated 06/26/2024, reflected the following assessments waiting to be transmitted: Resident #25's discharge assessment dated [DATE] was to be transmitted by 06/11/2024 and entry record dated 05/28/2024 was to be transmitted by 06/23/2024. Resident #53's comprehensive assessment dated [DATE] was to be transmitted by 06/15/2024. Resident # 162's discharge assessment dated [DATE] was to be transmitted by 06/21/2024 and entry record dated 06/04/2024 was to be transmitted by 06/17/2024. Resident #113's entry record dated 06/04/2024 was to be transmitted by 06/17/2024. Resident #5's quarterly assessment dated [DATE] was to be transmitted by 06/19/2024 was to be transmitted by 06/20/2024. Resident #212's discharge assessment dated [DATE] was to be transmitted by 06/20/2024. Resident #115's entry record dated 06/06/2024 was to be transmitted by 06/21/2024. Resident #20's comprehensive assessment dated [DATE] was to be transmitted by 06/21/2024. Resident #117's discharge assessment dated [DATE] was to be transmitted by 06/21/2024. Resident # 9's quarterly assessment dated [DATE] was to be transmitted by 06/21/2024. Resident #12's quarterly assessment dated [DATE] was to be transmitted by 06/21/2024. Resident #31's quarterly assessment dated [DATE] was to be transmitted by 06/21/2024. Resident # 52's quarterly assessment dated [DATE] was to be transmitted by 06/22/2024. Resident #114's entry record dated 06/10/2024 was to be transmitted by 06/24/2024. Resident # 112's entry record dated 06/11/2024 was to be transmitted by 06/25/2024. Resident #10's discharge assessment dated [DATE] was to be transmitted by 06/26/2024. Record review of an undated, handwritten document by the ADM reflected the facility had not transmitted since April 2024 due to management company changes. During an interview on 06/26/2024 at 10:15 a.m., the MDS nurse stated she oversaw the MDS for all residents at the facility. She stated the MDS must be transmitted or submitted to CMS within 14 days of completion of the MDS. She stated the facility was under new management since 06/01/2024 and she did not have access to a transmission portal to be able to submit the facility MDS's to CMS timely. She stated she knew they were late and should have been transmitted by the 14th day past completion. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 06/26/2024 at 11:00 a.m., the DON stated she was not responsible for the oversight of MDS transmission, completion or accuracy. She stated it was the MDS nurse's responsibility to complete and submit the MDS. She stated the regional MDS nurse was the one who provided oversight and monitored the MDS nurse. During an interview on 06/26/2025 at 4:45 p.m., the ADM stated she expected the MDS's to be transmitted timely and because of the company take over the access to the facility's transmission portal, had not been granted to the new company yet. She stated not transmitting on time could affect how CMS calculated the quality measures for the facility and the facility could be penalized monetarily for the late transmissions. Record review of the CMS RAI Version 3.0 Manual, last revised October 2023, reflected: For a Quarterly, Significant Correction to Prior Quarterly, Discharge or PPS assessment, encoding must occur within 7 days after the MDS completion Date . Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. Care plans are not required to be transmitted. Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 +14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days) . Discharge Assessment Submit by Z0500B + 14.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 4 of 16 resident reviewed (Residents #30, #36, #45 and #212) for assessments. 1. The facility failed to ensure Resident #30's diagnosis of anxiety was coded on her MDS. 2. The facility failed to ensure Resident #36's dialysis (is a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) status was coded on his MDS. 3. The facility failed to ensure Resident #45's vision impairment was reflected on his MDS. 4. The facility failed to ensure Resident #212's fall on 04/03/24 was coded on her MDS. These failures could place residents at risk of not having individual needs met. Findings include: 1. Record review of Resident #30's face sheet, dated 06/24/24, reflected a [AGE] year-old, female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #30 had diagnoses which included Parkinson's disease (is a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) and generalized anxiety disorder (means that you are worrying constantly and can't control it). Record review of Resident #30's quarterly MDS assessment, dated 04/18/24, reflected Resident #30 was understood and understood others. Resident #30 had a BIMS score of 15, which indicated her cognition was intact. Resident #30 had depression, but it did not include a diagnosis of anxiety. Record review of Resident #30's care plan, dated 03/27/23, reflected Resident #30 had depression and anxiety related to the disease progress. Intervention included administer medications as ordered. 2. Record review of Resident #36's face sheet, dated 06/25/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #36 had a diagnosis which included end stage renal disease (is the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own). Record review of Resident#36's quarterly MDS assessment, dated 05/13/24, reflected Resident #36 was understood and understood others. Resident #36 had a BIMS score of 15, which indicated his cognition was intact. The MDS did not indicated Resident #36 received dialysis treatment while a resident of the facility and within the last 14 days. Record review of Resident #36's care plan, dated 02/17/23, reflected Resident #36 needed hemodialysis (is a treatment to filter wastes and water from your blood) related to renal failure. Intervention included resident received dialysis 3 times a week. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #36's Dialysis Communication Records, dated April-May 2024, reflected treatment on: *04/18/24 *04/23/24 *04/25/24 *05/04/24 *05/07/24 *05/11/24 3. Record review of Resident #45's face sheet, dated 06/24/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #45 had diagnoses which included nontraumatic intracerebral hemorrhage (bleeding into the brain tissue) and glaucoma (is a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye called the optic nerve). Record review of Resident #45's quarterly MDS assessment, dated 04/05/24, reflected Resident #45 was usually understood and sometimes understood others. Resident #45 had adequate hearing and vision, and clear speech. Resident #45 had a BIMS score of 00, which indicated severe cognitive impairment. The MDS assessment did not indicated Resident #45's vision impairment. Record review of Resident #45's care plan, dated 04/05/23, reflected Resident #45 had impaired visual function related to glaucoma. Intervention included tell the resident where you are placing their items. Be consistent. 4. Record review of Resident #212's face sheet, dated 06/24/24, reflected a [AGE] year-old, female who was admitted to the facility on [DATE] and readmitted on [DATE], and 05/25/24. Resident #212 had diagnoses which included pulmonary embolism (is a sudden blockage in your pulmonary arteries, the blood vessels that send blood to your lungs), Type 2 diabetes (is a chronic medical condition in which the levels of sugar, or glucose, build up in your bloodstream), and chronic kidney disease, stage 4 (severe loss of kidney function), and lack of coordination. Record review of Resident #212's quarterly MDS, dated [DATE], reflected Resident #212 was understood and understood others. Resident #212's BIMS score was not indicated on her MDS, dated [DATE]. Resident #212's MDS did not reflect a fall had occurred. Record review of Resident #212's quarterly MDS, dated [DATE], reflected a BIMS score of 15, which indicated her cognition was intact. Resident #212 required partial assistance for oral and personal hygiene, and dressing, and dependent for toilet hygiene. Resident #212 did not have any falls since admission/entry or reentry or the prior assessment. Resident #212 did not have any falls in the last month, last 2-6 months prior to admission/entry or reentry. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a care plan dated 03/22/24, revised 05/30/24, reflected Resident #212 had a fall on 04/3/24 which was not witnessed. Intervention included encourage resident to pull call light for assistance. Record review of the facility's Incident Report, dated 04/01/24-04/30/24, reflected: *Un-witnessed fall, Resident #212, 04/03/24, 9:35 a.m. During an interview on 06/26/24 at 2:30 p.m., the MDS coordinator said she had been employed at the facility since 05/01/24. She said she was responsible for certain sections of the MDS. She said Resident #212's fall should be coded, if it occurred during the 7 day look back or assessment period of the dated MDS. She said Resident #30's anxiety diagnosis should be coded on her MDS. She said if Resident #45's care plan stated he had impaired vision related to glaucoma, then his vision should be coded inadequate on the MDS. She said the resident's vision status was given by the SW or the MDS coordinator asked the nursing staff. She said Resident #36 being on dialysis should be coded if he attended during the assessment period. She said Resident #36 attended dialysis, three times a week. She said it was important for the resident's MDS's to be accurate, so it showed on the facility's 802 (summary of resident's triggered care areas on their MDS), it affected the facility's billing, and showed the care the residents needed or received. She said inaccurate MDS's risked lack of care to the residents and information not being placed on the resident's care plan. During an interview on 06/26/24 at 3:05 p.m., the DON said accuracy of the MDS was the responsibility of the MDS coordinator. The DON said she was not responsible for the oversight of MDS transmission, completion or accuracy. She said the regional MDS coordinator was the one who provided oversight and monitored the MDS coordinator. She said the MDS's should reflect the resident's status. She said Resident #212's fall, Resident #30 anxiety diagnosis, and Resident #36 dialysis status should be on their MDS. She said Resident #45 had impaired vision related to glaucoma so his vision would not be adequate. She said inaccurate MDS's affected the resident's plan of care and the facility's billing. During an interview on 06/26/24 at 4:45 p.m., the ADM said the MDS coordinator was responsible for accurate MDS assessments. She said she expected the MDS coordinator to complete and submit, timely and accurate MDS's. She said the care plan was based on the MDS assessment. She said an inaccurate MDS assessment placed residents at risk for not being accurately taken care of. Record review of the facility's Minimum Data Set (MDS) Policy for MDS assessment Data Accuracy 2.2021, dated 10/2023, reflected .the purpose of the MDS policy is the ensure each resident receives an accurate assessment by qualified staff to address the needs of the resident .the MDS is a core set of screening, clinical, and functional status elements .which forms the foundations of a comprehensive assessment for all residents .the items in the MDS standardize communicate about resident problems and conditions within nursing homes .require that .the assessment accurately reflects the resident's status

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on interview and record review the facility failed coordinate assessments with the Pre-Admission Screening and Resident Review (PASRR) program under Medicaid for 1 of 5 residents (Resident #23) reviewed for PASRR screenings. The facility failed to conduct an accurate PASRR Level 1 and 2 screening for Resident #23. This failure could place residents at risk for not receiving appropriate services, depression, and decreased quality of life. Findings include: Record review of Resident #23's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: Hemiplegia affecting right dominant side (paralysis on the right side of the body due to damage to the brain or spinal cord) , Type II Diabetes (group of diseases that result in too much sugar in the blood) , Acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood) and PTSD (a disorder that develops when a person has experienced or witnessed a scary, shocking or terrifying or dangerous even) and Bipolar Disorder (episodes of mood swings ranging from depressive lows to manic highs). During record review of the (admission) MDS, dated [DATE], reflected Resident #23 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. The Level II Preadmission screening and resident review of conditions did not indicate Resident #23 had a serious mental illness. Resident #23 was able to make herself understood and was understood by others. Resident #23 had a BIMS of 11, which moderate cognitive impairment and had active diagnoses which included depression, bipolar disorder, and post-traumatic stress disorder. Record review of the (current) MDS, dated [DATE], reflected Resident #23 was not able to complete the BIMS assessment. Resident #23 had active diagnoses which included depression, bipolar disorder, and post-traumatic stress disorder. Record review of Resident #23's, undated, care plan reflected Resident #23 had impaired cognitive function/dementia or impaired thought processes related to impaired decision making and long-term memory loss. The care plan revealed Resident #23 had an order for psychotropic medications related to behavioral management and potential for behavioral problems related to PTSD and bipolar disorder. The care plan revealed Resident #23 had a diagnosis of depression and took antidepressants and no PASRR 1. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/2024 at 1:26 PM, the MDS nurse said she had been at the facility for approximately 1 month and she did not have access for PASRR screenings after the new owner took over the facility. She said she did not have access after the end of May. The MDS nurse said the previous company took the passwords and she did not have access. The MDS nurse said the ADM was aware. The MDS nurse said social services knew what the resident needed like out-patient Psychiatric services for one on one therapy. The MDS nurse said there were some resources who came out and talk to the residents. The MDS nurse said if a resident came in the facility with a mental illness, they would obtain the information from their records. The MDS nurse said the mental illness diagnosis did not have to be the primary to receive services. She said if a resident had mental illness, it would be captured on the MDS, and care planned. The MDS nurse said she had not received a list of residents who were PASRR positive that had not received services. The MDS nurse said she was not clear if Resident #23 was receiving services out-patient. During an interview on 6/26/2024 at 3:04 PM, the SW said she has done MDS before and she was not responsible for PASRR. The SW said the MDS nurse was responsible for PASRR. The SW said PASSR was a service the facility offered where the resident received additional services for DME, therapy, service coordination and mental health services for PASSR positive residents. The SW said the facility used a visiting Psychiatry group in the facility and the local mental health authority provide the PASRR and checked to see if a resident needed their services. The SW said not all PASRR positive residents received or wanted services. The SW said a positive PASRR would be care planned. The SW said Resident #23 received Psychiatric services and the referral was made. During an interview on 6/26/2024 at 2:40 PM, the ADON said she did not know much about the PASRR. She said the SW handle the PASRR. The ADON said if a resident had a level 2 or level 3. The ADON said the PASRR positive resident should be care planned. The ADON said if a resident who was PASRR positive, may not get the care they needed if it was not completed, and the resident was positive. The ADON said she would not be aware if PASRR was completed on Resident #23 or not. The ADON said the MDS nurse and SW talk about the PASRR. During an interview on 6/26/2024 at 3:40 PM, the DON said she expected the PASRR to be completed. The DON said she was aware the MDS was having problems with getting things transmitted. The DON said 06/01/24, the facility was purchased. The DON said the facility did not have a username or password to submit. The DON said the MDS nurse reached out to corporate. The DON said the facility was currently not doing anything right now for the PASRR positive residents. The DON said the SW did all the referrals for PASRR and counseling services and said the PASRR positive residents should be care planned if they were positive or when the resident refuses . During an interview on 6/26/2024 at 4:37 PM, the ADM said she expected the MDS to capture psychiatric diagnosis and completing timely and accurately. The ADM said it could affect the resident and was how we base our care plan to care for them correctly. The ADM said a diagnosis of bipolar would indicate positive PASRR and would be a yes on the PASRR screening as positive. The ADM said she expected services to be care planned even if refused . During record review of the facility's policy, dated 10/30/2017, titled PASRR Evaluation PE Policy and Procedure revealed reflected .1. It is the policy of Creative Solutions in Healthcare facilities to ensure the LIDDA and/or LMHA complete a PE within the appropriate time periods (14 days). 2. The nursing facility will monitor for the LA to enter the PE into the TMHP portal within 3 business days of the IDT meeting.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interviews and record review, the facility failed to ensure all Pre-Admission Screening and Resident Review (PASRR) Level I residents with mental illness and intellectual disabilities were provided with a PASRR Evaluation assessment for 2 of 5 residents (Residents #32 and #58) reviewed for PASRR screening, in that: 1. The facility failed to coordinate with the Local Intellectual/Developmental Disability and/or Local Mental Health Authority (Local Authority) to ensure an accurate PASRR Level I Evaluation and a PASRR Level II Evaluations were conducted for Resident #32 who had a serious mental illness. 2. The facility failed to coordinate with the Local Intellectual/Developmental Disability and/or Local Mental Health Authority (Local Authority) to ensure an accurate PASRR Level I Evaluation and a PASRR Level II Evaluations were conducted for Resident #58 who had developmental disability and a mental illness. These failures could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs. Findings include: 1. Record review of Resident #32's face sheet, dated 06/26/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #32 had diagnoses which included hepatitis C (a viral infection that causes liver swelling, called inflammation), dementia (term used to describe a group of symptoms affecting memory, thinking and social abilities) and major depressive disorder (Major depressive disorder [MDD], also known as clinical depression, is a mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities). Record review of Resident #32's quarterly MDS assessment, dated 04/30/2024, reflected Resident #32 had a BIMS of 15, which indicated no cognitive impairment. Resident #32 had little interest or pleasure in doing things 7-11 days of the past 14 days, felt down, or depressed 2-6 days of the last 14 days, and had a poor appetite and trouble concentrating 2-6 days of the last 14 days. Resident #32 required supervision for ADLs. Record review of Resident #32's care plan, dated 06/19/2023, reflected Resident #32 had potential to feel depressed related to admission and recent loss of wife. An intervention was listed and arrange for psychiatric consult as needed. Record review of Resident #32's PASRR level 1 screening, dated 02/16/2024, completed by the RN case manager at a local hospital, reflected .mental illness .is there evidence or an indicator this is an individual that has a mental illness .No (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/2024 at 10:00 a.m., the MDS nurse said she was responsible for entering the information for PASRR on all residents. She said Resident #32 should have been PASRR positive related to his diagnosis of major depressive disorder. She said she was not the MDS nurse who submitted the original PL1. She stated his PL one was not submitted and accepted until 02/16/2024 even though he admitted [DATE]. She stated it appeared the previous MDS nurse put the information into the portal but never followed up to see if the PASRR was not accepted and remained in invalid status until 02/16/2024 when it was resubmitted. Attempt made on 06/26/2024 at 10:15 a.m. to interview previous MDS nurse with no return call. During an interview on 06/26/2024 at 11:00 a.m., the DON said if Resident #32 had a diagnosis of major depressive disorder, then mental illness should have been marked on the PASRR Level 1. She said, then the LA decided if the resident qualified. She said the MDS coordinator was responsible for PASRR Level 1s. She said if a PASRR Level 1 was not done correctly the resident, specialized services were not received. During an interview on 06/26/2024 at 4:45 p.m., the ADM said mental illnesses should be on the PASRR Level 1. She said the MDS Coordinator was responsible for PASRR being completed correctly and ensuring they were approved in the portal. She said when the PASRR Level 1 assessments were not correct, residents lost out on services available to them. 2. Record review of Resident #58's face sheet, dated 06/25/24, reflected Resident #58 was [AGE] years old and was admitted to the facility on [DATE]. Resident #58 had diagnoses which included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), Cerebral Palsy (a group of conditions that affect movement and posture caused by damage that occurs to the developing brain, most often before birth), and difficulty walking. Record review of Resident #58's admission MDS assessment, dated 02/23/24, reflected Resident #58 was not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability. Resident #58 was understood and understand others. Resident #58 had a BIMS score of 11, which indicated moderate cognitive impairment. The MDS indicated active diagnoses of bipolar disorder and cerebral policy. Record review of a care plan, dated 05/10/24, reflected Resident #58 had the potential for psychosocial well-being related to anxiety, bipolar disorder, cerebral palsy, and depression. There was an intervention to initiate referrals as needed. Record review of a List of PASRR Positive Residents, provided by the facility on 06/24/24, reflected Resident #58 was PASSR positive. Record review of Resident #58's PASSR Level 1 Evaluation, dated 01/23/24, reflected Resident #58 did not have a mental illness, intellectual disability, or developmental disability. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/24 at 10:24 a.m., the MDS Coordinator said Resident #58 was PASRR positive and her PASRR Level 1 Evaluation was incorrect. She said the PASRR Level 1 Evaluation completed in 01/24 indicated Resident #58 was PASRR negative. She said Resident #58 should have been marked as positive due to her diagnoses. The MDS Coordinator said she began working at the facility in May 2024. She said she conducted an audit at the first of June 2024 and had caught the mistake. The MDS Coordinator said she was unable to request a new PASRR Level 1 Evaluation because she did not have an access number because of changes in the company since 06/01/24. She said a PASRR Level II was not conducted. During an interview on 06/26/24 at 8:33 a.m., Resident #58 said she heard of PASRR Services. She said she did not know if she would have used the PASRR services or not because she never had them before. During an interview on 06/26/24 at 3:59 p.m., the DON said she did not know why a new PASRR Level 1 Evaluation was not requested for Resident #58 since she had a diagnosis of bipolar disorder and Cerebral palsy. She said with those diagnoses she would have expected for a new PASRR Level 1 Evaluation to have been requested. She said the resident not being appropriately evaluated could have caused the resident to have not received PASSR services. She said the MDS Coordinator was responsible for requesting a correct PASRR Level 1 Evaluation. She said there was a lapse of MDS Coordinators until May and that may have been why it was missed. During an interview on 06/26/24 at 4:41 p.m., the Administrator said she would have expected for a new PASRR Level 1 Evaluation to have been requested for Resident #58. She said the resident should be PASRR positive due to her diagnosis of bipolar and cerebral palsy. She said her PASRR Level 1 Evaluation not being correct and not having a PASRR Level II Evaluations could cause Resident #58 not to have received the services she needed. Record review of the facility's, undated, Preadmission Screening and Resident Review (PASRR) policy reflected .all persons needing admission to a nursing facility must have a preadmission screening for possible mental illness and or mental retardation (DD/ID) (Level 1) .all persons who reside in a nursing facility are subject to resident review . The policy did not address accuracy of the PASRR Level 1. 44128

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interview and record review the facility failed to ensure a baseline care plan was developed and implemented for each resident that included the instructions for resident care needed to provide effective and person-centered care of the resident that met professional standards of quality of care for 2 of 4 residents (Residents #163 and #213) reviewed for baseline care plans. 1. The facility failed to complete a baseline care plan with Resident #163 and Resident #213 within 48 hours of admission. 2. The facility failed to provide Resident #213 or Resident #213's RP, a copy of the summary of the baseline care plan. These failures could place residents at risk of not receiving care and services to meet their needs. Findings include: 1. Record review of Resident #163's face sheet, dated 06/26/2024, reflected an 86- year-old- female who was admitted to the facility on [DATE]. Resident #163 had diagnoses which included chronic atrial fibrillation (an irregular and often very rapid heart rhythm. An irregular heart rhythm is called an arrhythmia), hypertension (high blood pressure), and mild cognitive impairment (the stage between the expected decline in memory and thinking that happens with age and the more serious decline of dementia). Resident #163 was her own responsible party/representative. Record review of the EHR reflected no admission MDS assessment was completed for Resident # 163. Record review of the baseline care plan acknowledgment form dated 06/19/2024, reflected a copy of the baseline care plan was given to Resident #163 and Resident #163's representative. Record review of Resident #163's baseline care plan reflected it was completed on 06/24/2024. During an interview on 06/25/2024 at 12:22 p.m., Resident #163 stated she had not had any meeting discussing her care since she was admitted and had not received a copy of her baseline care plan. Resident #163 stated she would have liked to have a meeting so she could know what was actually going on in the facility and with her care. 44933 (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #213's face sheet, dated 06/25/24, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #213 had diagnoses which included Alzheimer's disease (is a type of dementia that affects memory, thinking, and behavior), retention of urine (is caused by a blockage that partially or fully prevents urine from leaving the bladder or urethra, or a failure of the bladder to squeeze hard enough to expel all of the urine)., overflow incontinence (the inability to control urination), hypertension (high blood pressure), and spinal stenosis (the spaces inside the bones of the spine get too small). Resident #213's RP/RR was a family member. Record review of the EHR reflected Resident #213 was admitted to the facility less than 21 days ago. No MDS for Resident #213 was completed prior to exit. Record review of Resident #213's baseline care plan, reflected it was initiated on 06/24/24. Resident #213's care plan was initiated more than 48 hours after admission which was on 06/20/24. Record review of Resident #213's Baseline Care Plan Acknowledgement, dated 06/20/24, reflected .a copy of the baseline care plan was provided to the resident .06/20/24 00:00 .Struck out by: LVN D . Stuck out reason: Technical Error .Struck Out Date: 06/20/24 . There was no evidence of another Baseline Care Plan Acknowledgement for Resident #213 or Resident #213's RP/RR in the facility's electronic charting system. During an interview on 06/25/24 at 8:37 a.m., Resident #213 said she was admitted to the facility because she could no longer care for herself at home. She said she did not recall receiving a copy of her plan of care from the facility. She said maybe her family member did when she was admitted . Attempted interview on 06/26/24 at 1:20 p.m., with LVN D by phone was unsuccessful. Attempted interview on 06/26/24 at 1:25 p.m. with Resident #213's RP/RR by phone was unsuccessful. Attempted interview on 07/01/24 at 11:57 a.m. with Resident #213's RP/RR by phone was unsuccessful. During an interview on 06/25/2024 at 3:13 p.m., LVN B stated the charge nurse who admitted the new resident was responsible for starting the baseline care plan the day of admission and the Social Worker and MDS nurse were responsible for completing the baseline care plan. She did not know the baseline care plan needed to be completed within 48 hours. She stated there was a form in the EHR that the nurses were trained to always use called acknowledgement of the baseline care plan. LVN B stated she was not sure why that form was filled out or what the purpose of it was. During an interview on 06/26/2024 at 2:00 p.m., the MDS nurse said the baseline care plan was completed by the floor nurse who received the resident for admission. It was one of many assessments completed on admission, but the baseline care plan, the admission assessment, and the skin assessment were priority to complete the day the resident was admitted because they were time sensitive. The MDS nurse said she had not given any resident a copy of their base line care plan, asked them to sign it, or given them a copy of their medication and treatments. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/2024 at 11:00 a.m., the DON said baseline care plans were used in place of a comprehensive care plan until one could be developed to direct resident care according to their goals and choices. The DON said the baseline care plan needed to be completed with each department and discussed with the resident and resident representative. The DON said the baseline care plan was given to the resident and family along with a list of any medications and treatments the resident received. The DON said it was her responsibility to inform the nurses of the facility policy on baseline care plans. The DON said she was not aware the nurses were not providing the resident with the baseline care plans or that baseline care plans were not being completed timely. The DON said the resident could have felt left out or rejected when not given the opportunity to take part in their care plan. During an interview on 06/26/2024 at 4:45 p.m., the Administrator said the baseline care plans were an interdisciplinary form that was discussed with the residents on admit. The Administrator said it was the DON's responsibility to ensure the floor nurses completed the baseline care plan and provided a copy to the resident and the family. Record review of the facility's policy titled Base Line Care Plan reflected .Completion and implementation of the baseline care plan within 48 hours of a resident's admission {was} intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and ensure the resident and representative, if applicable, are informed of the initial plan of delivery of care and services by receiving a written summary of the baseline care plan.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 16 residents (Resident #45) reviewed for care plans. The facility failed to ensure Resident #45 care plan was implemented when the resident did not have his abdominal binder (is a wide compression belt that encircles your abdomen) over his PEG feeding tube (Percutaneous endoscopic gastrostomy; is a tube inserted surgically into the stomach through the abdominal wall) on 06/24/24 which was a care plan intervention. This failure could place residents at risk of not having individual needs met and cause residents not to receive needed services. Findings include: Record review of Resident #45's face sheet, dated 06/24/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #45 had diagnoses which included nontraumatic intracerebral hemorrhage (bleeding into the brain tissue) and dysphagia (difficulty swallowing). Record review of Resident #45's quarterly MDS assessment, dated 04/05/24, reflected Resident #45 was usually understood and sometimes understood others. Resident #45 had adequate hearing and vision, and clear speech. Resident #45 had a BIMS score of 00, which indicated severe cognitive impairment. Resident #45 had a feeding tube (tubes mainly inserted into the gastrointestinal [GI] tract to provide a patient with a route for enteral nutrition [is a way of sending nutrition right to the stomach or small intestine]) while a resident of the facility and within the last 7 days. Record review of Resident #45's care plan, dated 03/20/23, revised on 06/02/23, reflected Resident #45 required tube feeding related to a diagnosis of dysphagia. Resident #45 was known to pull out the feeding tube and move the abdominal binder to get to his tube. Intervention included abdominal binder for PEG tube protection at all times. During an observation and interview on 06/24/24 at 11:47 a.m. revealed Resident #45 was in the dining room, in a specialty wheelchair. Resident #45 was playing with his shirt and raised his shirt up to expose his abdomen. Resident #45's abdomen had a PEG tube with a dressing over. Resident #45 did not have an abdominal binder around his PEG tube. Attempted to interview Resident #45. Resident #45 kept repeating, why when questions asked. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/24 at 1:30 p.m., RN E said resident care plan interventions should be followed. She said Resident #45's abdominal binder should be always over his PEG site if it was a care plan intervention. She said if Resident #45's abdominal binder was not over his PEG site then it risked being dislodged. She said if Resident #45's PEG tube was dislodged then he would have to be sent out for surgery to replace it. During an interview on 06/26/24 at 3:05 p.m., the DON said she expected Resident #45's abdominal binder to be always on like the care plan intervention said. She said it was the LVNs responsibility to ensure Resident #45's abdominal binder was over his PEG site. She said LVN P should have ensured Resident #45 had his abdominal binder on Monday (06/24/24). She said not following Resident #45's care plan intervention, risked his PEG tubing being pulled out. She said if Resident #45's PEG tubing was pulled out, it risked him missing feedings, trauma to the site and infection. Attempted interview on 06/26/24 at 4:00 p.m., with LVN P by phone was unsuccessful and a recording stated, no longer in service. During an interview on 06/26/24 at 4:45 p.m., the ADM said she expected Resident #45 to have on his abdominal binder over his PEG site if it was ordered and on his care plan. She said the charge nurses were responsible for making sure Resident #45 had the abdominal binder on. She said if the abdominal binder was not over Resident #45's PEG site, the tubing could come out. Record review of the facility's, undated, Comprehensive Care Planning policy reflected .the facility will develop and implement a comprehensive person-centered care plan for each resident .interventions are the specific care and services that will be implemented .the facility will ensure that services provided or arranged are delivered

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interview and record review the facility failed to ensure residents had a discharge summary that included a recapitulation of the resident's stay that included, but was not limited to diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results for 1 of 2 residents (Resident #61) reviewed for discharge summaries. The facility failed to ensure Resident #61 had a discharge summary. This failure could place residents at risk for interruption of care after discharge, receiving the wrong care after discharge, and rehospitalization after discharge. Findings include: Record review of Resident #61's face sheet, dated 06/26/2024, reflected Resident #61 was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #61 had diagnoses which included sepsis (a serious condition in which the body responds improperly to an infection), hypertension (high blood pressure), and anxiety (uncontrolled nervousness). Record review of Resident #61's physician orders reflected on 05/03/2024 an order was received for Resident #61, written by LVN A, Discharge home with home health, physical therapy, all medications, and personal belongings. Record review of Resident #61's EHR, as 06/26/2024, reflected Resident #61 did not have a discharge summary which included a recapitulation of the resident's stay which included, but was not limited to diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results. During an interview on 06/26/2024 at 11:27 a.m., the SW stated she started a discharge summary for Resident #61. She stated the nursing staff were responsible for completing the discharge summary that would include the required clinical information. She stated she was not sure if nursing completed the discharge summary or if the summary was lost at the physician's office when it was out for signature. She stated the discharge summary for Resident #61 was unlocatable. She stated the discharge summary was to be completed prior to the resident's discharge so they would have a copy of important information about their stay prior to going home. During an interview on 06/26/2024 at 4:45 p.m., the Administrator stated the discharge summaries were completed for Resident #61 by the Social Worker and nurses, and a copy was sent to the physician to sign. The ADM was unsure why a copy of Resident #61's discharge summary was unlocatable. During an interview on 06/26/2024 at 11:00 a.m., the DON stated the nursing discharge summary was her responsibility to ensure it was completed. She said in addition to the discharge summary the charge nurse at the time of discharge was to print the medication review and give the remaining medications to the resident to discharge home. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/2024 at 11:15 a.m. attempted to contact LVN D that was responsible for Resident #61's discharge summary and no return call was received. Record review of Discharge Process Policy, dated October 2022, reflected the facility will ensure a smooth discharge process to include a discharge process and documentation of recapitulation of the resident's stay that included patient diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain personal hygiene for 1 of 4 resident reviewed for quality of life. (Resident #213) The facility failed to remove Resident #213's unwanted facial hair. This failure could place residents who required assistance from staff for ADLs at risk of not receiving care and services to meet their needs which could result in poor care, feelings of poor self-esteem, lack of dignity and health. Findings included: Record review of Resident #213's face sheet, dated 06/25/24, indicated Resident #213 was an [AGE] year-old, female and was admitted to the facility on [DATE] with diagnosis including Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior). Record review of the MDS assessment indicated Resident #213 was admitted to the facility less than 21 days ago. No MDS for Resident #213 was completed prior to exit. Record review of a care plan, dated 06/24/24, indicated Resident #213 had ADL self-care performance deficit. Intervention included bathing: supervise as needed. Record review of Resident #213's Skin Assessment-Shower/Bath sheet, dated 06/22/24, indicated .Resident #213 received a shower but was not shaved .CNA G . During an observation on 06/24/24 at 11:32 a.m., Resident #213 was walking in her room with her rollator. Resident #213 had five to ten, medium, blonde hair noted to her chin. During an observation and interview on 06/25/24 at 8:37 a.m., Resident #213 was sitting on the side of her bed. Resident #213 had five to ten, medium, blonde hair noted to her chin. Resident #213 said she had been admitted to the facility because she could not take care of herself at home anymore. She said she had received a shower since she got to the facility, but the aides did not know what they were doing. She said she could not remember the name of the aide who helped shower her, but she did not shave her. She said she did not want chin hair and would let someone remove it. She said no woman wanted facial hair. She said chin hair was embarrassing. During an observation and interview on 06/25/24 at 3:50 p.m., CNA G said she was the aide who showered Resident #213 on 06/22/24. She said she did not shave Resident #213 on 06/22/24. She said she had accidently circled, yes, on the skin assessment. CNA G took the skin assessment sheet and circled, no with her initials. She said she did not recall if Resident #213 had facial hair when she showered her on 06/22/24. She said she did not know if Resident #213 had facial hair because she was not assigned to her on 06/25/24. She said aides were responsible for shaving resident with showers or bed baths. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 06/25/24 at 3:55 p.m., CNA H said she had Resident #213 today. She said she had not noticed Resident 213's facial hair today. She said Resident #213 had refused her shower today because she did not feel good. CNA H went to Resident #213 room and looked at her face. CNA H said Resident #213 did have some chin hair. CNA H said when Resident #213 felt better, she would take care of it. CNA H said it was the aide's responsibility to remove facial hair for resident who needed help. She said it was important to remove unwanted facial because it could be embarrassing to the female resident. During an interview on 06/26/24 at 1:35 p.m., LVN F said the aides should remove female facial hair with showers and as needed. She said the charge nurse should be ensuring female resident facial hair was removed. She said charge nurses had to sign the shower sheet after the aides completed bed bath or showers. She said the shower sheets also had a place to document if the resident was shaved or not. She said it was the facility's responsibility to assistance residents with ADL care. She said unwanted facial hair could cause self-esteem and dignity issues. During an interview on 06/26/24 at 3:05 p.m., the DON said CNAs were responsible for removing unwanted facial hair from men and women. She said facial hair should be removed with showers and when requested by the resident. She said charge nurse should ensure CNAs performed showers/bed baths and removed facial hair. She said not removing Resident #213's facial hair was a dignity issue. Record review of an undated facility's Shaving, Electric/Safety Razors policy and procedure, indicated .it is usually done as a part of a daily personal hygiene .although every other day is sufficient .it is done to promote cleanliness and a positive body image .usually, the resident or a staff member performs the procedure, but the nurse can shave the resident if illness or disability prevents independence .

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 44933 Based on interview and record review, the facility failed to ensure the activities program was directed by a qualified professional who was a qualified therapeutic recreation specialist or an activities professional who completed a training course approved by the State for 1 of 1 facility reviewed for quality of life. The facility did not ensure the Activity Director was qualified to serve as the director of the activities program. This failure could place residents at risk of not receiving a program of activities that meets their assessed activity needs. Findings include: Record review of a Personnel File Review Sheet, undated, indicated .Activity Director .no licensed activity director . Record review of a copy of an email provided by the ADM, given on 06/24/24, indicated .APN Credentialing Center .date paid June 04, 2024 .1xAPNCC Competency Exam . A posted note was attached to the email which stated .NCAD is scheduled to take her test next week for activity director certification . During an interview on 06/24/24 at 4:30 p.m., the ADM said the new company took over June 1st, 2024. She said the facility's current AD was not certified but was taking her certification test the following week. She said the facility's current AD was not working under a certified AD certificate nor was there a corporate AD on staff. During an interview on 06/25/24 at 11:00 a.m., the HR Coordinator said the facility did not have a certified AD. She said it had been at least 6 months since the facility had a certified AD. During an interview on 06/24/24 at 2:20 p.m., the Activity Director said she had been employed at the facility since the end of December 2024. She said she had previously worked at the facility in 2021 as the activity director assistant. She said she had also worked at an assisted living facility for 2 years prior to be hired in December 2024. She said when she was initial hired her job title was activity supervisor. She said she knew some of the residents from previous time at the facility. She said she developed the activities for the resident when she started by getting to know them the first week of hire. She said she also got activity ideas from resident council meeting minutes and research online ideas. She said she looked at the resident's care plans upon hire but the care plan for activities had bare minimal information. She said upon hire, the old company did not assist her in getting her certification. She said she had no guidance from a certified AD. She said when she was initially hired with the old company, the facility did not have an AD for a month and half. She said being a certified AD was important because they had more knowledge on topics like dementia to help plan activities. She said she had been doing one on one with residents but had not been documenting until the new company took over and explained her responsibilities. (continued on next page)

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 06/26/24 at 3:05 p.m., the DON said the current AD was not certified. She said the AD had been employed at the facility since the end of December 2024. She said she did not know why the facility was required to have a certified AD. During an interview on 06/26/24 at 4:45 p.m., the ADM said it was important to have a certified AD, so they knew what to do, how to provide 1 on 1 activities, and engage the residents. She said not having a certified AD risked residents having a hard stay due to boredom, depression, and anxiety. Record review of an undated Job Description Activity Director form, indicated .these are legitimate measures of the qualifications for the Activity Director .must be certified Activity Director .

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observation, interview, and record review, the facility did not ensure treatment and services was provided, consistent with professional standards of practice, to promote healing and prevent new ulcers from developing for 1 of 4 residents reviewed for quality of care. (Resident #38) 1. The facility failed to appropriately assess Resident #38's skin and wounds after readmission from 06/20/24 through 06/23/24. A new wound to the right lateral glute was identified by the facility on 06/24/24 when it was a Stage III pressure injury (a full thickness loss of skin extending to the subcutaneous tissue). 2. The facility failed to follow previous wound care recommendations from the wound care physician for wounds to the sacrum and left foot for Resident #38 from 06/20/24 through 06/23/24. 3. The facility failed to provide appropriate skin and wound care after readmission on 06/20/24 through 06/23/24. 4. The facility failed to notify the Dietician of Resident #38's wounds. 5. The facility failed to order supplements to promote wound healing. 6. The facility failed to provide appropriate wound care when LVN A placed a urine-soaked brief over a newly placed dressing during wound care to the unstageable wound to the sacrum. These failures resulted in the identification of an Immediate Jeopardy (IJ) on 06/25/24 at 5:30 p.m. While the IJ was removed on 06/26/24 at 11:05 a.m., the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for developing avoidable pressure injuries and the worsening of existing pressure injuries. Findings included: Record review of Resident #38's face sheet dated 06/25/24 indicated Resident #38 was [AGE] years old and was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of dementia, Type 2 Diabetes Mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), and heart disease. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #38 was usually understood and usually understood others. The MDS indicated a BIMS score of 99 which indicated Resident #38 was unable to complete the interview. The MDS indicated Resident #38 was dependent on staff for all ADLs. The MDS indicated Resident #38 was at risk of developing pressure ulcers/injuries. The MDS did not indicate any unhealed pressure ulcers/injuries. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the care plan last revised on 06/03/24 indicated Resident #38 had potential for impairment to skin integrity and pressure ulcers related to incontinence of bowel and bladder, decreased mobility, use of anticoagulant medications, scratches buttocks causing abrasion or broken skin. There was an intervention to follow facility protocols for treatment of injury. The care plan indicated Resident #38 had an unstageable deep tissue injury to the left medial foot. There were interventions to administer and encourage compliance with supplements to promote wound healing and to administer medication and treatment (skin prep every day) as ordered. The care plan indicated Resident #38 had actual impairment related to an open wound area of the sacrum (area located at the base of the lumbar spine where it connects to the pelvis). There was an intervention to encourage good nutrition and hydration in order to promote healthier skin. Record review of Resident #38's consolidated physician orders dated 06/25/24 indicated an order to cleanse sacrum with wound cleanse and pat dry, apply collagen sheet and cover with island border, daily and as needed for wound treatment. There was an order to cleanse a Stage 3 pressure wound to the right lateral glute (right upper buttock) with wound cleanse, pat dry, apply collagen, cover with dry dressing every day, and as needed, with a start date of 06/24/24. The consolidated physician orders did not indicate orders for wound care for a deep tissue injury to the left foot, Vitamin C, Zinc, a protein supplement, or a dietary consultation. Record review of a facility Weekly Skin Assessments and Treatments In-Service Training Report for nursing staff dated 05/28/24 indicated, .when wound care nurse is not here you are responsible for weekly skin assessments and corresponding wound progress assessments. For every wound the resident has you must complete a weekly skin observation .Treatments are to be completed as ordered . Record review of Resident #38's electronic medical record accessed on 06/24/24 and 06/25/24 did not indicate dietary notes or a skin assessment for 06/20/24. Record review of a Weekly Skin assessment dated [DATE] at 2:45 p.m. indicated Resident #38 had a pressure (an injury to the skin from prolonged pressure), venous (a wound on the leg or ankle caused by abnormal or damaged veins), arterial (an ulcer caused from arterial insufficiency), or diabetic (an ulcer caused by complications with diabetes) ulcer. The assessment did not indicate the type, location, or size of the ulcer. Record review of a Weekly Skin assessment dated [DATE] at 6:27 a.m. indicated Resident #38 had a deep tissue injury to right buttocks and left medial foot with current treatments in place for both. The assessment did not indicate the size of the injuries. Record review of a Weekly Skin Assessment for Resident #38 dated 06/24/24 at 1:07 a.m. indicated, .Noted bleeding to sacrum (area that is located at the base of the lumbar spine, where it connects to the pelvis) area, and to bil (bilateral buttocks) . The size was documented as 5 centimeters x 5.5 centimeters. The assessment did not indicate a pressure, venous, arterial, or diabetic ulcer. Record review of a Weekly Skin assessment dated [DATE] at 19:27 a.m. indicated Resident #38 had a pressure, venous, arterial, or diabetic ulcer. The assessment did not indicate the type, location, or size of the ulcer. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a Wound Evaluation and Management Summary report by the Wound Care Physician dated 06/05/24 indicated an Unstageable DTI (deep tissue injury) of the left, distal (sites located away from a specific area), medial (middle) foot undetermined thickness. The deep tissue injury to the left foot measured 2 centimeters in length x 1.8 centimeters in width. The depth of the wound was no measurable. The Dressing Treatment Plan indicated, Primary Dressing: Betadine apply once daily for 23 days. The report indicated an Unstageable DTI of the right, medial buttock (sacrum). The wound size was 2.8 centimeters in length x 0.8 centimeters in width x 0.1 centimeters in depth. The Dressing Treatment Plan indicated, Primary Dressing: Collagen sheet apply once daily for 30 days. Secondary Dressing: Gauze Island with border apply once daily for 30 days. The report was signed by the Wound Care Physician. The report did not indicate a pressure injury to the right later glute. Record review of a Wound Care Evaluation and Management Summary report by the Wound Care Physician dated 06/12/24 indicated Resident #38 was not seen due to a non-wound-related hospitalization since last visit. Record review of Consult to Wound Care for High Risk Braden Score hospital record dated 06/13/24 at 11:21 a.m. indicated, Resident #38 was admitted to the hospital on 06/12/24. The record indicated a Braden Score of 13 which indicated Resident #38 was at moderate risk for pressure injury. The record indicated a pressure injury to the left foot that measured 3 centimeter in length x 3.2 centimeter in width x 0.0 centimeter in depth. The pressure injury to the left foot was staged as a deep tissue pressure injury. The wound was black in color and was intact. The record indicated a wound to buttocks (sacrum wound) that measure 3 centimeters in length x 1 centimeter in width x 0.1 centimeter in depth. The wound was described as red in color with defined edges. The pressure injury was staged as a deep tissue pressure injury. The record indicated a pressure injury to right trochanter (right glute). The record indicated the wound measured 1 centimeter in length x 1 centimeter in width x 0.0 centimeter in depth. The wound was described as pink, red, and non-blanchable. The pressure injury was staged as a Stage 2 pressure injury. The note was signed by a registered nurse and a physician. Record review of Progress Note, Hospital Day 6, dated 06/18/24 at 11:36 a.m. indicated Resident #38 had an unstageable pressure injury to ball of left foot and a sacral pressure injury. There was no documentation of measurements or wound description. The progress note was signed by a Nurse Practitioner. Record review of a Readmission Nurses' Note dated 06/20/24 at 6:30 p.m., indicated Resident #38 was readmitted from the hospital. The notes did not include an assessment of the skin or wound care. The note was signed by LVN R. Record review of Hospice Skilled Nursing Visit Note dated 06/20/24 between 6:37 p.m. and 8:40 p.m. indicated an unstageable pressure ulcer to the left medial proximal foot great toe. The wound measurements were 2 centimeters in length x 1.5 centimeters in width. The notes indicated the wound to the sacrum had a dry and intact dress. The note indicated the wound was not visualized due to the fact Resident #38 was hollering with position change for visualization. The note indicated an area to the right posterior lateral outer lower torso hip (right glute). The note indicated this was a Stage 1 pressure ulcer. An additional note describing the wound indicated, Scatter areas of 'white' tissue that are intact. There were no measurements of the area. The Hospice Skilled Nursing Visit Note indicated a Pressure Ulcer Risk Assessment total score of 9 which indicated Resident #38 was a very high risk for pressure ulcers. The Hospice Skilled Nursing Visit Note was signed by Hospice Nurse T. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a Hospice Skilled Nursing Visit Note dated 06/21/24 at 10:00 a.m. indicated, .Wounds not observed at this time as the nurse stated they just turned him and got him settled. Facility staff does wound care . The note was signed by Hospice Nurse S. Record review of a Nursing Progress Note for Resident #38 dated 06/24/24 at 7:08 p.m. indicated, New stage 3 pressure wound of right lateral glute noted 2 cm x 0.9 cm x 0.1 cm light serous drainage noted no foul odor or s/s (signs or symptoms) infection. 25% slough (dead tissue separating from living tissue) noted to wound bed surrounding skin intact normal color. Edges are intact and flush to skin. Hospice notified. NEW ORDER per (Wound Care Physician): Cleanse with wound cleanser, pat dry, apply collagen cover with border gauze QD (daily). Continues with Unstageable DTI (deep tissue injury) of he left distal medial foot 2.7 cm x 2.5 cm x UTD (unable to determine) area is not open dark purple in color. Continues with unstageable to right medial buttock that has extended to left buttock/sacral area. 7.5 cm x 1.2 cm x 0.1 cm. [NAME] eschar to wound bed <25% . Record review of a Weekly Ulcer assessment dated [DATE] at 7:29 p.m. indicated Resident #38 had an ulcer to the left distal medial foot. The type of ulcer was pressure. The Pressure Ulcer Stage was deep tissue injury. The documented wound measurement was 2.5 centimeters in length x 3 centimeters in width. The depth could not be measured. The assessment indicated the current wound treatment was to cleanse with wound cleanser, pat dry, apply betadine every day. There was a note to continue orders from the Wound Care Physician. Record review of a Weekly Ulcer assessment dated [DATE] at 7:36 p.m. indicated Resident #38 had an ulcer to the sacrum. The type of ulcer was pressure. The Pressure Ulcer Stage was deep tissue injury. The documented wound measurement was 5 centimeters in length x 8.7 centimeters in width. The depth could not be measured. The assessment indicated the current wound treatment was to cleanse with wound cleanser, pat dry, apply collagen, and cover with a border gauze daily. There was a note that indicated, wound labeled per (Wound Care Physician) as unstageable of the right medial buttock has extended over to the sacral area. Record review of a Weekly Ulcer assessment dated [DATE] at 7:48 p.m. indicated Resident #38 had an ulcer to the right lateral glute. The type of ulcer was pressure. The Pressure Ulcer Stage was Stage III. The documented wound measurement was 2.7 centimeters in length x 1 centimeters in width. The depth could not be measured. The assessment indicated the current wound treatment was to cleanse with wound cleanser, pat dry, apply betadine every day. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a Wound Administration Record for June 2024 for Resident #38 indicated an order to cleanse right medial buttocks with wound cleanse and pat dry, apply collagen sheet and cover with island border gauze daily with a discontinued date of 06/24/24. The documentation of wound care to the right medial buttock indicated Resident #38 did not receive wound care of this wound on 06/20/24, 06/21/24, 06/22/24, 06/23/24, and 06/24/24. There was an order to cleanse sacrum with wound cleanse and pat dry. Apply collagen sheet and cover with island border gauze daily and as needed one time a day for wound treatment. The documentation of wound care to the right medial buttock indicated Resident #38 did not receive wound care of this wound on 06/20/24, 06/21/24, 06/22/24, 06/23/24, and 06/24/24.There was an order to cleanse an unstageable deep tissue injury of the left distal medial foot with wound cleanser, pat dry, they apply betadine everyday times 30 days. The order was discontinued on 06/13/24. The documentation of wound care to the unstageable deep tissue injury of the left distal medial foot indicated Resident #38 did not receive wound care of this wound on 06/02/24, 06/06/24, 06/20/24, 06/21/24, 06/22/24, 06/23/24, and 06/24/24. There was an order for a stage 3 pressure wound of the right lateral glute to cleanse with wound cleanser, pat dry, apply collagen, and cover with a dry dressing every day and as needed. The documentation of wound care to the right lateral glute indicated Resident #38 did not receive wound care of this wound on 06/20/24, 06/21/24, 06/22/24, and 06/23/24. During an observation and interview on 06/24/24 at 11:08 a.m., LVN F provided wound care to Resident #38. She said Resident #38 had been out to the hospital and was not on the Wound Care Physician's list on 06/19/24. There was wound to the sacrum that was measured by LVN F. The wound measured 7.5 centimeters in length x 7.2 centimeters in with. She said this wound was unstageable because of the slough to the wound bed. There was a wound to right glute 2 centimeters in length x 0.9 centimeters in width. She said this wound was a stage III. Each wound was cleansed with wound cleaner and a collagen dressing was applied. The deep tissue injury to the left foot was not observed and wound care to the wound was not provided by LVN F. During an interview on 06/25/24 on 2:49 p.m., the Wound Care Physician said typically if she was present in the facility, staff would let her know when a resident had returned to the facility. She said if she was not present in the facility staff wound not have to notify her unless there was a new skin issue. She said anytime wound care was not done there was a problem with that. She said Resident #38 had a pressure injury on the left foot and unstageable pressure injury to the right buttock when he left to the hospital. She said she was notified 6/24/24 of the new pressure injury to the right glute. She said staff were allowed to call her for new orders. She said she would expect to be notified anytime a new wound was found. During an observation and interview on 06/25/24 at 3:40 p.m., LVN A provided wound care to Resident #38. LVN A said it was the first time he was seeing Resident #38's wounds. LVN A measured the deep tissue injury to the left foot. The measurements were 2.5 centimeters x 3.0 centimeters. The wound appeared black and was not open. LVN A measured the wound to the right glute. The wound measured 2.7 centimeters x 1 centimeter. The wound was Stage III. The wound open with a small amount of slough. LVN A measured the wound to the sacrum. The wound measured 5 centimeters x 8.7 centimeters. The wound bed was red with slough. During the wound care LVN A did not remove a urine-soaked brief that was under Resident #38. After cleansing the wound to the sacrum, LVN A pulled the urine-soaked brief over the clean dressing in order to turn the resident in bed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/26/24 at 11:12 a.m., LVN R said when she came on duty on 6/20/24, Resident #38 was already at the facility. She said she did complete his readmission assessment. She said she did not complete a skin assessment because the hospice nurse was in the room admitting him to hospice. She said she was in the room during part of the skin assessment by the nurse. She said she was 100% sure it was done. She said she did not obtain any wound care orders. She said she did not provide any wound care. She said she contacted the ADON off and on during the night of 06/20/24 concerning Resident #38's orders, what needed to be done, and what the resident needed. She said she called the ADON and gave her a verbal report on the morning of 6/21/24 and the ADON told her she would handle it. During an interview on 06/26/24 at 1:34 p.m., a family member of Resident #38 said they were notified of Resident #38's wounds on 6/25/24. They said they were made aware of the new wound at that time. They said Resident #38 only had two wounds present that they were aware of while he was in the hospital. During an interview on 06/26/24 at 1:48 p.m., Hospice Nurse S said Hospice Nurse T was the on-call Hospice nurse when Resident #38 was readmitted to the facility. She said Hospice Nurse T was the nurse that assessed Resident #38. She said Hospice Nurse T did not complete a skin assessment because Resident #38 was agitated and tried to bite her. She said no wound care orders were placed at that time. She said she would have expected for the facility to have followed up on obtaining a skin assessment and obtaining wound care orders. Especially, since he had been to the hospital and had previous wound care orders from the Wound Care Physician. During an interview on 06/26/24 at 1:56 p.m., Hospice Nurse T said she did a skin assessment on Resident #38. She said she was able to observe all wounds except for the sacrum. She said he became agitated and was hitting and biting staff. She said a facility CNA was in the room helping her. She said she documented the wounds in her notes. She said the wound to the right glute was not open when she did the assessment on 06/20/24. She said it was a white area. She said it was only at risk. She said she called the Hospice MD and notified him that she was unable to assess the sacral wound. She said she also told Hospice Nurse S. She said hospice worked in coordination with the facility. She said hospice had 5 days to complete a skin assessment. During an interview on 06/26/24 at 2:40 p.m., LVN A said he had provided care to Resident #38 beginning the morning of 06/21/24. He said Resident #38 had returned on the night of 06/20/24. He said he did not complete a skin assessment. He said he did not know Resident #38 had any wounds and did not lay eyes on his wounds until 6/25/24. He said on the 06/21/24 he was not aware of any skin issues Resident #38 had. He said there were no orders on 06/21/24 for wound care for Resident #38. He said if there had been it would have been his responsibility to have provided wound care. He said at times they do have treatment nurses that volunteer to do wound care for the day. He said there was not a treatment nurse on 6/21/24. He said the admitting nurse should done a skin assessment within 4 hours. Any skin issues should have been assessed and the doctor should have been called to receive orders for the wound. He said during wound care on 06/25/24, he did cover up the new dressing to the sacrum with the urine-soaked brief. He said he was just so focused wound care and did not think about the urine-soaked brief. He said he had been in-serviced on proper incontinent care during wound care. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/26/24 at 3:03 p.m., the ADON said LVN R did not do a skin assessment when Resident #38 was readmitted to the facility. She said even though the hospice nurse did a skin assessment, she would have expected for LVN R to have done a skin assessment immediately. She said the previous orders from the Wound Care Physician should have been immediately restarted to the two wounds that were present on 6/12/24. She said LVN R should have communicated with the hospice nurse concerning wound care. She said she would have expected LVN R to have seen the new skin issue and obtained doctor's orders. She said she had talked to LVN R on the night of 06/20/24 about what all needed to be done. She they discussed assessments, oxygen needs, dietary needs, and care in general. She said she thought between LVN R and the hospice nurse, everything was taken care. She said she did not go in to assess the resident's wounds on 06/21/24. She said that would have been LVN A's responsibility. She said the admitting nurse was responsible for obtaining orders including supplements and a dietary consult. She said all wound care was documented in resident's electronic medical record on the Wound Care Administration Form. She said it was her job and the DON's job to monitor to make sure those things were being done. She said they had a meeting each morning and they went over the new admissions to make sure the assessments had been done. She said if a resident had an incontinent episode, the resident should be cleaned, and a dry brief should have been placed under the resident prior to wound care. She said a resident not receiving timely wound care could cause worsening skin issues, could cause gangrene, or the resident could expire. She said by a wet brief being placed over a freshly cleaned and dressed wound could cause germs to get in the wound and make it worse. During an interview on 06/26/24 at 3:29 p.m., LVN F said she was a charge at the facility. She said she was acting as the treatment nurse on 6/24/24. She 6/24/24 was the first time she provided wound care for Resident #38. She said the nurses were responsible for wound care to their residents. She said 6/24/24 was the first time she had ever assessed his wounds. She said the admitting nurse had 4 hours to do a skin assessment. She said the admitting nurse should then restart any previous orders and obtain new orders for any new skin issues. During an interview on 06/26/24 at 3:59 p.m., the DON said the facility had not had a full-time treatment nurse since first of June 2024. She said the charge nurse was responsible for providing wound care since they did not have a treatment nurse. She said she would have expected for LVN R to have completed a skin assessment on Resident #38 on 6/20/24 regardless of whatever assessments the hospice nurse had completed. She said the nurse should have then called the doctor and/or hospice to get a treatment order. She said the skin assessment should have been completed with 4 hours by the admitting nurse. She said the resident did go from the 06/20/24 to the 06/24/24 without wound care. She said by a resident not having skin assessments could cause the resident to miss treatments and cause a wound to worsen. She said the treatment nurse typically makes the dietician notification. She said now the charge nurse should report to her any skin issues and was responsible for notifying the dietician. She said when Resident #39 readmitted to the facility, supplements should have been ordered. She said she was not notified of any new wounds on 6/20/24 or 6/21/24. She did not find out about the new wound until 6/24/24. She said she had notified the dietician. She said she would have expected for supplements to have been started on 6/21/24. She said not having supplements could delay wound healing. She said LVN A should have completed the incontinent care before starting wound care. She said urine-soaked brief could cause infection to a wound. She said a resident not receiving wound care could cause a delay in healing and cause a wound to worsen. She said all wound care treatments were charted on the Wound Care Administration Form in the electronic medical record. She said herself and the ADON monitor by doing audits Monday - Friday to make sure resident receive the appropriate wound care. She said she was not working on 6/21/24 but she would have expected for the ADON to have followed up. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/26/24 at 4:41 p.m., the Administrator said she expected skin assessments to be completed within 4 hours of admission by the treatment nurse, designee, or the charge nurse. She said she would have expected for Resident #38 to have been assessed within 4 hours of being readmitted to the facility. She said she would have expected for the physician to have been notified and the dietician to have been notified of any skin issues so new wound care orders could be obtained. She said Resident #38 needed wound orders so his wounds would not heal. She said she would have expected wound orders for wounds present prior to the hospital stay to have been restarted as long as the wounds were of the same caliber. She said if they had changed, she would have expected the wound care doctor to be notified for order clarification. She said she would have expected for the wound care doctor to have been notified of the new wound. Record review of a Skin Assessment facility policy dated 08/15/16 indicated, .It is the policy of this facility to establish a method whereby nursing can assess a resident's skin integrity to ensure appropriate intervention are initiated in a timely manner .All new admits and resident returning from a hospital stall will have a head-to-toe skin assessment completed by the Treatment Nurse/designee within four (4) hours of the resident's arrival at the facility .If the Treatment Nurse/designee is not available, then the charge nurse should complete the skin assessment with four (4) hours of the resident's arrival at the facility .The DON (Director of Nursing) or designee, along with the Treatment Nurse/designee and other team members will review for the follow-up assessment and recommendations .Any alterations in skin integrity will be treated according to physician orders. Notify DON and responsible family member. Documentation will then be entered into the resident's chart . Record review of a Pressure Injury: Prevention, Assessment and Treatment facility policy dated 08/12/16 indicated, .Nursing personnel will continually aim to maintain the skin integrity, tone, turgor, and circulation to prevent breakdown, injury, and infection .Early prevention and/or treatment is essential upon initial assessment of the condition of the skin on admission and whenever a change in skin status occurs. The nurse will determine if prevention and/or treatment of pressure sore(s) is indicated and notify the Treatment Nurse/designee of any potential problems .Notify the physician of pressure sore and obtain and follow any orders as directed by the physician .Notify family and dietary department. Document notification .Maintain adequate nutrition .Assess for early signs of skin breakdown and report any abnormal findings .Treatment Nurse/designee or Director of Nursing will assess site and evaluate for appropriate stage .Notify physician; obtain an order and monitor site daily .Assessment of the pressure injury should also include the site, size, and WxLxD of the injury. Surrounding tissue, color, exudate, wound edges, sinus tracts, odor, tunneling and undermining should also be documented at least weekly and upon decline . Record review of a Skin Integrity Management facility policy dated 10/05/16 indicated, .If wound is noted, perform an assessment and initiate a treatment plan as soon as possible .Correction of the resident's underlying medical, surgical, and/or nutritional problems must be accomplished if proper healing of pressure sores etc. is to occur .Wound care should be performed as ordered by the physician . The Administrator was notified of an IJ on 06/25/24 at 5:32 p.m., was given a copy of the IJ template, and a Plan of Removal (POR) was requested. The Plan of Removal was accepted on 06/26/24 at 8:08 a.m. and included the following: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/25/2024 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services had determined that the condition at the facility constituted an Immediate jeopardy to resident health and safety. Problem: F 686 Treatment/Services to Prevent/Heal Pressure Ulcer Interventions: o A head-to-toe assessment was completed on resident # 38 on 6/25/24 by the DON. Weekly ulcer assessments for resident #38 were completed on 6/25/24 to include measurements by DON and Regional Compliance Nurse. o The MD was notified on 6/25/24 of resident #38 new pressure wounds by the DON. Orders were received for treatment and implemented on 6/25/24. o The Dietician was notified on 6/25/24 of resident #38 new pressure wounds by the DON. Recommendations were received and implemented on 6/25/24. o Wound care treatments for residents #38 were completed by the DON as ordered on 6/25/24. o 100% skin rounds were initiated on 6/25/24 by DON, ADON and Compliance Nurse. No additional pressure wounds were identified. o All wound care orders were reviewed on 6/25/24 by DON, ADON, and Compliance Nurse to ensure wound care recommendations are being followed appropriately for all residents. o All residents with wounds have appropriate supplements in place to promote wound healing. Reviewed and completed by the DON and Compliance Nurse on 6/25/24. o Administrator, DON, and ADON were in-serviced 1:1 by the Regional Compliance Nurse on 6/25/24 on the following topics. Completed 6/25/24. o Pressure Injury Prevention, Assessment, and Treatment Policy o Skin Integrity management Policy and Skin assessment policy to include appropriate skin care on admission and readmission which includes skin assessments on admission and readmission. o Notification of a Change in Condition Policy- will notify MD with any new or worsening pressure wounds. o Abuse and Neglect - failure to provide a physician ordered treatment to a pressure wound. o Incontinent care to include- placing a clean brief when wound care is being provided. In-services: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o The following in-services were initiated by Regional Compliance Nurse, DON on 6/25/24 for all charge nurses. Any charge nurses not present or in-serviced on 6/25/24 will not be allowed to assume their duties until in-serviced. All new hires will be in-serviced during orientation. All agency staff or staff on leave will in serviced prior to assuming their next assignment. o Pressure Injury Prevention, Assessment, and Treatment Policy to include providing appropriate wound care. o Skin Integrity management Policy and Skin assessment policy to include appropriate skin assessments on admission and readmission. o Notification of a Change in Condition Policy- will notify MD with any new or worsening pressure wounds. o Abuse and Neglect - failure to provide a physician ordered treatment to a pressure wound. o Incontinent care to include- placing a clean brief when wound care is being provided o All charge nurses will complete wound care for their assigned residents during their shift. o Policies for Pressure Injury Prevention, Assessment, Treatment policy, and Skin Integrity were reviewed on 6/25/24 by the Divisional Director of Clinical, Compliance Nurse, Area Director, Administrator, and DON. No revisions to the policies were made. o The Medical Director was notified of the immediate jeopardy situation on 6/25/24 by the administrator. o An ADHOC QAPI meeting was held with the Administrator, DON, ADON,

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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** 44596 Based on observations, interviews, and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 3 of 10 residents (Resident #54, Resident #16, Resident #52) reviewed for quality of care. 1. The facility failed to distribute Residents #54, #16, and #52 protective smoking aprons. Residents #54, #16, and #52 were observed smoking without a protective smoking apron on 06/24/2024 at the 9:00 a.m., smoke break. This failure could place residents at the facility who smoked at risk for contributing to burns or serious injuries. Findings Included: 1.Record review of Resident #54's undated face sheet revealed he was a 63- year-old male, admitted to the facility on [DATE] with the diagnoses of heart failure (your heart can not supply enough blood to meet your body's needs), tremors(nervous system condition, also known as a neurological condition, that causes involuntary and rhythmic shaking), and psychosis (condition of the mind or psyche that results in difficulties determining what is real and what is not real.) Record review of Resident #54's quarterly MDS assessment revealed Resident #54 was a smoker with a BIMS score of 02, which indicated severe cognitive impairment. Resident #54 required supervision and set up for ADLs. Record review of Resident #54's care plan dated 09/28/2023 revealed he was a smoker and had the potential for injury related to smoking. Intervention dated on 03/04/2024 stated that he was a supervised smoker and an intervention initiated on 09/25/2023 stated that smoking material was to be maintained by staff. Record review of Resident #54's smoking assessment dated [DATE] completed by LVN F, indicated he was not a safe smoker and must wear protective apron while smoking. 2. Record review of Resident #16's face sheet revealed a [AGE] year-old male admitted on [DATE] with the diagnoses of cerebrovascular disease (conditions that affect blood flow to your brain. Conditions include stroke, brain aneurysm, brain bleed, and carotid artery disease), hemiplegia (one sided paralysis), and diabetes type 2. Record review of Resident #16's quarterly MDS dated [DATE] indicated Resident #16's BIMS score was 15, he smoked, and he required substantial to maximal assistance for all ADLs. Record review of Resident #2's care plan on 06/10/2024 revealed he was a smoker and had the potential for injury related to smoking. Intervention dated on 03/04/2024 stated that he was a supervised smoker that wore a smoking apron and that he was to be informed of the facility's smoking policy and potential consequences of noncompliance. (continued on next page)

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	676187	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House of Marshall Health & Rehabilitation	5915 Elysian Fields Road Marshall, TX 75672

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the smoking assessment completed by LVN F on 06/07/2024 indicated Resident #16 could not light or extinguish his smoking material independently. An intervention was marked that Resident #16 required a fire-resistant smoking apron while smoking. 3. Record review of Resident #52's face sheet revealed a [AGE] year-old male admitted on [DATE] with the diagnoses of cerebrovascular infarction (the pathologic process that results in an area of necrotic tissue in the brain), dementia, and chronic kidney disease (a condition characterized by a gradual loss of kidney function over time). Record review of Resident #52's quarterly MDS dated [DATE] indicated Resident #52's BIMS score was undetermined, she smoked, and she required substantial to maximal assistance with ADLs. Record review of Resident #52's care plan on 06/10/2024 revealed she was a smoker and had the potential for injury related to smoking. Intervention dated on 03/04/2024 stated that she was a supervised smoker that wore a smoking apron and that she was to be informed of the facility's smoking policy and potential consequences of noncompliance. Record review of the smoking assessment completed by the SW on 06/11/2024 indicated Resident #52 could not light or extinguish her smoking material independently and had an accident in the past with smoking materials and had visible burn marks on her clothing. An intervention was marked that Resident #52 required a fire-resistant smoking apron while smoking. During an observation on 06/24/2024 at 9:02 a.m., Resident # 54, #16, and #42 were noted to be smoking a cigarette without wearing a fire-resistant smoking apron as directed in their safe smoking assessments/ care plans. In an interview on 06/24/2024 at 9:14 a.m., Housekeeper C stated residents were not allowed to have cigarettes inside of their rooms. After residents were done smoking, a specified staff member from nursing, housekeeping, or maintenance would collect cigarettes and lighters and place them in a box. This box was secured inside of the nursing closet. He stated that residents were also not allowed to smoke by themselves, and they must be supervised at all times. He stated there was a list of residents that had to wear smoking aprons to protect them from burning themselves. He stated he normally put the aprons on everyone prior to lighting the cigarette's but he forgot to put the aprons on this morning until he saw the surveyor approach and then he remembered. During an interview and observation on 06/23/2024 at 9:20 a.m., Resident #16 stated that sometimes they put the apron on him and sometimes they did not. He stated it just depended on who took them out as to whether they were given the apron to wear or not. A small round burn hole was to the top of the right leg of the gray sweatpants Resident #16 was wearing. He stated he dropped ashes on his lap several months ago while not wearing the smoking apron but had not burned himself. During an interview on 06/25/2024 at 3:30 p.m., the DON stated it was the responsibility of the person taking the residents outdoors to smoke to not only supervise the resident's safety but to also put protective aprons on the residents that required it. She stated there was a list in the box where the smoking material was stored of all the residents that needed aprons. The DON stated not using the aprons for people that needed the protection could lead to the burns and injury to the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/2024 at 4:45 p.m., the ADM stated it was the responsibility of the person supervising the smoke break to ensure all smoking policies were followed. The ADM stated not applying the smoking aprons could lead to the resident setting themselves on fire. During record review of the facility's policy dated 11/1/2017 titled: Smoking Policy revealed Smoking policies must be formulated and adopted by the facility. The policies must comply with all applicable codes, regulations, and standards, including ordinances. The facility is responsible for informing residents, staff, visitors, and other affected parties of smoking policies through distribution and/or posting. The facility is responsible for enforcement of smoking policies which must include at least the following provisions: . 1. Matches. Lighters or other ignition sources for smoking are not permitted to be kept or stored in a resident's room .2. Smoking assessment will be done regularly for each resident who smokes .3. If the facility identifies the resident needs assistance/supervision and/or additional protective devices for smoking, the facility includes this information in the resident's care plan and reviews and revises the pal periodically as needed . 5. Smoking or using an e-cigarette/vape is prohibited in any area where flammable liquids, combustible gas, or oxygen are used or stored and in any hazardous locations. There areas must be posted with No smoking signs .11. The resident will be informed of the smoking policy upon admission and in conjunction with care plan meeting thereafter. Employees will be informed of the smoking policy upon hire and as needed thereafter.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review the facility failed to ensure that a resident who was incontinent of bladder received appropriate treatment and services, and an indwelling catheter is not used unless there is valid medical justification for catheterization and the catheter is discontinued as soon as clinically warranted for 1 of 3 residents (Resident #213) reviewed for quality of care. 1. The facility failed to ensure LVN L placed an order by MD K, to consult MD J, a local urologist (is a doctor who specializes in diagnosing and treating diseases of the urinary system), about removal of Resident #213 indwelling catheter and bladder retraining. 2. The facility failed to ensure LVN L successfully contact MD J's office to for consultation of removal of Resident #213 indwelling catheter and possible bladder retraining. These failures could place residents who had urinary catheters at risk of not receiving care needed. Findings included: Record review of Resident #213's face sheet, dated 06/25/24, indicated Resident #213 was an [AGE] year-old, female and was admitted to the facility on [DATE] with diagnosis including Alzheimer's disease (is a type of dementia that affects memory, thinking, and behavior), neuromuscular dysfunction of bladder (is when a person lacks bladder control due to brain, spinal cord or nerve problems), overflow incontinence (the inability to control urination), and retention of urine (is caused by a blockage that partially or fully prevents urine from leaving the bladder or urethra, or a failure of the bladder to squeeze hard enough to expel all of the urine). Record review of the facility's EHR reflected Resident #213 was admitted to the facility less than 21 days ago. No MDS for Resident #213 was completed prior to exit. Record review of a baseline care plan, dated 06/24/24, indicated Resident #213 had an indwelling catheter. Intervention included position catheter bag and tubing below the level of the bladder and in a privacy bag. Record review of Resident #213 progress notes, dated 05/26/24-06/26/24 indicated: *06/21/24 at 1:49 p.m. by LVN L: .This nurse [LVN L] spoke with family members at bedside and got update information on F/C [foley catheter] . [Resident #213] been foley cath dependent since [DATE] and had prolapse bladder (occurs when the bladder bulges into the vaginal space) with colposcopy (is a diagnostic procedure that allows your provider to check your cervix (lower part of your uterus) and the wall of your vagina for abnormal tissue) with perineoplasty (is a surgery that tightens the area between your anus and vagina (perineum)) back in Jan and [DATE] .family wants to try resident with NO foley cath and feels that resident is fixated with having a foley cath and being foley cath dependent . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*06/21/24 at 2:03 p.m. by LVN L: .sent detailed message to DR [MD K] with history of foley and asked to d/c it due to nursing facility diagnosis and family request . *06/21/24 at 3:42 p.m. by LVN L: .spoke with. [MD K] and updated given on foley cath and care of foley diagnosis .gave order to check with urologist [MD J] before removing and get some orders for bladder retraining . *06/25/24 at 4:20 p.m. by LVN B: .UA/CS (is a lab test to check for bacteria or other germs in a urine sample) in AM . *06/26/24 at 11:23 a.m. by LVN L: .this nurse [LVN L] phoned urologist office .spoke with receptionist for update on care and family's concerns of long-term usage of foley catheter and resident's different behaviors, upset, and anxious .nurse for [MD J] to call facility .last office visit at urologist was 4/18/24 . Record review of Resident #213's order summary dated 06/25/24 did not reveal an order to consult MD J about removal of Resident #213's indwelling catheter and bladder training. During an observation on 06/24/24 at 11:32 a.m., Resident #213 was in her room walking towards her bathroom with the foley catheter bag. She was visibly upset and frantic about the foley catheter bag leaking. On Resident #213's floor, was several puddles yellow liquid. Resident #213 was holding the foley catheter bag above her bladder. Several staff came to assist Resident #213 and told her to let staff empty the bag not herself. During an observation and interview on 06/25/24 at 8:37 a.m., Resident #213 was sitting on the side of her bed. She said she had the foley because she needed it. She said she was concerned about getting a bladder infection. She said she wanted her catheter changed because she did not like that stuff in her tubing. In Resident #213's catheter tubing was a small amount of segment noted. Periodically, during the interview Resident #213 would lift the catheter bag above her bladder. During an interview on 06/26/24 at 11:14 a.m., LVN L said she had contacted MD K's office about Resident #213's family members concern about Resident #213 being dependent on the foley catheter. She said Resident #213's family members felt she isolated herself because of the foley catheter and was getting fixated with it. She said MD K returned her call and said he was not comfortable making the decision to discontinue Resident #213's indwelling catheter. She said MD K ordered MD J to be consulted for removal and bladder retraining. She said she contacted MD J's office, but it was a late Friday (06/21/24) afternoon and got the on call answering service. She said she did not leave a message with the answering service but told them she would call back on Monday (06/24/24). She said she did not call back on Monday (06/24/24) and had not followed. She said she had forgotten about following up with MD J's office, it was not on her to-do list. She said she had not written a progress note about contacting MD J's office. She said she should have written a note and contacted MD J's office by now. She said during morning meeting, they discussed new admissions, and she was responsible for foley catheters and anticoagulant monitoring. She said not contacting MD J's office about possible foley catheter removal and bladder retraining, placed Resident #213 at risk for infection, pain, and discomfort. She said Resident #213 had an order for a UA with C/S for a possible UTI because she was acting more anxious and tearful. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/24 at 3:05 p.m., the DON said she was not aware Resident #213 had received an order from MD K to contact MD J for possible removal of the foley catheter. She said she had been at a conference last week. She said she expected the nursing staff who received the order, to contact MD J's office and put the order in from MD K so everyone was aware of what was going on. She said she would have expected the order to have been completed by Monday (06/24/24) since it was received on Friday (06/21/24). She said she expected doctor's orders to be followed promptly. She said if Resident #213 did not need the foley then it increased her risk for infection. During an interview on 06/26/24 at 4:45 p.m., the ADM said she expected staff to following physician's orders. She said consultations or appointments should be placed on the 24-hour report and facility's dashboard. She said not removing Resident #213's foley catheter and not doing bladder retraining placed her at risk for UTIs, bladder not getting strong, and injury if tubing being pulled. On 07/01/2024 at 11:39 a.m., called MD J's office and left voicemail on the nurse's line. Return phone call was not returned by the end of the day. Record review of an undated facility's Catheter Insertion, Male/Female policy and procedure indicated . urinary catheterization is performed only when necessary and usually reserved for a specific purpose and restricted to short-term treatment . Record review of an undated facility's Physician's orders policy and procedure indicated .to monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident .person responsible: medical records/designee .verbal or telephone orders by the physician or nurse practitioner .nurse will receive the order and read the order back to the prescriber to ensure it is correct .the nurse will enter the order into PCC for the resident and select either verbal or telephone .if the order requires documentation, it will be directed to the proper electronic administration record once the order is completed . immediately transcribe verbal/telephone orders into the patient's medical record .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure dialysis service were provided consistently with professional standards of practice for 3 of 3 resident reviewed for dialysis services. (Resident #36, Resident #212, and Resident #112) 1. The facility failed to ensure post-dialysis assessments were completed and documented on Resident #36 and Resident #212's dialysis communication forms. 2. The facility failed to document Resident #112's dialysis communications. These failures could place residents who received dialysis at risk for complications and not receiving proper care and treatment to meet their needs. Findings included: 1. Record review of Resident #36's face sheet, dated 06/25/24, indicated Resident #36 was a [AGE] year-old, male and was admitted to the facility on [DATE] and 05/02/24 with diagnosis including end stage renal disease (is the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own). Record review of Resident #36's quarterly MDS assessment, dated 05/13/24, indicated Resident #36 was understood and understood others. Resident #36 had a BIMS score of 15, which indicated his cognition was intact. The MDS did not indicated Resident #36 received dialysis treatment while a resident of the facility and within the last 14 days. Record review of a care plan dated 02/17/23, indicated Resident #36 needed hemodialysis (is a treatment to filter wastes and water from your blood) related to renal failure. Intervention included resident received dialysis 3 times a week. Record review of Resident #36's order summary, dated 06/25/24, indicated transport resident to local dialysis center on Tuesday-Thursday-Saturday for hemodialysis chair time 10:30 a.m., one time a day, start date 03/13/24. Record review of Resident #36's Dialysis Communication Record forms, from March 2024, April 2024, and May 2024, indicated missing or incomplete facility nurse assessment upon return from dialysis for the following dates: *03/12/24 *03/14/24 *03/19/24 *03/23/24 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*03/26/24 *03/28/24 *04/02/24 *04/04/24 *04/06/24 *04/11/24 *04/18/24 *04/25/24 *05/04/24 *05/07/24 *05/11/24 *05/16/24 2. Record review of a face sheet, dated 06/24/24, indicated Resident #212 was a [AGE] year-old, female, admitted to the facility on [DATE], 11/22/23, and 05/25/24 with diagnoses including pulmonary embolism (is a sudden blockage in your pulmonary arteries, the blood vessels that send blood to your lungs), Type 2 diabetes (is a chronic medical condition in which the levels of sugar, or glucose, build up in your bloodstream), and chronic kidney disease, stage 4 (severe loss of kidney function), and lack of coordination. Record review of Resident #212's quarterly MDS, dated [DATE], indicated Resident #212 was understood and understood others. Resident #212's BIMS score was not indicated on her MDS dated [DATE]. Resident #212's quarterly MDS dated [DATE], indicated a BIMS score of 15, which indicated her cognition was intact. Resident #212 received dialysis while a resident of the facility and within the last 14 days. Record review of a care plan, dated 12/06/23, revised 03/22/24, indicated Resident #212 needed hemodialysis related to renal failure. Intervention included monitor vital signs. Record review of Resident #212's order summary, dated 06/24/24, indicated Dialysis days Monday-Wednesday-Friday have ready by 10 am, one time a day, start date 05/10/24. Record review of Resident #212's Dialysis Communication Record forms, from March 2024, April 2024, and May 2024, indicated missing or incomplete facility nurse assessment upon return from dialysis for the following dates: *03/11/24 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*03/13/24 *03/25/24 *03/27/24 *03/29/24 *04/05/24 *04/08/24 *04/11/24 *04/12/24 *04/19/24 *04/22/24 *04/26/24 *04/29/24 *05/06/24 *05/15/24 44128 3. Record review of Resident #112's face sheet dated 06/26/24 indicated Resident #112 was a [AGE] year-old female and admitted on [DATE] with diagnoses including acute kidney failure, chronic kidney disease, and unsteadiness on feet. Record review of Resident #112's admission MDS assessment dated [DATE] indicated Resident #112 was understood and understood others. The MDS indicated Resident #112 had a BIMS score of 13 which indicated intact cognition. The MDS indicated Resident #112 had an active diagnosis of acute kidney failure. The MDS indicated Resident #112 received dialysis within the last 14 days of the assessment period. Record review of Resident #112's care plan dated 06/24/24 indicated Resident #112 needed dialysis (HEMO). Intervention included monitor labs and report to the physician as need, monitor/document/report to physician any signs or symptoms of infection to access site, and to monitor/document/report to the physician as needed any signs or symptoms of renal insufficiency. Record review of Resident #112's consolidated physician's orders dated 06/26/24 indicated and order with a start date of 06/14/24 for dialysis every Monday, Wednesday, and Friday afternoon. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #112's electronic medical record did not indicate any communication from between the facility and the dialysis center. During an interview on 06/24/24 at 10:01 a.m., Resident #112 said she received dialysis every Monday, Wednesday, and Friday. She said she had not had any problems with dialysis. During an interview on 06/26/24 at 8:26 a.m., the DON said Resident #112 did receive dialysis. The dialysis communication forms were requested at this time. During an interview on 06/26/24 at 8:26 a.m., the DON said Resident #112 did receive dialysis. The dialysis communication forms were requested at this time. During an interview on 06/26/24 at 12:40 p.m., the DON said they did not have completed dialysis communication forms for Resident #112. She said she was waiting for them to be faxed from the dialysis center. They were not received prior to exit. During an interview on 06/26/24 at 1:30 p.m., RN E said a dialysis communication form had to be completed before the dialysis resident left for treatment and when they returned. She said the dialysis communication form should be entirely filled out. She said when Resident #36, Resident #112 and Resident #212 returned from dialysis, vital signs should be done and documented on the dialysis communication form. She said the charge nurse should review the dialysis center portion for any pertinent informant then fill out the bottom portion of the form. She said dialysis communication forms were important to notice if the resident had a change of condition and it relayed information between staff, facility, and treatment center. She said when the dialysis communication forms were not done, the resident could have issues and staff would be unaware. During an interview on 06/26/24 at 3:05 p.m., the DON said the charge nurses were responsible for filling out the dialysis communication forms. She said the form should be filled out with the resident's information before they leave and when they return from dialysis treatment. She said she expected the nurses to fill in the vitals and complete an assessment of the access site. She said the dialysis communication form provided continuity of care. She said the form was important to monitor the resident's vital and see a possible issue. She said not completing the dialysis communication form placed the resident at risk for staff not being aware of signs of hypotension and fluid overload if the treatment was not completed. During an interview on 06/26/24 at 4:45 p.m., the ADM said the charge nurses sent the dialysis communication form with the resident to dialysis treatment. She said the dialysis resident should return to the facility with the form filled out by the treatment center section. She said the charge nurse should then fill out the bottom portion on the form. She said the form should be filled out in its entirety. She said when the dialysis communication was not done or missed documentation then it risked a breakdown in communication between the facility and dialysis center. She said the DON, ADON, and Medical Records should be overseeing the completion of the dialysis communication form. Record review of a Dialysis facility policy dated November 2013 indicated, .The facility will document the resident's vital sign, general appearance, orientation, and additional baseline data as need. The resident's clinical record will be documented with this information. The date and time of the resident's return to the facility will be recorded by the nurse .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate administering of all drugs and biologicals, to meet the needs of 1 of 16 residents reviewed for pharmacy services. (Residents #45) The facility failed to keep, in stock, medications for Resident #45. Resident #45 did not receive Levetiracetam (is a medicine used to treat epilepsy (seizures)), Hydrochlorothiazide (is commonly used to treat high blood pressure), or Scopolamine patch (helps prevent nausea and vomiting) on 06/04/24, 06/05/24 and 06/06/24. This failure could place residents at risk for inaccurate drug administration. Findings included: 1. Record review of Resident #45's face sheet, dated 06/24/24, indicated resident #45 was a [AGE] year-old, male and was admitted to the facility on [DATE] and 11/28/23 with diagnoses including nontraumatic intracerebral hemorrhage (bleeding into the brain tissue), hypertensive crisis (a sudden, severe increase in blood pressure), and convulsions (a condition in which muscles contract and relax quickly and cause uncontrolled shaking of the body). Record review of Resident #45's quarterly MDS assessment, dated 04/05/24, indicated Resident #45 was usually understood and sometimes understood others. Resident #45 had adequate hearing and vision, and clear speech. Resident #45 had a BIMS score of 00, which indicated severe cognitive impairment. Record review of a care plan, dated 04/05/23, indicated: *Resident #45 had hypertension. Intervention included give anti-hypertensive (a class of drugs that are used to treat hypertension) medications as ordered. *Resident #45 had a seizure disorder. Intervention included give seizure medications as ordered by doctor. *Resident #45 had nausea and vomiting related to disease process, cerebral hemorrhage, and seizure disorder. Intervention included administer anti-emetics (are medications that can manage nausea and vomiting) as ordered routinely. Record review of Resident #45's order summary dated 06/24/24, indicated: *Hydrochlorothiazide tablet 25mg, give 1 tablet enterally one time a day for hypertension. Start date 07/01/22, no end date. *Levetiracetam oral solution 100mg/ml, give 5 ml via g-tube two times a day for seizures. Start date 11/29/23, no end date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676187	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House of Marshall Health & Rehabilitation	5915 Elysian Fields Road Marshall, TX 75672

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Scopolamine Transdermal Patch 72-hour 1mg/3 days, apply 1 mg transdermal (the application of a medicine or drug through the skin) one time a day every 3 days for nausea and vomiting, behind the ear. Start date 03/29/23, no end date. Record review of Resident #45's MAR, dated 06/01/24- 06/30/24 indicated: *Hydrochlorothiazide tablet 25mg, give 1 tablet enterally one time a day for hypertension. 06/06/24 0900: Hold/See Nurse Notes by LVN F *Levetiracetam oral solution 100mg/ml, give 5 ml via g-tube two times a day for seizures. 06/04/24 2000: Other/See Nurse Notes by RN N 06/05/24 2000: Other/See Nurse Notes by RN N 06/06/24 0800: Other/ See Nurse Notes by LVN F 06/06/24 2000: Hold/ See Nurse Notes by LVN O *Scopolamine Transdermal Patch 72-hour 1mg/3 days, apply 1 mg transdermal (the application of a medicine or drug through the skin) one time a day every 3 days for nausea and vomiting, behind the ear. 06/06/24 0900: Hold/See Nurse Notes by LVN F Record review of Resident #45's progress notes dated 05/25/24-06/25/24 indicated: *06/05/24 3:19 a.m. by RN N: Levetiracetam oral solution 100mg/ml, give 5 ml via g-tube two times a day for seizures, on order. *06/06/24 5:54 a.m. by RN N: Levetiracetam oral solution 100mg/ml, give 5 ml via g-tube two times a day for seizures, on order. *06/06/24 7:51 a.m. by LVN F: Levetiracetam oral solution 100mg/ml, give 5 ml via g-tube two times a day for seizures, med unavailable. *06/06/24 9:26 a.m. by LVN F: Hydrochlorothiazide tablet 25mg, give 1 tablet enterally one time a day for hypertension, med unavailable. *06/06/24 9:26 a.m. by LVN F: Scopolamine Transdermal Patch 72-hour 1mg/3 days, apply 1 mg transdermal (the application of a medicine or drug through the skin) one time a day every 3 days for nausea and vomiting, behind the ear, med unavailable. *06/06/24 11:33 p.m. by LVN O: Levetiracetam oral solution 100mg/ml, give 5 ml via g-tube two times a day for seizures, medication not available from pharmacy. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/26/24 at 1:35 p.m., LVN F said she took care of Resident #45 on 06/06/24. She said Resident #45 had 3 medications not available that day for administration. She said the facility had been having issues with the pharmacy due to change of ownership and pharmacy company. She said nursing staff were not able to order resident's medication through the facility's computer system during the change. She said the resident's prescription number to match their medications had also changed. She said nursing staff could not see what had or had not been ordered which caused duplicate refill orders. She said the new pharmacy company complained about the duplicate orders then would not fill the orders. She said there was a lack of communication between the nurses related to reordering of resident's medications. She said it depended on what the medication was being taken for, depended on the risk to the resident if a dose was missed. She said Resident #45 missing his Levetiracetam, risk him having seizures. She said Resident #45 missing his Hydrochlorothiazide, risk him having high blood pressure. She said Resident #45 missing the application on his Scopolamine Patch, risked him having nausea and vomiting. During an interview on 06/26/24 at 3:05 p.m., the DON said the facility had a process in place when ownership change regarding ordering resident's medications. She said the facility was still able to order and receive medication from the old pharmacy until everything switch over to the new pharmacy. She said the nursing staff had to fax new prescription numbers for the new pharmacy. She said she was not made aware Resident #45 had missed doses for 3 medications. She said she expected to be notified when resident missed medication doses. She said Resident #45 missing his medication place him at risk for hypertension, stroke, hypertensive crisis, headache, seizure, and nausea/vomiting. During an interview on 06/26/24 at 4:45 p.m., the ADM said charge nurses were responsible for ensuring resident had their prescribed medication for administration. She said she expected the nursing staff to notify the DON, resident's physician, and ADM when medication doses were missed. She said Resident #45 missed doses of his medication placed him at risk for seizure, high blood pressure which could result in a heart attack and stroke, and other health issues. She said the ADON/DON should oversee the charge nurse to ensure medication was reordered timely and doses not missed. Record review of an undated facility's Ordering Medications policy and procedure, indicated .medications and related products are received from the pharmacy supplier on a timely basis .the facility maintains accurate records of medication order and receipt .reorder medication three to four days in advance of need to assure an adequate supply is on hand .

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications (a medication used in excessive doses and including duplicate therapy or for excessive duration; or without adequate monitoring, or without adequate indications for its use; or in the presence of adverse consequences which indicated the dose should be reduced or discontinued) for 1 of 3 residents reviewed for pharmacy services. (Resident #30) The facility failed to ensure Resident #30 antibiotic was discontinued after her urine culture (checks urine for germs (microorganisms) that cause infections) results showed no organism growth. This failure could place residents receiving antibiotics at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased antibiotic-resistant infections (happens when germs like bacteria and fungi develop the ability to defeat the drugs designed to kill them). Findings include: Record review of Resident #30's face sheet, dated 06/24/24, indicated Resident #30 was a [AGE] year-old, female and was admitted to the facility on [DATE] and 07/11/23 with diagnoses including Parkinson's disease (is a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), sepsis (is a serious condition in which the body responds improperly to an infection), and acute kidney failure (occurs when your kidneys suddenly become unable to filter waste products from your blood). Record review of Resident #30's quarterly MDS assessment, dated 04/18/24, indicated Resident #30 was understood and understood others. Resident #30 had a BIMS score of 15, which indicated her cognition was intact. Resident #30 was always continent of urine and bowel. The MDS did not indicate Resident #30 had a urinary tract infection in the last 30 days. Resident #30 had received an antibiotic in the last 7 days of the assessment period. Record review of a care plan dated 07/25/23, indicated Resident #30 had occasional bladder incontinence related to disease process of Parkinson's disease. Intervention included encourage fluids during the day to promote hydration and decrease chance for urinary tract infection. Record review of Resident #30's MAR dated 04/01/24-04/30/24 indicated Keflex (Cephalexin) Oral Capsule 500mg (is used to treat infections caused by bacteria, including upper respiratory infections, ear infections, skin infections, urinary tract infections and bone infections), give 1 capsule by mouth three times a day for UTI for 7 days. Record review of Resident #30's progress notes dated 04/01/24-06/26/24 indicated: *04/09/24 at 1:02 p.m. by LVN P: .Resident #30 Parkinson's seems to be getting worse .she is shaking more, and it is hard for her to get words out .she is crying saying that she is cared and doesn't want to die yet .this nurse [LVN P] faxed resident's physician explaining what is happening .waiting on reply back . (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*04/09/24 at 5:00 p.m. by LVN P: .labs .UA with C/S . *04/10/24 at 3:30 a.m. by RN N: .clean cath (is a method of collecting a urine sample to be tested) UA collected awaiting lab pick up . *04/11/24 at 3:51 p.m., by LVN A: .UA results .sent to MD Q with no new orders noted . *04/12/24 at 1:35 p.m., by LVN A: .new order received and carried out for Keflex 500mg 1 cap po tid x 7 days dx uti .ID administered at this time .PO fluids encouraged throughout shift .Resident [Resident #30] c/o slight dysuria and some odor to urine .Resident [Resident #30] is afebrile (no fever) . Record review of Resident #30's urinary analysis lab results, received on 04/10/24, indicated normal results except for abnormal results for leukocyte esterase (is a screening test used to detect a substance that suggests there are white blood cells in the urine) and positive catalase bacteria screen (an indicator of urinary tract infection). Notation on Resident #30's urinary analysis results indicated Keflex 500mg 1 tablet by mouth, three times a day x 7days on 04/11/24. Record review of Resident #30's urine culture and sensitivity results, received on 04/10/24, indicated pathogens not detected. No notation on Resident's urine culture results to indicated faxed to Resident #30's provider. During an interview on 06/26/24 at 1:30 p.m., RN E said lab results were normally faxed to doctor when they came back from the lab company. She said if a resident c/s resulted after the UA results, then she would contact the doctor with new lab results. She said giving antibiotics when the c/s did not show growth of an organism made residents less susceptible for future treatment of infections. During an interview on 06/26/24 at 1:55 p.m., the ADON said she was the Infection Control Preventionist. She said she was responsible for antibiotic usage and monitoring, reviewing lab results, tracking and trending infections, in-services, and care plan related to infection control. She said regarding Resident #30's antibiotic use with no organism growth, she thought MD Q said the benefits outweighed the risk. She said she thought MD Q continued the antibiotics even after she received the c/s result of no growth. She said she thought the UA and c/s results were faxed to MD Q. She said she did not remember if MD Q replied to the faxed results. She said she would have to look through Resident #30's information to find out. She said the facility's policy was for antibiotics to be discontinued if the c/s did not show an organism was growing. She said the facility did not want resident to be prescribed too many antibiotics. She said excessive use of antibiotic risked resident become resistant to antibiotics. She it was important for the facility and doctors to follow the Antibiotic Stewardship policy and procedures. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/24 at 3:05 p.m., the DON said she expected the nursing staff to fax the doctor UA and c/s results. She said the facility's physicians also had access the electronic charting system to look up the lab results also. She said she expected nursing staff to call the doctor to inform them of the negative c/s results and receive new orders. She said she did not know and could not find proof in Resident #30's chart, MD Q was notified about her negative c/s result. She said staff were supposed to document in the progress note when they notified the physician about something. She said the progress note then populated on the 24-hour report. She said the facility tried to educate the physician on the McGeer criteria (resident care decisions regarding initiation of antibiotics.) that needed to be met to start antibiotics. She said but at the end of the day, it was up to the doctor to discontinue antibiotics if it did not meet criteria. She said the ICP was responsible for overseeing this process. During an interview on 06/26/24 at 4:45 p.m., the ADM said the ADON and DON was responsible for monitoring antibiotic use. She said she expected nursing staff to notify the doctor when results came in, to see if the antibiotic needed to be changed or discontinued. She said treating resident with antibiotic without an indication, risked certain antibiotic no longer working. During an interview on 07/01/24 at 12:18 p.m., the MA for MD Q's office said she could only see in their system where the facility faxed Resident #30's UA results and MD Q ordered Keflex to be started. She said she could not see where the facility faxed Resident #30's c/s results. She said sometimes the facility staff directly called MD Q about things too. She said the facility would have documentation to show if they called MD Q with Resident #30's c/s results being negative. She said depending on the resident's symptoms, fever or dysuria, MD Q may or may not have discontinued the antibiotic with no organism growth on the c/s. During an interview on 07/01/24 at 1:20 p.m., LVN A said he was not normally assigned Resident #30, so he was probably helping on 04/10/24. He said according to his notes, he only sent the UA results and other labs to MD Q's office. He said UA results typically returned 48 hours after the lab was sent out and the c/s took about 72 hours. He said it look liked MD Q responded to the fax the next day and ordered antibiotics. He said he did not send or call MD Q the c/s results because he would have documented it in a progress note. He said he was not sure if another nurse faxed or called MD Q with the negative c/s results, but staff were supposed to document in a progress note when a doctor was contacted. Record review of a facility's Antimicrobial Stewardship- Infection Control policy and procedure updated 03/2024 indicated .treatment with antibiotics is only appropriate when the practitioner determines, on basis of an assessment, that the most likely cause of the patient's symptoms is a bacterial infection .the facility will communication to each attending physician, nurse practitioner, and the medical director our criteria for initiation of antibiotics in long-term care residents .when a culture and sensitivity is ordered .communicate c&s results to the physician/prescriber as soon as available to determine if current antibiotics/anti-infective therapy should be continued, modified, or discontinued .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interview, and record review, the facility failed to ensure residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record and PRN orders for psychotropic drugs are limited to 14 days. Except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order for 1 (Resident #4) of 16 residents reviewed for pharmacy services. The facility failed to ensure Resident # 4's prn lorazepam was discontinued or reviewed by a physician to extend usage after 14 days. This failure could place residents at risk of receiving unnecessary psychotropic medications with possible medication side effects, adverse consequences, decreased quality of life, and dependence on unnecessary medications. Findings included: Record review of an undated face sheet revealed Resident #4 was a [AGE] year-old female, admitted to the facility on [DATE] with the diagnoses of anemia (low iron in the blood), atrial fibrillation (irregular heart rhythm), and depression. Record review of Resident #4's significant change MDS assessment dated [DATE] indicated Resident #4 was unable to complete the BIMS assessment and she required substantial assistance from staff for ADL care. Record review of Resident #4's care plan revealed she was had orders for Clonazepam and lorazepam for panic disorder. Record review of Resident #4's MD orders revealed: 05/08/2024 Lorazepam 0.5mg every 6 hours as needed for anxiety. 05/22/2024 Clonazepam 0.25 mg twice daily for panic disorder. Record review of Resident #4's MAR for May 2024 revealed Resident #4 had taken lorazepam 0.5mg every 6 hours prn, 7 times in May of 2024. Record review of Resident #4's MAR for June 2024 revealed Resident #4 had not taken any of the lorazepam 0.5mg every 6 hours prn in the month of June 2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/2024 at 2:20 p.m , MD K stated it was their duty to make sure mediations were not overprescribed to the residents. MD K stated Resident #4 was on hospice and hospice must have written the lorazepam order and not put an end date with it. MD K stated having a routine anti-anxiety med and a prn anti-anxiety med could lead to over sedation, which could in turn lead to the resident not eating, not getting up, becoming dehydrated, and becoming depressed. During an interview on 06/25/2024 at 11:00 a.m. the DON was asked how long a psychotropic drug could be ordered PRN, she stated, 14 days I believe then you discontinue it and ask doctor for validation, and they can reinstate it. She said she did not know why Resident #4 had a prn lorazepam order for antianxiety medication that was almost 2 months old and still active. Record review of facility policy titled Psychotropic/Psychoactive Medication Policy and dated 01/2023 revealed the following: A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, . Anti-anxiety . 5. Residents will not receive PRN does of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record. The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document rationale for the extended order the duration of the PRN order will be indicated in the order.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on observation, interview, and record review, the facility failed to ensure that residents were free of significant medication errors for 1 of 5 residents (Residents #45) reviewed for pharmacy services. The facility failed to ensure Residents #45 received his prescribed Levetiracetam (is a medicine used to treat epilepsy (seizures)) as scheduled for 06/05/24 and 06/06/24. This failure could place residents at risk of medical complications and not receiving the therapeutic effects of their medications. Findings included: Record review of Resident #45's face sheet, dated 06/24/24, indicated resident #45 was a [AGE] year-old, male and was admitted to the facility on [DATE] and 11/28/23 with diagnoses including nontraumatic intracerebral hemorrhage (bleeding into the brain tissue) and convulsions (a condition in which muscles contract and relax quickly and cause uncontrolled shaking of the body). Record review of Resident #45's quarterly MDS assessment, dated 04/05/24, indicated Resident #45 was usually understood and sometimes understood others. Resident #45 had adequate hearing and vision, and clear speech. Resident #45 had a BIMS score of 00, which indicated severe cognitive impairment. Record review of a care plan, dated 04/05/23, indicated: *Resident #45 had a seizure disorder. Intervention included give seizure medications as ordered by doctor. Record review of Resident #45's order summary dated 06/24/24, indicated: *Levetiracetam oral solution 100mg/ml, give 5 ml via g-tube two times a day for seizures. Start date 11/29/23, no end date. Record review of Resident #45's MAR, dated 06/01/24- 06/30/24 indicated: *Levetiracetam oral solution 100mg/ml, give 5 ml via g-tube two times a day for seizures. 06/04/24 2000: Other/See Nurse Notes by LVN N 06/05/24 2000: Other/See Nurse Notes by LVN N 06/06/24 0800: Other/ See Nurse Notes by LVN F 06/06/24 2000: Hold/ See Nurse Notes by LVN O Record review of Resident #45's progress notes dated 05/25/24-06/25/24 indicated: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*06/05/24 3:19 a.m. by LVN N: Levetiracetam oral solution 100mg/ml, give 5 ml via g-tube two times a day for seizures, on order. *06/06/24 5:54 a.m. by LVN N: Levetiracetam oral solution 100mg/ml, give 5 ml via g-tube two times a day for seizures, on order. *06/06/24 7:51 a.m. by LVN F: Levetiracetam oral solution 100mg/ml, give 5 ml via g-tube two times a day for seizures, med unavailable. *06/06/24 11:33 p.m. by LVN O: Levetiracetam oral solution 100mg/ml, give 5 ml via g-tube two times a day for seizures, medication not available from pharmacy. During an interview on 06/26/24 at 1:35 p.m., LVN F said she took care of Resident #45 on 06/06/24. She said Resident #45 had 3 medications not available that day for administration. She said the facility had been having issues with the pharmacy due to change of ownership and pharmacy company. She said nursing staff were not able to order resident's medication through the facility's computer system during the change. She said the resident's prescription number to match their medications had also changed. She said nursing staff could not see what had or had not been ordered which caused duplicate refill orders. She said the new pharmacy company complained about the duplicate orders then would not fill the orders. She said there was a lack of communication between the nurses related to reordering of resident's medications. She said it depended on what the medication was being taken for, depended on the risk to the resident if a dose was missed. She said Resident #45 missing his Levetiracetam, risk him having seizures. During an interview on 06/26/24 at 3:05 p.m., the DON said the facility had a process in place when ownership change regarding ordering resident's medications. She said the facility was still able to order and receive medication from the old pharmacy until everything switch over to the new pharmacy. She said the nursing staff had to fax new prescription numbers for the new pharmacy. She said she was not made aware Resident #45 had missed doses for 3 medications. She said she expected to be notified when resident missed medication doses. She said Resident #45 missing his medication place him at risk for hypertension, stroke, hypertensive crisis, headache, seizure, and nausea/vomiting. During an interview on 06/26/24 at 4:45 p.m., the ADM said charge nurses were responsible for ensuring resident had their prescribed medication for administration. She said she expected the nursing staff to notify the DON, resident's physician, and ADM when medication doses were missed. She said Resident #45 missed doses of his medication placed him at risk for seizure, high blood pressure which could result in a heart attack and stroke, and other health issues. She said the ADON/DON should oversee the charge nurse to ensure medication was reordered timely and doses not missed. Record review of an undated facility's Ordering Medications policy and procedure, indicated .medications and related products are received from the pharmacy supplier on a timely basis .the facility maintains accurate records of medication order and receipt .reorder medication three to four days in advance of need to assure an adequate supply is on hand .

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	676187	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House of Marshall Health & Rehabilitation	5915 Elysian Fields Road Marshall, TX 75672

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933 Based on interview and record review, the facility failed to ensure an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 3 resident reviewed for infection control. (Resident #46 and Resident #50) The facility failed to isolate Resident #46 and Resident #50 after urine cultures (test checks urine for germs (microorganisms) that cause infections) revealed ESBL (enzymes break down and destroy some commonly used antibiotics) in their urine. This failure could place residents at risk for being exposed to health complications and infectious diseases. Find included: 1. Record review of Resident #46's face sheet, dated 06/26/24, indicated Resident #46 was a [AGE] year-old, female and was admitted to the facility on [DATE] and 12/06/22 with diagnoses including chronic kidney disease (means you have mild to moderate loss of kidney function) and Type 2 diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). Record review of Resident #46's quarterly MDS assessment, dated 01/20/24, indicated Resident #46 was understood and understood others. The MDS indicated a BIMS score of 14, which indicated her cognition was intact. Resident #46 was always incontinent for urine and bowel and required moderate assistance for toilet hygiene. Resident #46 received an antibiotic during the last 7 days of the assessment period. Record review of a care plan dated 03/23/23 indicated Resident #46 had bladder incontinence related to activity intolerance, disease process, overactive bladder, and impaired mobility. Resident #46 used briefs but placed incontinent pads, towels, and sheets into her briefs. Record review of a care plan dated 04/04/24 indicated Resident #46 had an history of reoccurring UTIs. Intervention included administer antibiotics if ordered and monitor for adverse reactions or side effects. Record review of Resident #46's order summary, dated active as of 01/01/24, did not reveal isolation orders for ESBL in her urine. Record review of Resident #46's progress notes, dated 01/01/24-03/26/24, did not reveal Resident #46 being on contact isolation (used to help keep individuals safe from spores that spread through contact with a patient or objects in a patient's room.) for ESBL in her urine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #46's culture and sensitivity results dated 12/19/23 indicated .moderate pathogens detected .Escherichia coli .antibiotic notes .ESBL (Extended Spectrum Beta-lactamase detected . are usually multi-drug resistant .antibiotic resistance genes .ESBL 1 . Record review of Resident #46's Infection Control Surveillance Form, dated 01/10/24, indicated .positive .e coli . No type of isolation was noted .DON . 2. Record review of Resident #50's face sheet, dated 06/26/24, indicated Resident #50 was a [AGE] year-old, female and admitted to the facility on [DATE] with diagnoses including dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and type 2 diabetes (a chronic medical condition in which the levels of sugar, or glucose, build up in your bloodstream), and need for assistance with personal care. Record review of Resident #50's admission MDS assessment, dated 02/06/24, indicated Resident #50 was rarely/never understood and rarely/never had the ability to understand others. Resident #50's BIMS score was not assessed due to her being rarely/never understood. Resident #50 had short-and-long term memory recall problem and severely impaired cognitive skills for daily decision making. Resident #50 was dependent for toilet hygiene and was always incontinent of urine and bowel. Resident #50 received an antibiotic during the last 7 days of the assessment period. Record review of Resident #50's care plan, dated 02/09/24, indicated urinary tract infection, effective. Intervention included give antibiotic therapy as ordered. Record review of a care plan, dated 03/05/24, indicated Resident #50 had a urinary tract infection. Intervention included give antibiotic therapy as ordered. Record review of Resident #50's order summary, dated active as of 03/01/24, did not reveal isolation orders for ESBL in her urine. Record review of Resident #50's progress notes, dated 02/01/24-06/26/24, did not reveal Resident #50 being on contact isolation for ESBL in her urine. Record review of Resident #50's culture and sensitivity results dated 02/02/24 indicated .high pathogens detected .Escherichia coli .low pathogens detected .enterococcus faecalis .antibiotic notes .ESBL (Extended Spectrum Beta-lactamase detected .are usually multi-drug resistant .antibiotic resistance genes .detected ESBL 1 . Record review of Resident #50's culture and sensitivity results dated 02/16/24 indicated .high pathogens detected .Escherichia coli . antibiotic notes .ESBL (Extended Spectrum Beta-lactamase detected .are usually multi-drug resistant .antibiotic resistance genes .detected ESBL 1 . Record review of Resident #50's Infection Control Surveillance Form, dated 02/04/24, indicated what type of precautions/or isolation implemented .universal precautions (safety precautions used with every client) . ADON . Record review of Resident #50's Infection Control Surveillance Form, dated 02/18/24, indicated what type of precautions/or isolation implemented .none .DON . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/26/24 at 1:30 p.m., RN E said resident with ESBL in their urine required contact isolation. She said if a resident needed isolation precautions started, and ordered would be placed in the electronic charting system and progress note written. She said the LVN was responsible for sending the lab work to the doctor. She said the nurse and the doctor should fully review the result to make sure information such as ESBL was seen. She said isolating a resident with ESBL was important to prevent the spread of the infection. During an interview on 06/26/24 at 1:55 p.m., the ADON said she was the Infection Control Preventionist. She said she was responsible for antibiotic usage and monitoring, reviewing lab results, tracking and trending infections, in-services, and care plan related to infection control. She said the charge nurses were responsible for sending lab work to the doctor. She said when a resident had an infection requiring isolation, the doctor was notified, and orders were received which was all documented in a progress note. She said if the resident had ESBL, they would be placed in contact isolation until antibiotics were completed. She said she was not aware Resident #50 and Resident #46 had ESBL in their urine. She said Resident #50 and Resident #46 had not been placed on contact isolation from ESBL lab results on 12/19/23, 02/02/24, or 02/16/24. She said the area where the lab company stated the resident had ESBL was easily missed, and she would do an in-service with the nursing staff to look closer at the lab results. She said it was important to isolation residents with MDRO to prevent the spread of the infection. During an interview on 06/26/24 at 3:05 p.m., the DON said the nurse and ICP were responsible for reading the lab results and ensuring residents with MDROs were isolated. She said Resident #46 and Resident #50 should have been placed on contact isolation for ESBL in their urine. She said when isolation was needed for a resident, the doctor was notified then orders were received. She said nursing staff should document when the doctor was notified and the resident being on isolation status in progress notes. She said contact isolation of resistant organisms was important to prevent the spread of the infection. She said it was also important for infection control and prevent cross contamination. During an interview on 06/26/24 at 4:45 p.m., the ADM said the ICP was responsible for ensuring lab results were closely reviewed and residents placed in isolation for resistant infections. She said isolating a resident with ESBL was important to prevent the spread of the infection to residents and staff. Record review of a facility's Infection Control Plan: Overview policy, updated 03/2024, indicated .the facility will establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent he development and transmission of disease and infection .determines that a resident needs isolation to prevent the spread of infection, the facility will isolate the resident . Record review of a facility's Fundamentals of Infection Control Precautions policy and procedure dated 03/2024, indicated .resident placement .appropriate placement is significant component of isolation precautions .when available, a private room is important to prevent direct or indirect contact transmission when the source resident has poor hygiene habits, contaminates the environment, or cannot be expected to assist in maintaining infection control precautions to limit transmission of microorganisms .when possible, a resident with highly transmissible or epidemiologically important microorganisms is placed in a private room with handwashing and toilet facilities to reduce opportunities for transmission of microorganisms . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility's Enhanced Barrier Precautions policy, dated 04/01/24, indicated . Multidrug-resistant organism (MDRO) transmission is common in long term care (LTC) facilities .many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs .implementing contact versus enhanced barrier precautions .