STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676190	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stillhouse Rehabilitation and Healthcare Center	2900 Stillhouse Road Paris, TX 75462

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observations, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 3 of 23 residents (Resident #63, Resident #25, and Resident #42) reviewed for comprehensive person-centered care plans. 1. The facility failed to ensure Resident #63's grab bar was included on the care plan. 2. The facility failed to ensure Resident #25's comprehensive care plan addressed that he received an anticoagulant medication and that he required the use of assist/grab bars. 3. The facility failed to ensure Resident #42's care plan was person-centered to include his lack of triggers and unwillingness to discuss his history of trauma. These failures could place residents at risk of unmet care needs, not receiving necessary medications, and decreased quality of life. Findings included: 1. Record review of the face sheet, dated 03/27/2024, revealed Resident #63 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of Down Syndrome (genetic disorder caused by an extra copy of chromosome 21, which causes physical and mental developmental problems), unspecified dementia without behavioral disturbances (a group of symptoms that affects memory, thinking, and interferes with daily life), need for assistance with personal care, other speech disturbances (communication disorder in which normal speech is impaired), extrapyramidal and movement disorder (involuntary or uncontrollable movements caused by certain antipsychotic or other drugs), and epilepsy (neurological disorder that causes seizures or unusual sensations and behaviors). (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the quarterly MDS assessment, dated 01/13/2024, revealed Resident #63 had unclear speech and was rarely or never understand by staff. The MDS revealed Resident #63 was rarely or never able to understand others. The MDS revealed Resident #63 had short-term and long-term memory problems. The MDS revealed Resident #63 had severely impaired decision-making ability. The MDS revealed Resident #63 required substantial or maximal assistance (help does more than half the effort) for the following tasks: rolling from left to right (on the bed), sitting to lying (on the bed), and lying to sitting on the side of bed. Record review of Resident #63's comprehensive care plan, revised on 02/23/2024, did not address the use of a grab bar. During an observation and attempted interview on 03/25/2024 at 9:55 AM, Resident #63 was laying in her bed against the grab bar with her legs drawn up near her face and crossed at the ankles. Resident #63 was rolling her tongue and repeatedly sticking it out of her mouth. Resident #63 was unable to communicate effectively as evidenced by grunting loudly when she was asked questions. During an observation on 03/25/2024 at 10:27 AM, Resident #63 was provided incontinent care by CNA F and CNA G. CNA F and CNA G used the log roll technique to turn Resident #63 while in the bed to change her incontinent brief. The grab bar was not used. During an interview on 03/27/2024 beginning at 1:54 PM, CNA G stated Resident #63 did not use the grab bar or try to help staff when she was provided care. CNA G stated she did not have access to the care plan. CNA G stated she relied on the nurse to tell her what the resident's needed. During an interview on 03/27/2024 beginning at 2:02 PM, LVN H stated grab bars should have been included on the care plan. LVN H stated it was important to ensure the care plan was updated so staff were aware of the interventions Resident #63 needed when providing care. 2. Record review of Resident #25's face sheet dated 03/26/2024, indicated a [AGE] year-old male who initially admitted to the facility on [DATE] with diagnoses which included hemiplegia (paralysis of half of the body) and hemiparesis (weakness of one entire side the body) following cerebrovascular disease (stroke) affecting left non-dominant side, diabetes mellitus (a group of diseases that result in too much sugar in the blood), atrial fibrillation (abnormal heart rhythm), and heart failure (heart muscle does not pump blood as well as it should). Record review of Resident #25's quarterly MDS assessment dated [DATE], indicated Resident was able to understand others and able to be understood. The MDS assessment indicated Resident #25 had a BIMS score of 12, indicating his cognition was moderately impaired. The MDS assessment indicated Resident #25 required partial/moderate assistance with chair/bed to chair transfer, toilet transfer and lying to sitting on the side of the bed. Record review of Resident #25's comprehensive care plan dated 02/29/24 did not indicate Resident #25 was receiving Xarelto (anticoagulant medication-blood thinner) or used grab/assist bars to help him with repositioning and transfers. Record review of Resident #25's order summary report dated 03/26/24, indicated Resident #25 had an order for Xarelto 20mg give one tablet by mouth daily with a start date of 03/11/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #25's CMA- medication administration record for the month of March 2024, indicated Resident #25 had received Xarelto 20mg one tablet daily since 3/12/24. During an observation on 03/25/24 at 09:59 AM, Resident #25 was lying in bed asleep. Resident #25 was noted to have assist/grab bars to each side of his bed. During an interview on 03/25/24 at 12:39 PM, Resident #25 said he was taking Xarelto and had just been restarted last week. During an observation on 03/26/24 at 10:43 AM, Resident #25 was lying in bed asleep. Resident #25 continued to have assist/grab bars to each side of his bed. During an interview on 03/26/24 at 4:07 PM, Resident #25 said he used the assist/grab bars to help him get in and out of bed. During an interview on 03/27/24 at 11:26 AM, Resident #25 said the assist/grab bars were already on the bed when he admitted to the facility. During an interview on 03/27/24 at 11:28 AM, LVN H said Resident #25's anticoagulant medication should have been on Resident #25's comprehensive care plan since it was part of his care. LVN H said the risks of his anticoagulant medication not being care planned was that he could have had internal bleeding or blood in his stools and staff be unaware. LVN H said new staff would not be aware of Resident #25 was receiving an anticoagulant medication. LVN H said the DON was responsible for updating the care plans. LVN H said the assist/grab bars should have been on the comprehensive care plan for his safety. During an interview on 03/27/24 at 11:47 AM, The ADON said she would assume Resident #25's anticoagulant medication be added to his comprehensive care plan. The ADON said Resident #25 was at risk for bleeding and required monitoring. The ADON said she was unsure of who was responsible for ensuring the care plans were updated and would review the policy. The ADON said she was unsure if the assist/grab bars should have been care planned. During an interview on 03/27/24 at 11:57 AM, the DON said Resident #25's care plan should have included that he was taking an anticoagulant medication because that was where staff could look to get pertinent information regarding the resident. The DON said the MDS Coordinator and herself were responsible for updating the care plans. The DON said they had not been including the assist/grab bars on the resident's care plan. During an interview on 03/27/24 at 1:42 PM, the Administrator said he was unsure if the anticoagulant medication should have been on Resident #25's care plan and would expect staff to follow the policy. The Administrator said he was unsure of what the policy indicated. The Administrator said the use of assist/grab bars should not be care planned because they did not care plan walkers or wheelchairs. 3. Record review of the face sheet, dated 03/27/2024, revealed Resident #42 was a [AGE] year-old male who initially admitted to the facility on [DATE] with diagnosis of PTSD (mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback, and avoidance of similar situations). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the quarterly MDS assessment, dated 01/02/2024, revealed Resident #42 had clear speech and was understood by others. The MDS revealed Resident #42 was able to understand others. The MDS revealed Resident #42 had a BIMS score of 11, which indicated his cognition was moderately impaired. The MDS revealed Resident #42 had no behaviors or refusal of care. The MDS revealed Resident #42 had an active diagnosis of PTSD. Record review of Resident#42's comprehensive care plan, revised 02/23/2024, did not include person-centered interventions to address Resident #42's lack of triggers or unwillingness to talk about his history of trauma. Record review of the psychiatry note, dated 03/11/2024, revealed Resident #42 had a psychiatric history of childhood PTSD. The visit note did not include identified triggers. During an observation and interview on 03/25/2024 beginning at 10:52 AM, Resident #42 was sitting up in his recliner with his feet elevated. Resident #42 had his television on and a plate of brown candies on his bedside table. Resident #42 stated he had a history of trauma from his childhood but did not want to talk about it. During an interview on 03/27/2024 at 10:07 AM, the DON stated the facility did not have an actual policy for trauma informed care. The DON stated the Social Worker completed an assessment and if a resident answered yes to diagnosis of PTSD or a history of trauma then it was investigated, care planned, and referral was completed for psychological services. During an interview on 03/27/2024 beginning at 1:54 PM, CNA G stated she had been working at the facility since 2002 and normally worked on A Hall. CNA G stated she did not know of anyone on her hallway that had a diagnosis of PTSD. CNA G stated she relied on the nurse to tell her if any of the resident's had PTSD. CNA G stated she did not have access to the care plan. During an interview on 03/27/2024 beginning at 2:02 PM, LVN H stated she was unaware Resident #42 had a diagnosis of PTSD. LVN H stated she would have been made aware through the care plan if a resident had a diagnosis of PTSD. LVN H stated Resident #42 had been in the military and she was unaware of any triggers Resident #42 had. LVN H stated it was important to ensure the comprehensive care plan included a care plan for PTSD that was person-centered to prevent re-traumatization and so the staff were aware of the interventions. During an interview on 03/27/24 beginning at 2:22 PM, the Social Worker stated staff were notified verbally or on the care plan if residents had a diagnosis of PTSD. The Social Worker stated Resident #42 had a diagnosis of PTSD but had not displayed behaviors or mood behaviors. The Social Worker stated Resident #42 liked to stay in his room, watch TV, and eat his candy. The Social Workers stated Resident #42's triggers should have been included on the care plan. The Social Worker stated he recently became aware Resident #42 had PTSD. The Social Worker stated it was important to ensure triggers were identified to reduce or prevent resident's from being triggered. During an interview on 03/27/2024 beginning at 2:48 PM, the DON stated she remembered a care plan meeting, in which she attended, where Resident #42's PTSD status was discussed. The DON stated it was discovered by his family that he was unwilling to talk about his history of trauma and triggers were not identified because he did not have any. The DON stated it should have been documented but she was unable to find the documentation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an attempted telephone interview with Resident #42's family member on 03/27/2024 at 2:53 PM to gather additional evidence, Resident #42's family member did not answer the telephone. A brief message was left and not returned before exiting the facility. During an interview on 03/27/2024 beginning at 3:20 PM, the DON stated Resident #42 did not have any identified triggers for his diagnosis of PTSD. The DON stated she would have notified the staff, through an in-service, of Resident #42's PTSD status if triggers were identified. The DON stated she would not have included his lack of triggers in the comprehensive care plan and only triggers should have been included in the care plan. The DON stated the care plan was how staff were notified of a resident's PTSD diagnosis. The DON stated the CNAs had access to the care plan. During an interview on 03/27/2024 beginning at 3:47 PM, the Administrator stated expected PTSD triggers or lack of triggers to have been documented in the medical record. The Administrator stated PTSD triggers should have been included on the care plan if they were identified. The Administrator stated he was unable to speak on who was able to access the care plan. The Administrator stated the MDS Coordinator and nursing management were responsible for ensure the care plan was updated. The Administrator stated the care plan should have been updated when the plan of care changes and according to regulatory requirements. The Administrator stated it was important to ensure PTSD triggers and assessments were documented so it could have been monitored. During an interview on 03/27/24 at 1:17 PM, the DON said they did not have a policy on comprehensive care plans. Record review of the facility's policy Bed Rails revised on 12/2023, indicated . 6. Update the resident care plan as needed related to the identified and/or ongoing need or resident choice for the use of bed rails. 47006

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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** 47006 Based on observations, interviews, and record review the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition for 1 of 6 residents (Resident #16) reviewed for quality of life. The facility did not ensure Resident #16 was provided assistance with eating during the lunch meal on 03/25/2024. This failure could place residents at risk for decreased food intake, weight loss, and a decreased quality of life. The findings included: Record review of the face sheet, dated 03/27/2024, revealed Resident #16 was a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, late onset (type of gradually progressive brain disorder that causes problems with memory, thinking, and behavior), need for assistance with personal care, and unspecified protein-calorie malnutrition (occurs when an individual does not consume sufficient protein and calories, leading to adverse effects on their health). Record review of the quarterly MDS assessment, dated 02/10/2024, revealed Resident #16 had clear speech and was usually understood by others. The MDS revealed Resident #16 was rarely or never able to understand others. The MDS revealed Resident #16 had a BIMS score of 4, which indicated severely impaired cognition. The MDS revealed Resident #16 had no behaviors or refusal of care. The MDS revealed Resident #16 usually required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) while eating. The MDS revealed Resident #16 had a weight loss of 5% or more in the last month or 10% in the last 6 months. The MDS revealed Resident #16 was on a mechanically altered diet. Record review of the comprehensive care plan, initiated on 01/31/2024, revealed Resident #16 had an unplanned weight loss. The interventions included: offer substitutes as requested and give supplements as ordered. The care plan further revealed Resident #16 had a potential nutritional problem related to malnutrition risk. The interventions included: diet as ordered by the physician, food in bowls as needed, and meals in dining room if resident agreed. The ADL care plan did not address eating. Record review of the order summary report, dated 03/27/2024, revealed Resident #16 had an order, which started on 10/28/2021, for regular diet mechanical soft texture, thin liquids consistency, FMP, health shake with meals, food in bowls-low vision. During an observation on 03/25/2024 at 12:18 PM, Resident #16 was sitting at the end of the table and was approximately 12 inches away from the tabletop. Resident #16 was using a fork for her soupy meat, which was falling off the fork while she was trying to bring it to her mouth. Resident #16's roll was big, and she had trouble biting it. Resident #16 took a small bite of her roll and placed it beside her bowls. Resident #16 did not have a health shake. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a lunch meal observation on 03/25/2024 at 12:31 PM, Resident #16 put her fork down and was sitting at the dining table, staring across the table. Resident #16 consumed less than 25% of her food. During an observation on 03/25/2024 at 12:36 PM, a staff member asked if Resident #16 was done eating. The staff member did not offer a substitute, health shake, or supplement and did not attempt to assist Resident #16 with eating. During an observation on 03/25/2024 at 12:42 PM Resident #16 took her clothing protector off and pushed herself slightly away from the table. During an interview on 03/27/2024 beginning at 1:54 PM, CNA G stated when a resident consumed less than 50% of a meal, she reported it to the nurse and then offered them a substitute or a supplement. CNA G stated when Resident #16 ate less than 50% of her meal the staff should have assisted her and offered her a health shake. CNA G stated Resident #16 used to have a good appetite but the last few weeks she had not been eating well. CNA G was not aware Resident #16 had a weight loss. CNA G stated it was important to ensure Resident #16 received assistance with her meals to prevent more weight loss. During an interview on 03/27/2024 beginning at 2:02 PM, LVN H stated when a resident ate less than 50% of their meal the CNAs were to notify the nurse and offer a health shake or supplement. LVN H stated Resident #16 was not a big eater and was usually assisted with her meals because she had trouble seeing. LVN H stated she encouraged a health shake because she normally only ate a few bites of each bowl. LVN H stated she always drank her health shake. LVN H stated Resident #16 has had some weight loss. LVN H stated it was important to ensure Resident #16 received assistance during meals and her ordered health shakes to prevent further weight loss and decrease the risk for decline in her skin integrity. During an interview on 03/27/2024 beginning at 2:48 PM, the DON stated there was no policy for therapeutic diets. The policy for ADLs for eating was requested and not provided upon exit of the facility. During an interview on 03/27/2024 beginning at 3:20 PM, the DON stated when a resident consumed less than 50% of their meal the CNA should have notified the nurse and offered a supplement. The DON stated Resident #16 had weight loss and her physician believed it could have been related to her age. The DON stated she expected the nursing staff to ensure assistance was provided and health shakes were provided during the meals. The DON stated the nurse in the dining room was responsible for monitoring to ensure assistance was provided and health shakes were offered. The DON stated it was important to ensure Resident #16 received assistance with eating and her health shakes to prevent further weight loss. During an interview on 03/27/2024 beginning at 3:47 PM, the Administrator stated he expected staff to ensure Resident #16 required assistance with eating and ordered health shakes. The Administrator stated the nurse in the dining room was responsible for monitoring to ensure assistance was provided and health shakes were offered. The Administrator stated it was important to ensure Resident #16 had a good meal intake to ensure her weight was maintained.

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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** 47612 Based on observation, interview and record review, the facility failed to follow their own established smoking policy for 1 of 6 residents reviewed for quality of care (Resident #3). The facility did not provide a smoking apron per their smoking assessment for Resident #3. The failure could place residents at risk of an unsafe smoking environment and burns. Findings included: Record review of a face sheet dated 03/27/2024 indicated Resident #3 was a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Paranoid Schizophrenia (pattern of behavior where a person feels distrustful and suspicious of other people and act accordingly) Dementia (loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life), other lack of coordination (problems with movement). Record review of the care plan last reviewed 07/17/2023, indicated Resident #3 was a smoker and would wear a smoking apron to prevent potential smoking injuries. A record review of Smoking Evaluation assessment dated [DATE] indicated Resident #3 had shaking and tremors while smoking. The Smoking Evaluation Assessment indicated the resident required a smoking apron while smoking. During an observation on 03/26/2024 at 10:45 a.m., Resident #3 was outdoors sitting in a wheelchair, without a smoking apron, with other smokers and 2 staff members. Housekeeper D was observed lighting a cigarette and handing it to Resident# 3. Resident #3 put the cigarette to her mouth before housekeeper D witnessed the surveyor watching and took the cigarette from Resident #3. CNA C was observed going into the facility to get the smoking apron. CNA C placed the smoking apron on Resident #3 and Housekeeper D gave Resident #3 the cigarette. During an interview with CNA C on 03/27/2024 at 1:34 p.m., stated Resident # 3 was supposed to wear a smoking apron. CNA C stated it was the responsibility of the staff member who took the resident to out to smoke to ensure Resident #3 had on a smoking apron. CNA C stated it was important, so the resident did not drop the cigarette on their clothes. CNA C stated the harm was Resident #3 could drop the cigarette or ashes could fall on her and she could get burnt. During an interview with LVN E on 03/27/2024 at 1:50 p.m. stated Resident #3 was to wear a smoking apron when smoking. LVN E stated it was the responsibility of the staff member that took the residents out to smoke to ensure Resident#3 had a smoking apron on. LVN E stated it was important for Resident #3 to wear a smoking apron because Resident #3 mental status was not there, and she could burn herself. LVN E stated the harm, Resident # 3 could burn herself. (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 with Housekeeper D on 03/27/2024 at 2:09 p.m., stated she gave Resident #3 the cigarette to hold while CNA C went to get the apron. Housekeeper D stated Resident #3 was supposed to have on a smoking apron before given a lit cigarette. Housekeeper D stated it was the responsibility of whoever took the residents out to smoke to ensuring Resident#3 had on a smoking apron. Housekeeper D stated it was important for Resident # 3 to have on the smoking apron, so she did not get burned if the fire came off the cigarette. Housekeeper D stated the harm was Resident # 3 could get burn if the fire fell on her. During an interview on 03/27/2024 at 2:19 p.m., the DON stated the Resident # 3 should have on a smoking apron when smoking but Resident #3 could hold an unlit cigarette without a smoking apron. The DON stated the staff knew to make sure Resident #3 had on a smoking apron. The DON stated it was important for Resident #3 to wear the smoking apron because she could drop the cigarette. The DON stated the harm was Resident #3 could drop the cigarette on herself. The DON stated she would monitor by putting in a check off system. During an interview on 03/27/2024 at 2:41 p.m., the Administrator stated he expected Resident # 3 to wear a smoking apron. The Administrator stated the staff were human and made a mistake. The Administrator stated Resident # 3's smoking apron was important incase embers fell on her. The Administrator stated the harm was if embers fell on to her person. The Administrator stated he would in-service the staff. Record review of the facility's policy titled, Smoking/Tobacco Policy Upon quarterly review by the IDT, or any time significant change of condition occurs, smoking residents will be re-assessed as to their ability to smoke safely .

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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** 47612 Based on observation, interview, and record review, the facility failed to ensure a resident received appropriate treatment and services to prevent urinary tract infections for 1 of 2 residents (Resident #2) reviewed for quality of care. The facility failed to ensure Resident #2's urinary (foley) catheter was properly secured to his leg. This failure could place residents with urinary catheters at risk for damage to the bladder, penis, or urethra (a hollow tube that lets urine leave your body), dislodging of the catheter, and urinary tract infections. Findings included: Record review of a face sheet dated 03/27/2024 indicated Resident #2 was a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Hemiplegia and Hemiparesis following cerebral infraction affecting the right dominant side (indicates paralysis on the right side of the body), Hemiplegia unspecified affecting left dominant side (indicates paralysis on the left side of the body), Vascular dementia (problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain) obstructive uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #2 was rarely/never understood by others and was rarely/never able to make himself understood. Record review of the MDS assessment indicated Resident #2 had a BIMS score of 0, which indicated his cognition was severely impaired. The MDS assessment indicated Resident #2 was dependent for all ADLs. The MDS assessment indicated Resident #2 had an indwelling catheter. Record review of the Order Summary Report dated 03/04/2024 indicated Resident #2 had an order to ensure catheter strap in place and holding every shift change as needed with an order start date of 02/22/2024. Record review of the care plan last reviewed 12/24/2023 indicated Resident #2 had an indwelling catheter with a goal for the resident to remain free from catheter related trauma through review date, and interventions to ensure the tubing was secure to facilitate flow of urine, prevent kinking of tubing, and accidental removal. During an observation on 03/26/2024 at 3:43 p.m., Resident #2 did not have a catheter strap in place. Resident #2's catheter tubing was not anchored to his leg or the linens. Resident #2 was non-interview able. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview with CNA C on 03/26/2024 at 3:43 p.m., Resident #2's catheter tubing was not anchored to his leg or the linens, and there was no catheter strap in place. CNA C stated she did not know why Resident #2 did not have a leg strap to secure the catheter tubing. CNA C stated the nurses were responsible for ensuring the residents catheter tubing were properly secured. CNA C stated it was important for the catheter to be secured so it did not get pulled. CNA C stated if the catheter was not properly secured it could get pulled out. During an interview with LVN E on 3/37/2024 at 1:50 p.m. stated it was the nurse's responsibility to ensure Resident # 2 catheter tubing was properly secured. LVN E stated Resident # 2 normally had a leg strap to secure his catheter. LVN E stated it was important for the catheter tubing to be secure to keep it from getting jerked out. LVN E stated the harm could be the catheter being pulled out when getting turned. During an interview on 03/27/2024 at 2:19 p.m., the DON stated the Resident # 2 should have had a leg strap to secure his catheter tubing. The DON stated it was the nurse's responsibility to ensure the catheters were secured properly. The DON stated it was important for the catheter tubing to be secure, so it did not get pulled out. The DON stated the harm could be pain or discomfort. The DON stated she would monitor everyday by putting a check off into the computer system. During an interview on 03/27/2024 at 2:41 p.m., the Administrator stated Resident # 2 had the right to ask not to wear a leg strap, and if he did, it needed to be care planned. The Administrator stated resident had the right to make his own choice. However, if that was not the case, he expected Resident # 2's catheter tubing to be secured properly. The Administrator stated it was nursing's responsibility for ensuring catheter tubing was secured properly. The Administrator stated it was important for the catheter tubing to be secure for dignity. The Administrator stated the harm could be if the catheter came out. The Administrator stated he would have the CNAs to monitor daily after showers. Record review of the facility's policy titled, Indwelling Urinary Catheter Care May secure the tubing with a securement device, as needed (PRN) to prevent migration. Friction, or tension of the catheter .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observations, interview, and record reviews, the facility failed to attempt to use alternatives prior to installing a side or bed rail, obtain informed consent prior to installation, ensure correct installation, use and maintenance of bedrails for 2 of 2 residents (Residents #63 and #25) reviewed for quality of care. 1. The facility failed to ensure informed consent for the use of Resident #63's bed rails were obtained prior to installation. 2. The facility failed to follow Resident #63's bed rail assessment, which did not recommend the use of bed rails. 3. The facility failed to document the attempt of alternatives used prior to installation of Resident #25's bed rails. 4. The facility failed to ensure an informed consent for the use of Resident #25's bed rails were obtained prior to installation. These failures could place residents at risk for entrapment with serious injury and even death. Findings included: 1. Record review of the face sheet, dated 03/27/2024, revealed Resident #63 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of Down Syndrome (genetic disorder caused by an extra copy of chromosome 21, which causes physical and mental developmental problems), unspecified dementia without behavioral disturbances (a group of symptoms that affects memory, thinking, and interferes with daily life), need for assistance with personal care, other speech disturbances (communication disorder in which normal speech is impaired), extrapyramidal and movement disorder (involuntary or uncontrollable movements caused by certain antipsychotic or other drugs), and epilepsy (neurological disorder that causes seizures or unusual sensations and behaviors). Record review of the quarterly MDS assessment, dated 01/13/2024, revealed Resident #63 had unclear speech and was rarely or never understand by staff. The MDS revealed Resident #63 was rarely or never able to understand others. The MDS revealed Resident #63 had short-term and long-term memory problems. The MDS revealed Resident #63 had severely impaired decision-making ability. The MDS revealed Resident #63 required substantial or maximal assistance (help does more than half the effort) for the following tasks: rolling from left to right (on the bed), sitting to lying (on the bed), and lying to sitting on the side of bed. Record review of Resident #63's comprehensive care plan, revised on 02/23/2024, did not address the use of a grab bar. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the order summary report, dated 03/27/2024, revealed Resident #63 did not have an order for the use of a grab bar. Record review of Resident #63's initial Bed Rail Safety Evaluation, dated 03/17/2024, revealed the IDT did not recommend the use of a bed rail. Record review of Resident #63's electronic medical record did not reveal a side rail consent form. Record review of the incident report, dated 03/23/2024, revealed Resident #63 obtained bruising and petechiae (round, pinpoint spots that form on the skin that look red, brown, or purple) on her forehead, which measured 4 cm x 4 cm, after she was observed with her forehead leaned against the grab bar while she was laying in the bed. During an observation and attempted interview on 03/25/2024 at 9:55 AM, Resident #63 was laying in her bed against the grab bar with her legs drawn up near her face and crossed at the ankles. Resident #63 was rolling her tongue and repeatedly sticking it out of her mouth. Resident #63 was unable to communicate effectively as evidenced by grunting loudly when she was asked questions. During an observation on 03/25/2024 at 10:27 AM, Resident #63 was provided incontinent care by CNA F and CNA G. CNA F and CNA G used the log roll technique to turn Resident #63 while in the bed to change her incontinent brief. The grab bar was not used. During an interview on 03/27/2024 beginning at 1:54 PM, CNA G stated Resident #63 did not use the grab bar or try to help staff when she was provided care. During an interview on 03/27/2024 beginning at 2:02 PM, LVN H stated grab bars located on the side of the bed were used to assist the resident with mobility. LVN H stated Resident #63 did not use the grab bar on her bed. LVN H stated she had not noticed Resident #63 leaning her head against the grab bar but knew an incident had occurred on 03/23/2024 where she was observed leaning against the grab bar and obtained bruising. LVN H stated if Resident #63 did not use the bed rail it should have been removed. LVN H stated if Resident #63's bed rail assessment stated bed rails were not recommended. She should not have had bed rails. LVN H stated it was important to ensure bed rails were used appropriately to prevent further injuries such as bruising and promote resident safety. During an interview on 03/27/2024 beginning at 3:20 PM, the DON stated Resident #63 used her grab bar with staff assistance. The DON stated she was up most of the day, so the day shift would not have been aware she used the grab bar. The DON stated Resident #63 did have some bruising and petechiae on her forehead and it was observed by the CNA, on 03/23/2024, that Resident #63 had been leaning her head against the grab bar. The DON stated the IDT determined the air mattress was causing her to lean in her bed and was removed. 2. Record review of Resident #25's face sheet dated 03/26/2024, indicated a [AGE] year-old male who initially admitted to the facility on [DATE] with diagnoses which included hemiplegia (paralysis of half of the body) and hemiparesis (weakness of one entire side the body) following cerebrovascular disease (stroke) affecting left non-dominant side, diabetes mellitus (a group of diseases that result in too much sugar in the blood), atrial fibrillation (abnormal heart rhythm), and heart failure (heart muscle does not pump blood as well as it should). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #25's quarterly MDS assessment dated [DATE], indicated Resident was able to understand others and able to be understood. The MDS assessment indicated Resident #25 had a BIMS score of 12, indicating his cognition was moderately impaired. The MDS assessment indicated Resident #25 required partial/moderate assistance with chair/bed to chair transfer, toilet transfer and lying to sitting on the side of the bed. Record review of Resident #25's comprehensive care plan dated 02/29/24 did not indicate Resident #25 required the use grab/assist bars to help him with repositioning and transfers. Record review of Resident #25's bed rail safety evaluation dated 10/24/23 indicated initial evaluation with the bed rail type assist bars checked. The evaluation indicated under alternative interventions attempted prior to bed rail use had none documented. The evaluation under the question Does the physical build or characteristics of the resident increase the risk of entrapment in gaps between the bed rails and equipment combination due to the residents: head size and body size with yes being checked. The evaluation under section IDT recommendation had bed rail recommended. Proceed to resident education re: risks and benefits and confirm informed consent has been obtained prior to installation of bed rail checked. The justification indicated needed for bed mobility. The evaluation indicated education was provided to the resident. Record review of Resident #25's bed rail safety evaluation dated 01/24/24, indicated quarterly evaluation with the bed rail type grab bars checked. The evaluation did not indicate any alternative interventions attempted prior to bed rail use. The evaluation under the IDT recommendation had Bed rail NOT recommended checked. Record review of Resident #25's electronic medical record did not reveal a side rail consent form. During an observation on 03/25/24 at 09:59 AM, Resident #25 was lying in bed asleep. Resident #25 was noted to have assist/grab bars to each side of his bed. During an observation on 03/26/24 at 10:43 AM, Resident #25 was lying in bed asleep. Resident #25 continued to have assist/grab bars to each side of his bed. During an interview on 03/26/24 at 4:07 PM, Resident #25 said he used the assist/grab bars to help him get in and out of bed. During an interview on 03/27/24 at 11:26 AM, Resident #25 said the assist/grab bars were already on the bed when he admitted to the facility. Resident #25 said he did not sign a consent for the assist/grab bars. During an interview on 03/27/24 at 11:28 AM, LVN H said assist/grab bars were given to the residents that were mobile. LVN H said there was a side rail assessment they completed but was unsure if they were required to obtain a consent for the use of bed rails. LVN H said she had never asked a resident to sign a consent for the use of the bed rails. During an interview on 03/27/24 at 11:47 AM, the ADON said when a resident had assist/grab bars they completed a quarterly assessment. The ADON said she was unsure if a consent should have been obtained prior to installation. The ADON said she checked off on Resident #25's side rail evaluation on 01/24/24 as bed rail NOT recommended as the assist/grab bars were not considered a bed rail. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/24 at 11:57 AM, the DON said assist/grab bars were utilized by resident who benefited from them for turning and repositioning. The DON said assist/grab bars were not considered a restraint so therefore no consent was needed to be obtained. The DON said Resident #25's bed rail evaluation was checked as bed rail NOT recommended as the assist/grab bars were not considered a bed rail. During an interview on 03/27/24 at 1:42 PM the Administrator said assist/grab bars were not considered a restraint, so no consent needed. Record review of the facility's policy Bed Rails revised on 12/2023, indicated . Bed rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths .1. After the facility has attempted alternatives to bed rails and determined that these alternatives failed to meet the resident's assessed needs, the facility interdisciplinary team (IDT) will assess the resident for risks of entrapment. The risks and benefits regarding the use of bed rails will be considered for each resident . 2. The facility should maintain evidence that it has provided sufficient information prior to installation so that the resident or resident representative could make an informed decision . 6. Update the resident care plan as needed related to the identified and/or ongoing need or resident choice for the use of bed rails. A. if the IDT determines bed rails are no longer needed or appropriate for resident use, discontinue the use of need rails. 47006

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 33249 Based on observation, interview, and record review, the facility failed to establish a system of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and determine that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 1 storage area reviewed for pharmacy services The facility failed to keep a record or receipt of controlled medications awaiting disposition to allow accurate and periodic reconciliation. This failure could place residents at risk for loss of prescribed medications, resident's safety, and drug diversion. Findings included: During an observation and interview on 03/26/2024 at 10:05 AM, the following medications were observed in the controlled medication storage cabinet with no medication log of the medications awaiting to be disposed: *Clonazepam 2 milligrams-30 RX# 501363197 *Tramadol 50 milligrams - 23 RX# 501380719 *Alprazolam 1 milligram-57 RX# 501380727 *Tramadol 50 milligrams 11 RX# 501344987 *Oxycodone 5 milligrams 58 RX# 501371736 *Alprazolam 1 milligrams 4 RX# 4522083-04663 The DON said the controlled medications awaiting to be disposed were kept in the locked cabinet behind two locks. The DON said she was the only one with the key to the door and the cabinet. The DON said her process when she reconciled medications that needed to be disposed of was when medications were brought to her, she checked the narcotic medication count and verified the count with the nurse. The DON said she stored the medication in the double locked cabinet until drug destruction with the pharmacist then at that time the narcotics were reconciled/logged. The DON said the pharmacy consultant and herself were responsible for reconciling the narcotic medications. The DON said the medications would not come up missing as she does not leave the cabinet, or the door unlocked. The DON said she had never had a log of the stored narctics for destruction. Record review of the facility's medication destruction binder 2024 indicated the narcotics were destroyed monthly with the pharmacist and 2 witnesses. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/2024 at 11:20 a.m., the Administrator said he expected the narcotics to be reconciled as the policy indicated. The Administrator said without accurately reconciling the stored narcotics there was not a way to account for the narcotics and possibly lose track of them. Record review of the facility's policy Controlled Medications-Storage and Reconciliation dated 12/2019 and revised on 1/2022 indicated it is the policy of this facility to safeguard access and storage of controlled drugs listed in Schedule ll of the Comprehensive Drug Abuse Prevention and Control Act ofr1976 and other drugs subject to abuse may be stored with non-controlled medications as part of a single unit package medication distribution system, if the supply of the medications was minimal and a shortage was readily detectable. The facility must maintain a process for monitoring, administration, documentation, reconciliation, and destruction of controlled substances . 13. Controlled medications remaining in the facility after the order has been discontinued are retained in the facility in a securely locked area with restricted access until destroyed by a DEA representative; destroyed by the facility's DNS (Director of Nursing Services) or authorized designee, and consultant pharmacist; or as otherwise directed by state law.

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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** 46928 Based on interview and record review, the facility failed to ensure residents' drug regimen was adequately monitored and free from unnecessary drugs for 2 of 5 residents (Resident #25 and Resident #42) reviewed for pharmacy services. 1. The facility failed to monitor Resident #25 for side effects/adverse reactions for the use of Xarelto (an anticoagulant medication- blood thinner). 2. The facility failed to ensure Resident #42's edema was monitored while taking furosemide. (Medication given to remove fluid and reduce swelling.) These failures could place residents at risk of swelling, bruising, and bleeding . Findings included: 1. Record review of Resident #25's face sheet dated 03/26/2024, indicated a [AGE] year-old male who initially admitted to the facility on [DATE] with diagnoses which included hemiplegia (paralysis of half of the body) and hemiparesis (weakness of one entire side the body) following cerebrovascular disease (stroke) affecting left non-dominant side, diabetes mellitus (a group of diseases that result in too much sugar in the blood), atrial fibrillation (abnormal heart rhythm), and heart failure (heart muscle does not pump blood as well as it should). Record review of Resident #25's quarterly MDS assessment dated [DATE], indicated Resident was able to understand others and able to be understood. The MDS assessment indicated Resident #25 had a BIMS score of 12, indicating his cognition was moderately impaired. The MDS assessment indicated Resident #25 required partial/moderate assistance with chair/bed to chair transfer, toilet transfer and lying to sitting on the side of the bed. Record review of Resident #25's comprehensive care plan dated 02/29/24 did not indicate Resident #25 was receiving Xarelto (anticoagulant medication-blood thinner). Record review of Resident #25's order summary report dated 03/26/24, indicated Resident #25 had an order for Xarelto 20mg give one tablet by mouth daily with a start date of 03/11/24. The order summary report did not indicate Resident #25 was being monitored for any side effects regarding his anticoagulant medication. Record review of Resident #25's medication administration record for the month of March 2024, indicated Resident #25 had received Xarelto 20mg one tablet daily since 3/12/24. The medication administration record did not indicate Resident #25 was being monitored for any side effects regarding his anticoagulant medication. During an interview on 03/25/24 at 12:39 PM, Resident #25 said he was taking Xarelto and had just been restarted last week. (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 03/27/24 at 11:28 AM, LVN H said if a resident was receiving an anticoagulant medication they monitored for signs and symptoms of bleeding. LVN H said the anticoagulant side effect monitoring task was on the medication administration record where they clicked off on it indicating it had been completed. LVN H reviewed Resident #25's orders and said Resident #25 was not being monitored for any side effects or adverse reactions regarding his anticoagulant medication. LVN H said Resident #25 should have been monitored for any abnormal bleeding. LVN H said the nurse who obtained the order was responsible for ensuring resident was being monitored for side effects/adverse reactions regarding the anticoagulant medication. LVN H said the MDS Coordinator and the ADON verified the orders were transcribed correctly. During an interview on 03/27/24 at 11:47 AM, the ADON said residents receiving anticoagulant medications were monitored for any side effects or adverse reactions. The ADON said she reviewed new orders at least weekly when she ran a report. The ADON said Resident #25 was not being monitored for any side effects or adverse reactions for the use of his anticoagulant medication. The ADON said resident was at risk for bleeding. When asked who was responsible for ensuring Resident #25 was being monitored for any side effects or adverse reactions, she said she had to review the policy. During an interview on 03/27/24 at 11:57 AM, the DON said a resident receiving an anticoagulant medication should be monitored for signs and symptoms of abnormal bleeding or bruising to ensure they do no bleed out. The DON said she was responsible for ensuring the monitoring was in place for residents on anticoagulant therapy. The DON said the nurse who obtained the order for anticoagulant therapy should have placed the side effect and adverse reactions monitoring for Resident #25. The DON said they reviewed any new orders during their morning clinical meeting. During an interview on 03/27/24 at 1:42 PM, the Administrator said he was unsure of the process, risks, or who was responsible for ensuring the monitoring was in place for side effects or adverse reactions regarding anticoagulant medications. 2. Record review of the face sheet, dated 03/27/2024, revealed Resident #42 was a [AGE] year-old male who initially admitted to the facility on [DATE] with diagnosis of edema (swelling) and retention of urine (not emptying the bladder fully). Record review of the quarterly MDS assessment, dated 01/02/2024, revealed Resident #42 had clear speech and was understood by others. The MDS revealed Resident #42 was able to understand others. The MDS revealed Resident #42 had a BIMS score of 11, which indicated his cognition was moderately impaired. The MDS revealed Resident #42 was taking a diuretic medication and had an indication for use. Record review of the comprehensive care plan, initiated on 04/28/2022, revealed Resident #42 was on diuretic therapy related to edema. The care plan interventions were administer medication as ordered, may cause dizziness, postural hypotension, fatigue, and an increased risk for falls, observe for possible side effects every shift, and monitor for increased risk for falls with position changes. Record review of the order summary report, dated 03/27/2024, revealed Resident #42 had an order, which started on 12/30/2023, for furosemide (diuretic) 40 mg - give 1 tablet by mouth one time a day for edema. The order summary report did not address monitoring for edema. Record review of the MAR, dated March 2024, revealed Resident #42 received furosemide (diuretic) 40 mg one time a day for edema. The MAR did not address monitoring for edema. (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 03/27/2024 beginning at 2:02 PM, LVN H stated edema should have been monitored with residents who received a diuretic medication. LVN H stated there should have been something to sign off or click off on the MAR for edema monitoring. LVN H stated she was unsure if Resident #42 received a diuretic. LVN H stated edema should have been checked daily to monitor the effectiveness of the diuretic medication and to monitor the improvement of the edema. During an interview on 03/27/2024 beginning at 3:20 PM, the DON stated long-term edema monitoring for diuretic use was evaluated by exception. The DON stated edema was not monitored, documented, or evaluated, for residents who received long-term diuretics, unless there was a new concern. The DON stated if a new edema concern was presented, then a change of condition assessment was completed, and it would have been documented in the progress notes and monitored for 3 days. During an interview on 03/27/2024 beginning at 3:47 PM, the Administrator stated he expected edema to have been monitored for Resident #42. The Administrator stated nursing staff were responsible for ensuring edema monitoring was completed. The Administrator stated it was important to ensure edema was monitored routinely to evaluate the effectiveness of medications. During an interview on 03/27/24 at 1:17 PM the DON said they did not have a policy on unnecessary medications. 47006

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	676190	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stillhouse Rehabilitation and Healthcare Center	2900 Stillhouse Road Paris, TX 75462

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review, the facility failed to ensure that it was free of medication error rate of 5 percent or greater. The facility had a medication error rate of 17.95 % based on 7 errors out of 39 opportunities, which involved 3 of 6 residents (Resident #'s 172, 16, and 17) reviewed for medication administration. The facility failed to ensure LVN A administered Resident #172's Levetiracetam (medication used to treat seizures) timely. The facility failed to ensure LVN A administered Resident #66's midodrine (medication to treat blood pressure), Eliquis (medication to coagulation of blood), and levothyroxine (medication for thyroid disease) timely. The facility failed to ensure MA B administered Resident #17's tramadol (medication for pain), levothyroxine (medication for thyroid disease), and Protonix (medication for gastric upset) timely. These failures could place residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. Findings included: 1) Record review of a face sheet dated 3/27/2024 indicated Resident #172 was an [AGE] year-old female who admitted on [DATE] with the diagnosis of high blood pressure, malnutrition, and arthritis. Record review of an Admission MDS assessment dated [DATE] indicated Resident #172 was understood and understood others. The MDS indicated Resident #172's BIMS score was 8 indicating she had moderately impaired cognition. Section I (Active Diagnosis) failed to indicate Resident #172 had seizures as an active diagnosis. Record review of an undated comprehensive care plan indicated Resident #172 was receiving an anticonvulsant for treatment of a seizure disorder. The goal of the care plan was Resident #172 would not be hospitalized and have maintained therapeutic ranges of the seizure medication. The interventions were to administer the medications as ordered, monitor laboratory levels as indicated, and monitor for changes in the ability to perform ADLs. During an observation on 3/26/2024 at 8:19 a.m., LVN A prepared Resident #172's Levetiracetam 750 milligrams for administration at 8:25 a.m. Record review of the consolidated physician's orders dated 3/27/2024 indicated Resident #172 was ordered levetiracetam 750 milligrams two times daily for seizures on 3/12/2024. Record review of the Medication Administration Audit Report dated 3/27/2024 indicated Resident #172 was to receive her Levetiracetam at 7:00 a.m. but received her ordered medication Levetiracetam at 8:25 a.m. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Record review of a face sheet dated 3/27/2024 indicated Resident #66 was an [AGE] year-old female who admitted on [DATE] with the diagnosis of low blood pressure. Record review of the Admission MDS dated [DATE] indicated Resident #66 was understood and understood others. The MDS indicated Resident #66's BIMS score was 4 indicating she had severe cognitive impairment. The MDS in Section I Active Diagnoses indicated Resident #66 had hypotension, deep vein thrombosis (blood clot), and thyroid disorder. Record review of an undated comprehensive care plan indicated Resident #66 had an altered cardiovascular status related to hypotension (low blood pressure). The goal of the care plan was Resident #66 would not have complications of her cardiac problems. The care plan interventions included to assess shortness of breath, monitor and report to the physician any symptoms of chest pain, heartburn, shortness of breath, and edema. The comprehensive care plan failed to indicate the administration of medications to treat hypotension. The care plan indicated Resident #66 received anticoagulant therapy for the prevention of blood clots, with the goal to be free from discomfort. The care plan interventions included to monitor and report symptom onset of shortness of breath, chest pain, and anxiety. The care plan indicated Resident #66 had hypothyroidism (low thyroid levels) with the goal of the care plan was she would be compliant with the thyroid replacement therapy. The care plan interventions included to administer the thyroid replacement therapy and monitor for low thyroid symptoms. Record review of the consolidated physician's orders dated 3/27/2024 indicated Resident #66 was ordered Midodrine 10 milligrams every 8 hours for low blood pressure and levothyroxine (treatment of thyroid disease) 125 micrograms ordered on 3/02/2024. The physician's orders indicated Resident #66 was ordered Eliquis (anticoagulant) 5 milligrams two times daily ordered on 2/29/2024. During an observation on 3/26/2024 at 8:35 a.m., LVN A prepared Resident #66's Midodrine 10 milligrams, and levothyroxine 125 micrograms for administration at 8:40 a.m. Record review of a Medication Administration Audit Report dated 3/27/2024 indicated Resident #66's Midodrine was scheduled at 6:00 a.m., but Resident #66 received the Midodrine at 8:40 a.m. Resident #66's blood pressure was 110/56 with her pulse 69 beats per minute. The report indicated Resident #66 received her ordered famotidine and levothyroxine at 8:40 a.m., instead of 6:30 a.m. During an interview on 3/26/2024 at 8:19 a.m., LVN A said she was late passing her medications because she passed medications on two halls and was unable to meet the standard 1 hour before and 1 hour afterwards. LVN A said this was why Resident #'s 127 and 66's medications were highlighted in red in the computerized system. LVN A said Resident #127 could have had a seizure and Resident #66 could have had low blood pressure issues. 3) Record review of a face sheet dated 3/27/2024 indicated Resident #17 was a [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnoses of primary arthritis. Record review of an annual MDS dated [DATE] indicated Resident #17 was understood and understood others. The MDS indicated Resident #17 had no cognitive deficits. The MDS indicated Resident #17 had no pain documented during the time of the assessment. Resident #17 in Section I (active diagnoses) indicated the diagnosis of arthritis, thyroid disease, and gastroesophageal disease. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the undated comprehensive care plan indicated Resident #17 had osteoarthritis with a goal of maintaining the current level of mobility. The interventions for Resident #17 included to administer the analgesics (pain relievers) as ordered by the physician. The care plan indicated Resident #17 had hypothyroidism (thyroid disease) with the goal of free from symptoms of low thyroid levels. The interventions indicated Resident #17 would receive the ordered thyroid replacement therapy. The care plan indicated Resident #17 had gastroesophageal disease (hyperacidity) with the goal of no re-hospitalization s and the interventions included to administer the medication as ordered. Record review of the consolidated physician's orders dated 3/27/2024 indicated Resident #17 was ordered tramadol 50 milligrams every 8 hours for pain starting on 3/21/2023, levothyroxine 125 microgram ordered on 7/22/2022, and Protonix 40 milligrams ordered on 2/02/2022. Record review of a Medication Administration Audit Report dated 3/27/2024 indicated Resident #17's tramadol was ordered to be administered at 6:00 a.m., but administered at 7:49 a.m. The report also indicated Resident #17 received her levothyroxine (treatment of thyroid disease) and Protonix (treatment of gastroesophageal reflux disease) at 7:50 a.m. During an observation and interview on 3/27/2024 at 7:45 a.m., Resident #17 received her ordered medications including the tramadol 50 milligrams, levothyroxine 125 micrograms, and Protonix 40 milligrams. Resident #17 told MA B her right shoulder was hurting. MA B responded she would tell the nurse. MA B said Resident #17 received her pain medication (tramadol) late because she had two halls to administer. MA B said she was often late administering medications because of the number of residents she was assigned and the time frame for medication administration which was one hour before and one hour after the ordered time. MA B said pain could increase when medications were not administered timely. During an interview on 3/27/2024 at 11:20 a.m., the Administrator said he expected the medication administrations to be timely according to the policy. The Administrator said the DON, ADON, and nurses were responsible for ensuring the medications were administered timely. The Administrator said when medications were not administered timely the resident's disease process being treated could have an exacerbation. During an interview on 3/27/2024 at 11:29 a.m., the DON said she expected the medication administrations to be timely which was 1 hour before and 1 hour after the ordered administration time. The DON said when nurses administered medications in a MA role they were terrible about staying within the limit. The DON said the computerized system does provide a late administration report and she indicated she was responsible for monitoring. The DON said late administration of medications could cause an ill effect on the resident's treatment regimen. Record review of a Medication Errors and Adverse Reactions policy dated 8/2007 and last revised on 12/2023 indicated it was the policy of this facility Medication Error means Manufacturer's specifications regarding the preparations and administration of the medication or biological; or Accepted professional standards and principles which apply to professionals providing services.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33249 Based on observation, interview, and record review, the facility failed to ensure that residents were free of significant medication errors for 3 of 10 residents (Resident's #172, #66, and #17) reviewed for pharmacy services. 1.The facility failed to ensure LVN A administered Resident #172's Keppra (medication used to treat seizures) timely. 2.The facility failed to ensure LVN A administered Resident #66's midodrine (medication to treat blood pressure), and Eliquis (medication to coagulation of blood timely. 3. The facility failed to ensure MA B administered Resident #17's tramadol (medication for pain), timely. This failure could place the resident at risk of medical complications and not receiving the therapeutic effects of their medications. Findings Included: 1) Record review of a face sheet dated 3/27/2024 indicated Resident #172 was an [AGE] year-old female who admitted on [DATE] with the diagnosis of high blood pressure, malnutrition, and arthritis. Record review of an Admission MDS assessment dated [DATE] indicated Resident #172 was understood and understood others. The MDS indicated Resident #172's BIMS score was 8 indicating she had moderately impaired cognition. Section I (Active Diagnosis) failed to indicate Resident #172 had seizures as an active diagnosis. Record review of an undated comprehensive care plan indicated Resident #172 was receiving an anticonvulsant for treatment of a seizure disorder. The goal of the care plan was Resident #172 would not be hospitalized and have maintained therapeutic ranges of the seizure medication. The interventions were to administer the medications as ordered, monitor laboratory levels as indicated, and monitor for changes in the ability to perform ADLs. During an observation on 3/26/2024 at 8:19 a.m., LVN A prepared Resident #172's Levetiracetam 750 milligrams for administration at 8:25 a.m. Record review of the consolidated physician's orders dated 3/27/2024 indicated Resident #172 was ordered levetiracetam 750 milligrams two times daily for seizures on 3/12/2024. Record review of the Medication Administration Audit Report dated 3/27/2024 indicated Resident #172 was to receive her Levetiracetam at 7:00 a.m. but received her ordered medication Levetiracetam at 8:25 a.m. 2) Record review of a face sheet dated 3/27/2024 indicated Resident #66 was an [AGE] year-old female who admitted on [DATE] with the diagnosis of low blood pressure. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Admission MDS dated [DATE] indicated Resident #66 was understood and understood others. The MDS indicated Resident #66's BIMS score was 4 indicating she had severe cognitive impairment. The MDS in Section I Active Diagnoses indicated Resident #66 had hypotension, deep vein thrombosis (blood clot), and thyroid disorder. Record review of an undated comprehensive care plan indicated Resident #66 had an altered cardiovascular status related to hypotension (low blood pressure). The goal of the care plan was Resident #66 would not have complications of her cardiac problems. The care plan interventions included to assess shortness of breath, monitor and report to the physician any symptoms of chest pain, heartburn, shortness of breath, and edema. The comprehensive care plan failed to indicate the administration of medications to treat hypotension. The care plan indicated Resident #66 received anticoagulant therapy for the prevention of blood clots, with the goal to be free from discomfort. The care plan interventions included to monitor and report symptom onset of shortness of breath, chest pain, and anxiety. The care plan indicated Resident #66 had hypothyroidism (low thyroid levels) with the goal of the care plan was she would be compliant with the thyroid replacement therapy. The care plan interventions included to administer the thyroid replacement therapy and monitor for low thyroid symptoms. Record review of the consolidated physician's orders dated 3/27/2024 indicated Resident #66 was ordered Midodrine 10 milligrams every 8 hours for low blood pressure. The physician's orders indicated Resident #66 was ordered Eliquis (anticoagulant) 5 milligrams two times daily ordered on 2/29/2024. .During an observation on 3/26/2024 at 8:35 a.m., LVN A prepared Resident #66's Midodrine 10 milligrams, and Eliquis 2.5 milligrams for administration at 8:40 a.m. Record review of a Medication Administration Audit Report dated 3/27/2024 indicated Resident #66's Midodrine was scheduled at 6:00 a.m., but Resident #66 received the Midodrine at 8:40 a.m. Resident #66's blood pressure was 110/56 with her pulse 69 beats per minute. The report indicated Resident #66 received her ordered midodrine and Eliquis at 8:40 a.m., instead of 6:30 a.m. During an interview on 3/26/2024 at 8:19 a.m., LVN A said she was late passing her medications because she passed medications on two halls and was unable to meet the standard 1 hour before and 1 hour afterwards. LVN A said this was why Resident #'s 127 and 66's medications were highlighted in red in the computerized system. LVN A said Resident #127 could have had a seizure and Resident #66 could have had low blood pressure issues. 3) Record review of a face sheet dated 3/27/2024 indicated Resident #17 was a [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with the diagnoses of primary arthritis. Record review of an annual MDS dated [DATE] indicated Resident #17 was understood and understood others. The MDS indicated Resident #17 had no cognitive deficits. The MDS indicated Resident #17 had no pain documented during the time of the assessment. Resident #17 in Section I (active diagnoses) indicated the diagnosis of arthritis, thyroid disease, and gastroesophageal disease. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the undated comprehensive care plan indicated Resident #17 had osteoarthritis with a goal of maintaining the current level of mobility. The interventions for Resident #17 included to administer the analgesics (pain relievers) as ordered by the physician. The care plan indicated Resident #17 had hypothyroidism (thyroid disease) with the goal of free from symptoms of low thyroid levels. The interventions indicated Resident #17 would receive the ordered thyroid replacement therapy. The care plan indicated Resident #17 had gastroesophageal disease (hyperacidity) with the goal of no re-hospitalization s and the interventions included to administer the medication as ordered. Record review of the consolidated physician's orders dated 3/27/2024 indicated Resident #17 was ordered tramadol 50 milligrams every 8 hours for pain starting on 3/21/2023, levothyroxine 125 microgram ordered on 7/22/2022. Record review of a Medication Administration Audit Report dated 3/27/2024 indicated Resident #17's tramadol was ordered to be administered at 6:00 a.m., but administered at 7:49 a.m. During an observation and interview on 3/27/2024 at 7:45 a.m., Resident #17 received her ordered medications including the tramadol 50 milligrams. Resident #17 told MA B her right shoulder was hurting. MA B responded she would tell the nurse. MA B said Resident #17 received her pain medication (tramadol) late because she had two halls to administer. MA B said she was often late administering medications because of the number of residents she was assigned and the time frame for medication administration which was one hour before and one hour after the ordered time. MA B said pain could increase when medications were not administered timely. During an interview on 3/27/2024 at 11:20 a.m., the Administrator said he expected the medication administrations to be timely according to the policy. The Administrator said the DON, ADON, and nurses were responsible for ensuring the medications were administered timely. The Administrator said when medications were not administered timely the resident's disease process being treated could have an exacerbation. During an interview on 3/27/2024 at 11:29 a.m., the DON said she expected the medication administrations to be timely which was 1 hour before and 1 hour after the ordered administration time. The DON said when nurses administered medications in a MA role they were terrible about staying within the limit. The DON said the computerized system does provide a late administration report and she indicated she was responsible for monitoring. The DON said late administration of medications could cause an ill effect on the resident's treatment regimen. Record review of a Medication Errors and Adverse Reactions policy dated 8/2007 and last revised on 12/2023 indicated it was the policy of this facility Manufacturer's specifications regarding the preparations and administration of the medication or biological; or Accepted professional standards and principles which apply to professionals providing services.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006 Based on observation, interview and record review, the facility failed to ensure food was prepared in a form designed to meet individual needs for 1 of 6 residents (Resident #16) reviewed for nutrition. The facility failed to ensure Resident #16 received her health shake with her lunch meal as ordered by the physician. This failure could place residents at risk for poor intake, weight loss, and unmet nutritional needs. The findings included: Record review of the face sheet, dated 03/27/2024, revealed Resident #16 was a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, late onset (type of gradually progressive brain disorder that causes problems with memory, thinking, and behavior), need for assistance with personal care, and unspecified protein-calorie malnutrition (occurs when an individual does not consume sufficient protein and calories, leading to adverse effects on their health). Record review of the quarterly MDS assessment, dated 02/10/2024, revealed Resident #16 had clear speech and was usually understood by others. The MDS revealed Resident #16 was rarely or never able to understand others. The MDS revealed Resident #16 had a BIMS score of 4, which indicated severely impaired cognition. The MDS revealed Resident #16 had no behaviors or refusal of care. The MDS revealed Resident #16 had a weight loss of 5% or more in the last month or 10% in the last 6 months. The MDS revealed Resident #16 was on a mechanically altered diet. Record review of the comprehensive care plan, initiated on 01/31/2024, revealed Resident #16 had an unplanned weight loss. The interventions included: offer substitutes as requested and give supplements as ordered. The care plan further revealed Resident #16 had a potential nutritional problem related to malnutrition risk. The interventions included: diet as ordered by the physician. Record review of the order summary report, dated 03/27/2024, revealed Resident #16 had an order, which started on 10/28/2021, for regular diet mechanical soft texture, thin liquids consistency, FMP, health shake with meals, food in bowls-low vision. During an observation on 03/25/2024 at 12:18 PM, Resident #16 was sitting at the end of the table and was approximately 12 inches away from the tabletop. Resident #16 did not have a health shake. During an observation on 03/25/2024 at 12:36 PM, a staff member asked if Resident #16 was done eating. The staff member did not offer a substitute, health shake, or supplement and did not attempt to assist Resident #16 with eating. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/2024 beginning at 1:54 PM, CNA G stated when a resident consumed less than 50% of a meal, she reported it to the nurse and then offered them a substitute or a supplement. CNA G stated when Resident #16 ate less than 50% of her meal the staff should have assisted her and offered her a health shake. CNA G stated Resident #16 used to have a good appetite but the last few weeks she had not been eating well. CNA G was not aware Resident #16 had a weight loss. CNA G stated it was important to ensure Resident #16 received her health shake to prevent more weight loss. During an interview on 03/27/2024 beginning at 2:02 PM, LVN H stated when a resident ate less than 50% of their meal the CNAs were to notify the nurse and offer a health shake or supplement. LVN H stated Resident #16 was not a big eater and was usually assisted with her meals because she had trouble seeing. LVN H stated she encouraged a health shake because she normally only ate a few bites of each bowl. LVN H stated she always drank her health shake. LVN H stated Resident #16 has had some weight loss. LVN H stated it was important to ensure Resident #16 received assistance during meals and her ordered health shakes to prevent further weight loss and decrease the risk for decline in her skin integrity. During an interview on 03/27/2024 beginning at 2:48 PM, the DON stated there was no policy for therapeutic diets. During an interview on 03/27/2024 beginning at 3:20 PM, the DON stated when a resident consumed less than 50% of their meal the CNA would have notified the nurse and offered a supplement. The DON stated Resident #16 had weight loss and her physician believed it could have been related to her age. The DON stated she expected the nursing staff to ensure assistance was provided and health shakes were provided during the meals. The DON stated the nurse in the dining room was responsible for monitoring to ensure assistance was provided and health shakes were offered. The DON stated it was important to ensure Resident #16 received assistance with eating and her health shakes to prevent further weight loss. During an interview on 03/27/2024 beginning at 3:47 PM, the Administrator stated he expected staff to ensure Resident #16 required assistance with eating and ordered health shakes. The Administrator stated the nurse in the dining room was responsible for monitoring to ensure assistance was provided and health shakes were offered. The Administrator stated it was important to ensure Resident #16 had a good meal intake to ensure her weight was maintained.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 33249 Based on interview and record review, the facility failed to electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS fiscal year 2024 for the first quarter (October 1, 2023, to December 31, 2023) reviewed for administration. The facility failed to transmit RN hours for: 11/18/2023, 11/19/2023, 12/02/2023, 12/03/2023, 12/16/2023, 12/17/2023, and 12/30/2023. This failure could place residents at risk for personal needs not being identified and met. Findings included: Record review of the CMS PBJ report for the first quarter of 2024 (October 1, 2023, through December 31, 2023) indicated there were no RN hours for the following dates: 11/18/23 (SA), 11/19/23 (SU), 12/02/23(SA), 12/03/23 (SU), 12/16/23 (SA), 12/17/23 (SU), and 12/30/23 (SA). Record review of the DON's punch detail report for November and December 2023 indicated RN hours on 11/18/2023, 11/19/2023, 12/02/2023, 12/03/2023, 12/16/2023, 12/17/2023, and 12/30/2023 were worked by the DON. During an interview on 03/27/2024 at 11:00 a.m., the HR manager indicated the payroll computerized system automatically transmits the hours to CMS. The HR manager said the DON does not clock in; therefore her hours must been inputted manually. The HR Manager stated that process was not captured prior to the submission to CMS. During an interview on 3/27/2024 at 11:20 a.m., the Administrator said the DON works numerous hours and forgot to log those hours since she does not actually punch in at a time clock. The Administrator said the DON was present those days indicated by CMS but not submitted timely. The Administrator said there was not a policy for payroll-based journal.