STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676204	A. Building B. Wing	02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Cedar Bayou	2000 W Baker Rd Baytown, TX 77521

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47572 Based on interview, observation, and record review, the facility failed to ensure one of twelve residents (Resident #3) reviewed for abuse, neglect, and/or exploitation remained free of abuse. -Resident #3 alleged that LVN B kicked her in her side/back after she had fallen in her restroom in November 2023 This failure could place residents at risk for abuse, pain, fear, and psychosocial impairment. The noncompliance was identified as PNC. The IJ began on 11/20/2023 and ended on 11/21/2023. The facility had corrected the noncompliance before the survey began. Findings include: Record review of Resident #3's face sheet dated 2/6/2024 revealed a [AGE] year-old woman admitted on [DATE]. The face sheet documented her diagnoses included dementia (group of symptoms that affects memory, thinking and interferes with daily life), major depressive disorder (MDD, mental health disorder having episodes of psychological depression), a history of falling, cerebral infarction (stroke), unspecified psychosis (symptoms of more than one disorder that don't fit the full criteria for any and can't be explained by another medical condition), schizoaffective disorder(mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder), unsteadiness on her feet, contractures (abnormal shortening of muscle tissue), abnormal posture, lack of coordination, hemiplegia (paralysis of one side of the body) and hemiparesis(one-sided muscle weakness), and chronic embolism and thrombosis (blood clots) of the deep veins on her right lower extremity. Record review of Resident #3's quarterly MDS dated [DATE] with an ARD of 1/1/2024 revealed a BIMS score of 9 indicating significant cognitive impairment. The MDS documented she had no potential indicators of psychosis, behaviors affecting others, rejection of care, or wandering behaviors. Per the MDS, Resident #3 had impairment to one side of her upper and lower extremities and used a wheelchair for mobility. The MDS revealed she either did not, or it was unknown if she had any unplanned or unexpected significant weight loss. The MDS documented she had received OT but it ended on 1/1/2024, and she had received PT from 9/6/2023 to 9/28/2023. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #3's care plan dated 1/17/2024 revealed a focus on her history of falls with interventions including encouragement to ask for assistance, ensuring the call light was within reach, and therapy as per physician's orders. The care plan documented a focus on her actual falls with interventions including an assistance bar in the restroom, bed in a low position, fall mats, ensuring her wheelchair was accessible from her bed, pharmacy consultation, and posting signs to remind her to ask for assistance. The care plan included a focus on her ADL deficit with interventions including assistance with bathing/showering, bed mobility, dressing, toileting, and transfers. The care plan revealed a focus on her physical mobility limitations with interventions including use of a wheelchair, monitoring to ensure the contractures were not worsening, and PT and OT as ordered. Record review of Resident #3's incident note dated 11/19/2023 revealed she had fallen while using the restroom unassisted. The note documented she was assessed and found with no injury. Record review of Resident #3's progress note dated 11/20/2023 revealed she was found lying on the floor in her bathroom. The note documented she had gone to the restroom unattended and fallen. Record review of Resident #3's nurse's note dated 11/22/023 revealed she was found on the floor next to her wheelchair in the bathroom. The note documented the CNA had assisted her to the restroom and stepped out for privacy. Per the note, when the CNA returned to the restroom Resident #3 was on the floor. The note revealed Resident #3 did not request assistance or press the call light prior to falling. The note documented no injuries were observed. Interview on 2/7/2024 at 1:14 PM with Resident #3, she said she had fallen many times recently, but she did not know why. Resident #3 said she recalled when a nurse had become upset with her after Resident #3 had fallen in November of 2023. Resident #3 said she did not know why the nurse became upset with her. Resident #3 said the nurse kicked her. Resident #3 said the nurse kicked her in the side or back. Resident #3 said it had hurt when she was kicked. Resident #3 said she did not know why the nurse kicked her. Resident #3 said she had not seen the nurse since that time. Resident #3 said she had never been treated in a similar manner by other staff at the facility. Interview on 2/7/2024 at 4:01 PM with Resident #3, she said when LVN B kicked her she felt like she was crazy. Resident #3 said the incident made her think something was wrong with her, and she had caused LVN B to kick her. Resident #3 said she was afraid of being thrown out of the facility. Resident #3 said she was also afraid she may be hurt again by other staff. Resident #3 said she was afraid of LVN B. Interview on 2/6/2024 at 8:38 AM with Resident #56 he said he had never had any concerns with abuse, neglect, and/or exploitation at the facility. Resident #56 said the CNA's were good, but the nurses would not answer the call lights. Mr. [NAME] said he had never seen or heard other residents being abused, neglected, and/or exploited. Interview on 2/8/2024 at 11:36 AM with Resident #22, he said he had no concerns with the care he received. Resident #22 said the staff took care of all his needs. Resident #22 said he had never told anyone he had any concerns with the care he received. Resident #22 denied ever being the victim of abuse, neglect, and/or exploitation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 2/8/2024 at 12:55 with Resident #71, she said she did not have any concerns with the staff being rude any longer. Resident #71 said she had informed the facility of her concerns and were immediately addressed. Resident #71 said she had never seen any staff being abusive to her or other residents. Resident #71 said she had no concerns with the care provided. Interview on 2/8/2024 at 1:01 PM with Resident #24, she said she did not recall ever telling anyone she had any concerns with the care she received. Resident #24 said she had no concerns with the care she received. Resident #24 denied ever being the victim of abuse, neglect, and or exploitation at the facility. Interview on 2/7/2024 at 1:51 PM with the Admin, she said she had interviewed Resident #3 on 11/20/2023 after former CNA A reported LVN B had kicked Resident #3. The Admin said she also sat in during the interview with LVN B and the DON after the incident. The Admin said LVN B had reported she put her foot on Resident #3's legs to stop her from getting up after she had fallen in her restroom. The Admin said LVN B said she had used her foot to stop Resident #3 from getting up so Resident #3 did not hurt herself. The Admin said she informed LVN B that she should not restrain a resident, and especially with her foot. The Admin said when she interviewed Resident #3, she said she had fallen in the restroom and LVN B was angry at her. The Admin said Resident #3 reported LVN came into the restroom and kicked her. The Admin said Resident #3 reported she was kicked in the upper body. The Admin said she informed LVN B that her actions constituted abuse. The Admin said LVN B's employment was terminated at that time. The Admin said Resident #3 was assessed by the DON and there were no injuries observed. The Admin said the facility provided an in-service training to all staff related to abuse, neglect, and/or exploitation of a resident. The Admin said typically after any allegation of abuse, neglect, and/or exploitation of a resident the facility surveyed all other residents related to the parties to ensure they were not any other victims. The Admin said she believed that was done after this incident. Interview on 2/7/2024 at 1:51 PM with the DON, she said she was informed on 11/20/2023 by CNA C that she had observed LVN B putting her foot on Resident #3's legs. The DON said she asked Resident #3 what had occurred. The DON said Resident #3 responded that LVN B had kicked her. The DON said Resident #3 said Resident #3 said LVN B kicked her because LVN B was upset that Resident #3 had fallen. The DON said she and the Admin interviewed LVN B. The DON said LVN B said she had put her foot on Resident #3 to stop her from getting up from a fall. The DON said LVN B was sent home at that time. The DON said she and the Admin investigated the allegations and CNA A reported she had seen LVN B kick Resident #3. The DON said LVN B was terminated at that time. The DON said after the incident the staff were provided with an in-service training related to abuse, neglect, and/or exploitation of the residents. The DON said other residents were interviewed and none reported any concerns. The DON said the staff are trained regularly to report any concerns that a resident may be the victim of abuse, neglect, and/or exploitation to the abuse coordinator. The DON said the abuse coordinator is the Admin. Interview on 2/8/2024 at 8:56 AM with CNA F, she said she had been employed for one year. CNA F said her primary duties included ensuring all residents' needs were met and their ADL's were completed. CNA F said she had been trained by the facility on resident abuse, neglect, and exploitation. CNA F said the different types of abuse included physical, verbal, sexual, mental, and neglect. CNA F said a resident who had been abused may become scared or withdrawn. CNA F said a resident may have physical signs or symptoms such as bruising. CNA F said if she thought a resident was the victim of abuse, neglect, and/or exploitation she would inform the Admin immediately. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 2/8/2024 with at 8:59 AM with LVN G, she said she had been employed for two weeks. LVN G said she had been trained by the facility on resident abuse, neglect, and exploitation. LVN G said the different types of abuse included physical, sexual, mental, verbal, and financial. LVN G said she would inform the abuse coordinator immediately if she was concerned a resident was the victim of abuse, neglect, and/or exploitation. LVN G said the Admin was the abuse coordinator. Interview on 2/8/2024 at 9:08 AM with MA H, she said she had been employed for five years. MA H said her primary duties included medication administration and resident care. MA H said she had been trained by the facility on resident abuse, neglect, and/or exploitation. MA H said abuse included verbal, physical, and sexual abuses and neglect. MA H said if she felt a resident was the victim of abuse, neglect, and/or exploitation she would inform the Admin immediately. Interview on 2/8/2024 at 9:46 AM with CNA D, she said she had been employed for three years. CNA D said her primary duties included providing resident care and assisting the residents with ADL's. CNA D said she had received resident abuse, neglect, and exploitation training from the facility. CNA D said the had been informed on different types of abuse including verbal, physical, and sexual, and what neglect entailed. CNA D said if she ever suspected a resident was the victim of abuse, neglect, and/or exploitation she would report that to the abuse coordinator immediately. CNA D said the abuse coordinator was the Admin. Interview on 2/8/2024 at 9:52 AM with CNA E, she said she had been employed since August of 2023. CNA E said she her primary duties included direct resident care and ensuring residents ADL's were completed. CNA E said she had been trained by the facility on resident abuse, neglect, and exploitation. CNA E said physical, verbal, sexual, and mental were types of abuse. CNA E said a resident may act scared, aggressive, or have other behavior changes if they were the victim of abuse, neglect, and/or exploitation. CNA E said a resident may have bruises or other physical signs of abuse as well. CNA E said she would immediately report any concerns a resident was the victim of abuse, neglect, and/or exploitation to her abuse coordinator, the Admin. Telephone interview on 2/8/2024 at 1:30 PM with LVN B, she said she had been in the room next door to Resident #3 and heard a loud noise. LVN B said she went to Resident #3's room and found her on the floor in her bathroom. LVN B said Resident #3 was lying with her head facing the door. LVN B said she had placed her foot under Resident #3's head to ensure it did not hit the floor. LVN B said she was informed that someone had said she had tried to kick Resident #3. LVN B denied kicking Resident #3 or any other residents at any time. LVN B said she did not know why anyone would say she had kicked a resident. LVN B said Resident #3 continually attempted to go to the restroom unassisted and fell . LVN B said she heard Resident #3 fall, and she put her foot under Resident #3's head to stop her head from falling to the ground. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 2/9/2024 at 11:28 AM with LVN S, she said she had been employed for almost two years. LVN S said her primary duties included obtaining resident blood glucose levels, obtaining vital signs, tracheostomy care, calling physicians and families, and documentation. LVN S said she had been recently trained on resident abuse, neglect, and exploitation. LVN S said abuse included physical, verbal, and sexual abuses, and resident exploitation. LVN S said a resident may become fearful, pull away from someone who had abused them, have behavior changes, bruising, and unexplained injuries if he/she had been the victim of abuse. LVN S said if she was concerned a resident was the victim of abuse, neglect, and/or exploitation she would inform the facility's abuse coordinator. LVN S said the facility's abuse coordinator was the Admin. LVN S said she had also received in-service training related to resident rights and restraints. LVN S said a resident should never be restrained without physician orders, and she was to report any incidents of a resident who was restrained without physician orders. Interview on 2/9/2024 at 11:34 AM with PTA N, he said he had recently received training related to resident abuse, neglect, and exploitation. PTA N said he was instructed to ask residents about their care and look for signs and symptoms of resident abuse, neglect, and/or exploitation. PTA N said he was instructed to inform the facility's abuse coordinator if he had any indication a resident was the victim of abuse, neglect, and/or exploitation. PTA N said he had also received in-service training related to resident restraints and rights. PTA N said he was informed that residents should never be restrained without physician's orders. PTA N said if he observed a resident being restrained without orders, he was required to inform the Admin and DON. PTA N said residents rights were protected by law. Interview on 2/9/2024 at 11:39 AM with CNA T, she said she had recently received an in-service training. CNA T said abuse included verbal, physical, and emotional abuse. CNA T said a resident may exhibit bruising or begin acting fearful if he/she was the victim of abuse, neglect, and/or exploitation. CNA T said if she had any concerns a resident was the victim of abuse, neglect, and/or exploitation she was required to inform the Admin. CNA T said she had also received in-service training related to resident restraint and rights. CNA T said residents were not to be restrained without a physician's order and to inform the Admin if she ever observed a resident restrained. CNA T said resident rights were the same as everyone else's and were protected by law. Interview on 2/9/2024 at 1:16 PM with MA Q, she said she had recently received an in-service training related to resident abuse, neglect, and exploitation. MA Q said she had learned that abused could include physical, verbal, mental, or sexual abuses, neglect, and/or misappropriation of resident property or funds. MA Q said if she was ever concerned a resident was the victim of abuse, neglect, and/or exploitation she would immediately inform the Admin. MA Q said a resident may become scared, isolate more often, act out in inappropriate manners, or have bruises or unexplained injuries if she/he was the victim of abuse, neglect, and/or exploitation. MA Q said she also was informed that residents were never to be restrained. MA Q said if a resident was acting out in an inappropriate manner, she was required to redirect him/her verbally or distract her/him. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 2/10/2024 at 10:44 AM with LVN K, she said she had been employed for seven months. LVN K said her primary duties included ensuring the residents' safety and care, assessing vital signs, medication administration, providing tracheostomy care, and documentation of care. LVN K said she had recently received in-service training related to resident restraints, resident abuse, neglect, and exploitation, resident elopement, and resident rights. LVN K said the in-service related to resident abuse, neglect, and exploitation informed her that abuse included physical, mental, sexual, and verbal abuse, neglect, and exploitation of residents' property or funds. LVN K said was also informed how to prevent resident abuse, neglect, and/or exploitation and the signs and symptoms of abuse. LVN K said if she was concerned a resident was the victim of abuse, neglect, and/or exploitation she would immediately report those concerns to the Admin, who was the facility's abuse coordinator. LVN K said she learned during the resident restraint in-service training that residents were never to be restrained. LVN K said a restraint could include anything prohibiting the movement of a resident including placing a bedside table in front of them or putting pillow around them. LVN K said if she was concerned a resident was restrained, she would first remove the restraint, and then she would tell the Admin and DON. LVN K said during the resident rights in-service training she was taught that residents had the same rights as anyone else, including the right to refuse care or treatment. LVN K said a resident's rights were protected by the staff, administration, and the law. Interview on 2/10/2024 at 10:50 AM with the ADON, she said she had recently received in-service training related to resident restraints, resident rights, and resident abuse, neglect, and exploitation. The ADON said she had learned during those in-service trainings the different types of abuse including physical, mental, sexual, neglect, and exploitation. The ADON said she also learned that no resident should ever be restrained. The ADON said she was instructed to inform the Admin if she was ever concerned a resident was the victim of abuse, neglect, and/or exploitation, or was restrained. The ADON said she was instructed that residents should have the same expectation of rights as anyone else. The ADON said residents could refuse care and/or treatments. Record review of the facility's internal investigation revealed that Resident #3 was restrained by a nurse, LVN B, after Resident #3 fell . The investigation documented LVN B was observed by another team member, CNA A, reported she observed LVN B kick and speak rudely to Resident #3. Per the investigation, Resident #3 was observed with no injuries after the incident. The investigation revealed LVN B denied kicking Resident #3, but she admitted to using her foot to hold Resident #3 down because she would not be still. The investigation documented the incident was confirmed to have occurred. Record review of a written statement prepared by the DON, documenting the statement from LVN B, dated 11/20/2023 revealed LVN B entered Resident #3's room and found her lying on the floor trying to get up. The statement documented LVN B held Resident #3 down and told her not to get up because she would hurt herself. Per the statement, Resident #3 continued to attempt to get up and LVN B used her foot to hold Resident #3 down while using her arms to attempt to take Resident #3's blood pressure. The note revealed LVN B attempted to hold Resident #3's hand down because Resident #3 was trying to mover her arm when LVN B was taking her blood pressure. The note documented when the incident was concluded, LVN B and CNA A helped Resident #3 back into her wheelchair. The statement was signed by the DON, the Admin, and LVN B. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a written statement prepared by the DON, documenting the statement of CNA A, dated 11/20/2023 revealed LVN B had asked CNA A to assist her transferring Resident #3 from the floor. The statement documented CNA A observed LVN B kick Resident #3 in the back and shove her hand because LVN B needed to take Resident #3's blood pressure. Per the statement, Resident #3 tried to move her arm again and LVN B shoved Resident #3's arm. The note revealed that CNA A said after she and LVN B moved Resident #3 to her wheelchair, LVN B told Resident #3 that she was going to break her neck and must want to die because she did not listen to LVN B. The statement was signed by the DON and CNA A. Record review of a written statement prepared by the DON, documenting the statement of CNA C, dated 11/20/2023 revealed Resident #3 had put herself on her toilet and fallen. The statement documented CNA C heard LVN B tell Resident #3 to lay there before I put my foot on your head so you don't move. Per the statement, CNA C went to Resident #3's room and found her on the floor and another CNA went to help her off the floor. The statement revealed CNA C did not witness any abuse but heard a verbally abusive statement. The DON said CNA C reported the incident to the ADON. Record review of Safe Survey Interviews dated 11/21/2023 revealed that seven interviews were conducted on the 100-Hall of the facility. Of the seven interviews, one reported the resident had experienced staff being physically abusive, rude, or rough with him at the facility. The resident reported the staff had placed mustard and milk on his tray indicating this was the abuse. All the residents denied seeing staff physically aggressive, rude, or abusive with other residents. All the resident reported they knew who to report concerns of abuse, neglect, and/or exploitation to. Record review of LVN B's personnel file revealed a copy of the facility's 5/7/2018 Abuse policy signed by LVN B. The file included two Acknowledgement of Abuse Policy forms dated 5/13/2019 and 7/22/2019. Two Abuse and Neglect exams dated 1/19/2021 and 4/14 of an unknown year that were completed by LVN B was in her personnel file. Record review of LVN B's employee termination form dated 11/22/2023 revealed she was terminated for misconduct. The form included a note which read Resident fell and kept trying to get up and team member restrained res with her foot to keep res from getting up. Res stated team member kicked her. Record review of the facility's Abuse policy dated 2/1/2017 revealed a policy statement which read The purpose of this policy is to ensure that each resident has the right to be free from any type of Abuse, Neglect, Intimidation, Involuntary Seclusion/Confinement, and or Misappropriation of property. The policy documented residents would not be subjected to abuse by anyone in the facility. Per the policy, if a resident was the alleged victim of abuse, the facility would identify the perpetrator and remove him/her from the facility until the end of the investigation. Record review of the facility's In-service and Education Record form dated 11/21/2023 revealed staff were provided in-service training on 11/21/2023. The form documented the curriculum for the training was the facility's Abuse policy dated 1/1/2023. The in-service was signed by multiple disciplines including CNA's, MA's LVN's RN's, housekeeping, staffing, and PT. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's POR revealed head-to-toe assessments would be completed for any non-verbal residents. The facility provided a total of nine skin assessments completed on 2/7/2024 for the non-verbal residents. The skin assessments were for Resident #'s 11, 13, 14, 28, 33, 35, 37, 62, and 63. Resident #11's skin assessment documented he had discoloration to his sacrum, a bunion on both large toes, yellow discoloration to the right side of his chest with a healing light pink scab. Resident #13's skin assessment revealed her skin was intact, but that she had a colostomy bag and G-Tube. Per Resident #14's skin assessment, he had a healing stage II pressure wound, dry skin, discoloration of the left knee, redness of his left second toe, and a scratch on his right second toe. Resident #28's skin assessment documented a fistula on his left arm and intact skin. Resident #33's skin assessment revealed both of her legs and arms had contractions, both feet had drop, and she had dry skin on the lower extremities. Per resident #35's skin assessment, her skin was intact and she had abdominal scarring from a former g-tube site. Resident #37's skin assessment documented his left arm was contracted, he had a G-Tube, pink scarring to both legs, and a scar on his left outer knee. Resident #62's skin assessment revealed she utilized a G-Tube, had dry scabs on her right legs, discoloration of both legs, pink circular discoloration on the upper back, and a light pink discoloration under the right breast. Per Resident #62's skin assessment, she had been treated for shingles in January 2024. Resident #63's skin assessment documented he received wound care to both feet daily. Resident #63's skin assessment revealed he had scarring to the scrum and buttocks, both hands and legs were had been contracted, and discoloration to both arms near the elbows. Record review of the facility's Focused Care Partner Rounds checklist revealed the facility had completed rounds for each resident on 2/7/2024, 2/8/2024, and 2/9/2024. The checklists included the following areas for review: odor in rooms, clean floors, dishes in the room, a full water pitcher within reach, a made and locked bed, the bed crank was down, a working and clean privacy curtain, clean closets, a neat and clean room and restroom, covering and labeling on the urinal and bed pan, no taped and/or handwritten signage, oxygen tubing labeled and off the floor, (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	clean walls free of holes, appropriate resident positioning, appropriate resident grooming, proper covering and labeling of a urine bag, call light placement, IV Pole cleanliness and placement, proper labeling and storage of toiletries, gloves available, soap and paper towels available, nasal cannulas and tubing dated within a week, bedside table and bedrail cleanliness, no medications in the rooms, air conditioner and/or heater functioning, toilet and sink free of leaks and/or cracks, and proper linen storage. Record review of the facility's daily incident report log dated 2/8/2024 revealed one incident was reviewed. The report documented Resident #3 had an incident on 2/7/2024. Per the report, the incident was number 1228. Record review of the facility's daily incident report log dated 2/9/2024 revealed two incidents were reviewed. Incident number 1229 for Resident #3 and incident number 1230 for Resident #10. Record review of the facility's daily incident report review dated 2/10/2024 revealed three incidents, incident numbers 1231, 1232, and 1233, were reviewed by both the DON and Admin. Record review of Resident #10's nurse's note dated 2/8/2024 revealed she was found sitting on the floor mat on the left side of the bed. The note documented her back was against the bed and her knees were brought up to her chest. Per the note, Resident #10 said she had slid down the bed when she was eating her lunch. The note revealed a head-to-toe assessment was completed and she was found to have redness to her upper back. The note documented Resident #10 was able to move both her upper and lower extremities, she denied hitting her head, and she was transferred back to the bed by two staff. Per the note, neurological assessments were initiated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's incident report #1228 revealed Resident #3 had an unwitnessed fall on 2/7/2023. The report documented a nurse was informed by another resident she was found on the floor in her restroom. Per the report, Resident #3 said she had attempted to stand and wash her hands and fell . The Report revealed Resident #3 was assessed for injuries with none noted and neurological assessments were conducted by a nurse. Record review of the facility's incident report #1229 revealed Resident #3 had an unwitnessed fall on 2/8/2024. The report documented she was found on the floor in the middle of her room. Per the report, Resident #3 reported she had fallen trying to stand and reach a pair of pants. The note revealed she had been assessed for injuries with none noted, she denied any pain, and she was not sent to the hospital. Record review of the facility's incident report #1230 revealed Resident #10 had an unwitnessed fall on 2/8/2024. The report documented she was found sitting on her fall mat on the left side of her bed. Per the report, Resident #10 was found with her back against the bed and her knees pulled up to her chest. The report revealed she reported she had been eating her lunch on her bed, that was placed on the bedside table, and she slid to the floor. The report documented a head-to-toe assessment was completed and she had redness to the upper back. Per the report, Resident #10 reported no pain, denied hitting her head, and was able to move her upper and lower extremities with no discomfort. The note revealed neurological assessments were initiated and she was transferred to her bed with the assistance of two staff. Record review of the facility's incident report #1231 dated 2/9/2024 revealed Resident #175 had reported he had fallen getting out of bed. The report documented Resident #175 had complained he fell on his left side hurting his shoulder and leg. Per the report, resident was assessed for injuries and no visible injuries were observed. The report revealed he was provided with as-needed pain medication. Record review of the facility's incident report #1232 dated 2/9/2024 revealed Resident #66 had a skin tear on her leg and blood on her sheets. The report documented Resident #66 was found in her room, sitting on her bed, with her feet in the seat of her wheelchair. Per the report, Resident #66 had a skin tear of the lower left leg. The report revealed she could not provide any information on what occurred. The note documented Resident #66 had asked how she had been injured. Per the note, Resident #66's skin tear was cleansed and covered with gauze. Record review of the facility's incident report #1233 dated 2/9/2024 revealed Resident #57's family member called the facility and reported Resident #57 was sliding out of bed. The report documented two nurses entered her room and found her on the floor, sitting on the fall mat, with her left side leaning against the bed. Per the report, Resident #57 was unable to provide an explanation of what occurred. The Report revealed she was transferred back to bed, the nurses conducted a head-to-toe assessment, an no injuries or pain was noted. The Admin was notified on 2/10/2024 at 9:57 AM, the Immediate Jeopardy was removed. While the IJ was removed on 2/10/24, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing education to facility staff.

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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** 47829 Based on interview and record review, the facility failed to implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care for 1 of 10 residents (Resident #129) reviewed for care plans, in that: -A baseline care plan was not completed for Resident #129 within 48 hours of admission. This failure could affect all newly admitted residents to the facility by placing them at risk of not receiving the care and services for health promotion and continuity of care. Findings included: Resident #129 Record review of Resident #129's Admission Record revealed he was a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included: metabolic encephalopathy (problem in the brain caused by chemical imbalance in the blood), type 2 diabetes mellitus (the body's impaired used of blood sugar), stroke (impaired blood flow to the brain), chronic gout (a painful condition in which uric acid builds in the blood and causes inflammation in the joints). No MDS to review [new admit]. No baseline or comprehensive care plan to review. Interview on 2/7/24 at 1:02 PM with MDS LVN. She said the purpose of the baseline care plan was to provide guidance on how to care for resident until the comprehensive care plan was completed. She said the baseline care plan ensures the resident receives continuity of care, so they can be as happy and comfortable as they can while transitioning into the facility. She said the admitting nurse should complete the baseline care plan and an RN would sign off on it. She said the baseline care plan should be completed withing 48 hours of admission. She said failure to complete a baseline care plan could mean disruption in the resident's routines and the resident may not get the necessary care. Record review and interview with the DON on 2/7/ 2024 at 1:25 PM of Resident #129's Admission Baseline care plan dated 2/4/2024, revealed that all areas were highlighted yellow, did not have any signatures, dates, and no data to print. The DON said this meant the baseline care plan was not completed. She said failure to complete the baseline care plan could mean the resident may not receive the care they should receive. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/8/24 at 9:50 AM with the Administrator. She said the purpose of the baseline care plan was to get an understanding of resident's goals at admission and provides baseline instruction on how to care for the resident. She said here expectation was for nurses to complete the baseline care plan within 48 hours of admission. She said failure to do so can result in improper care of the resident. Record review of the facility's policy titled Resident Assessment: Baseline Care plan dated 11/01/2019 revealed in part: A baseline care plan is required to be completed within 48 hours of admission. The baseline care plan must include: o Initial goals based on admission orders o Physician Orders o Dietary Orders o Therapy Services o Social Services o PASARR (if applicable) The facility must provide the resident and their representative with a summary of the baseline care plan to include as a minimum: o Resident's initial goals o A summary of medications and dietary instructions o Any services and treatments administered by the facility and personnel acting on behalf of the facility such as therapy or psych services. o Information to properly care for the resident upon admission. o Address specific health and safety concerns The BPOC will be amended with any changes in care needs and those changes will be communicated to the resident and/or the resident's representative and noted on the BPOC and in the clinical record. The BPOC will continue until the comprehensive plan of care is completed. The comprehensive plan needs to reflect on pervious goals. When the BPOC is no longer needed, it will be scanned into PCC . Include discharge plan as voiced by resident or representative.

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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** 47572 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan consistent with the resident rights and that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and failed to describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required for 1 of 12 residents (Resident #57) reviewed for care plans. -The facility failed to document the care plan with the use of Resident #57's scoop mattress usage. This failure could place residents at risk of attaining/maintaining their highest practicable physical, mental, and psychosocial well-being. Findings included: Record review of Resident #57's face sheet dated 2/9/2024 revealed a [AGE] year-old woman admitted on [DATE]. The face sheet documented her diagnoses included encephalopathy (medical term used to describe a disease that affects brain structure or function), cirrhosis of the liver (degenerative disease of the liver resulting in scarring and liver failure), cerebral infarction (stroke), Parkinson's Disease (brain condition that causes problems with movement, mental health, sleep, pain and other health issues), hypertension (high blood pressure), aphasia (comprehension and communication including reading, speaking, and/or writing disorder resulting from damage or injury to the specific area in the brain), dysarthria (difficulty in speech due to weakness of speech muscles), muscle weakness, difficulty walking, lack of coordination, cognitive communication deficit, and a displaced avulsion fracture of the left hip. Record review of Resident #57's admission MDS dated [DATE] with an ARD of 1/1/2024 revealed a BIMS score of 99 indicating she was unable to complete the interview. The BIMS documented she had both long and short-term memory problems, and could not recall the current season, the location of her room, staff names or faces, or that she was in a nursing home bed. Per the MDS, Resident #57 had no potential indicators of psychosis, behaviors affecting others, rejection of care, or wandering behaviors. The MDS documented Resident #57 she required assistance with bathing, dressing, and toileting prior to her admission. Per the MDS, Resident #57 required she had an impairment to one side of her upper and lower extremities, and she required a cane and or crutch to ambulate. The MDS revealed she was dependent on staff for all ADL's. The MDS documented she had not received OT services, but she was scheduled to begin them on 1/1/2024. Per the MDS, the facility had utilized no restraints or alarms for Resident #57's care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #57's care plan dated 1/3/2024 revealed a focus on her actual falls on 1/15/2024 and 1/18/2024 with interventions including a fall mat, monitoring for changes in mental status, and neurological assessments after a fall for seventy-two hours. The care plan documented a focus on her impaired cognitive function with interventions including medication administration, use of yes/no questions, cuing and reorienting, and monitoring for any changes in cognitive function. The care plan included a focus on Resident #57's ADL self-care deficit with interventions including her dependence on staff for all ADL care and an OT/PT evaluation and treatment as ordered. The care plan revealed a focus on her potential for impaired mobility, communication, and cognition with interventions including medication administration, monitoring for side effects of medications, and monitoring for tremors, rigidity, and limited range of motion. The care plan did not include any focus or intervention related to a scoop mattress or any other restraint devices. Record review of Resident #57's care plan dated 1/3/2024, observed on 2/9/2024 at 11:12 AM, revealed a focus on her actual falls with interventions including use of fall mats, monitoring for changes in mental status, neurological assessments after a fall for seventy-two hours following a fall, and the use of a scoop style mattress. Record review of resident #57's nurse's note dated 1/7/2024 revealed she was found sliding from the bed to the ground. The note documented the fall mats were in place and the bed was in its lowest position. Per the note, Resident #57 sustained no injuries. The note documented the staff should ensure her fall mats were in place at all times. Record review of Resident #57's incident note dated 1/18/2024 revealed a CNA had found her on the floor and informed the nurse. The note documented she was found lying face down on the fall mat. Per the note, Resident #57 was transferred back to her bed, no injuries were observed, and her vital signs were within normal limits. The note revealed her bed was in the lowest position and the fall mats were in place. Record review of Resident #57's nurse's note dated 1/22/2024 revealed she had rolled out of her bed onto the fall mat. The note documented she sustained no injuries. Per the note, Resident #57's family member believed she may have had a seizure and fallen from the bed. The note revealed her vital signs were within normal limits. Record review of Resident #57's nurse's note dated 1/30/2024 revealed she had been found on the floor. The note documented she was lying on the floor on the fall mat. Per the note, Resident #57 had no injuries and her vital signs were obtained. Record review of Resident #57's nurse's note dated 2/1/2024 revealed the facility was informed by the resident's family member that she was seen on the floor via video monitoring. The note documented she was found on her right side on the fall mat. Per the note, Resident #57 did not sustain any injuries. Record review of Resident #57's incident note dated 2/6/2024 revealed she was found on the fall mat sitting. Per the note, she sustained no injuries. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Electronic Health Record (EHR) dated 2/9/2024 revealed the facility had completed Morse Fall Scale assessments on Resident #57 on 12/30/2023, 1/11/2024, 1/15/2024, 1/18/2024, 1/30/2024, 2/1/2024, and 2/6/2024. The EHR documented all the assessments rated Resident #57 as having a high risk of falling except for the assessment completed 12/30/2023 which indicated a low risk of falling. Record review of Resident #57's Morse Fall Scale assessment dated [DATE] revealed a score of 55 indicating a high risk of falling. The assessment documented she had a history of falls, she did not ambulate, she was either on bedrest or used a wheelchair, and forgot her limits in ambulation. Observation on 2/9/2024 at 10:29 AM of Resident #57 revealed she was lying in her bed with her head elevated. Resident #57 was utilizing a G-Tube for nutrition. Resident #57's bed was in a low position and fall mats were placed on both sides of the bed. Resident #57 was lying on a scoop style air mattress. Observation on 2/9/2024 at 10:46 AM of Resident #57 revealed she was in a sitting position on the bed with her feet off the mattress near the fall mat. The ADON was informed immediately and intervened returning Resident #57 to bed. Interview on 2/9/2024 at 10:47 AM with the ADON, she said she did not know how long Resident #57 had been in a scoop mattress. The ADON said the scoop mattress was used to prevent a resident from falling from the bed or minimize the likelihood of falls. The ADON said a physician's order was not necessary for a scoop mattress. The ADON said a resident's use of a scoop mattress should be addressed in his/her care plan. Interview on 2/9/2024 at 11:00 AM with the MDS LVN, she said either she as the regional MDS coordinator or the facility's MDS coordinator was responsible for ensuring care plans were up to date. The MDS LVN said a resident who utilized a scoop mattress should have an intervention for falls noting the use of the scoop mattress. The MDS LVN said Resident #57 did not have an intervention related to falls indicating the use of a scoop mattress on her care plan. The MDS LVN said she would add that intervention to the care plan at that time. The MDS LVN said a scoop mattress was typically not utilized for a resident until other interventions such as fall mats and/or lowered bed position had been utilized. The MDS LVN said the care plan should be updated so all staff are aware of the interventions needed for a resident's care. The MDS LVN said if a resident's care plan was not updated regarding the use of a scoop mattress, if a resident was put to bed and the scoop mattress was not present the staff may not know to obtain a scoop mattress prior to assisting the resident into bed. Interview on 2/9/2024 at 11:28 AM with LVN S, she said she had been employed for almost two years. LVN S said her primary duties included obtaining resident blood glucose levels, obtaining vital signs, tracheostomy care, calling physicians and families, and documentation. LVN S said she was unsure how long Resident #57 had been using a scoop mattress. LVN S said Resident #57 was initially admitted to another hall but was moved to her hall recently. LVN S said she believed that Resident #57 had not had a scoop mattress when her room was on the other hall. LVN S said if a resident used a scoop mattress, that information should be found in the resident's care plan. Interview on 2/9/2024 at 11:34 AM with PTA N, he said he did not know how long Resident #57 had been utilizing a scoop mattress. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/10/2024 at 9:06 AM with the DON, she said she was unsure how long Resident #57 had been using a scoop mattress. The DON said a resident who utilized a scoop mattress should have a care plan related to that use. The DON said a care plan provided specific instruction on care required for a specific resident. The DON said the care plan provides specified information related to a resident's diet, care services, and interventions. The DON said if Resident #57 did not have a care plan with an intervention related to her scoop mattress use, the care provided to her would not match the care called for in the care plan. Record review of the facility's Resident Assessment policy dated 1/20/2021 revealed a policy statement which read in part .completing and conducting Comprehensive Care Plan Meeting and Reviews by day 21 after Admission. The Care Plan is revised every quarter, significant change of condition, Annual or as the resident condition changes on an individualized basis. The Care Plan process is an ongoing review process. The resident's Care Plan will include participation from residents' representatives, external partners PASRR, Hospice, Therapy, Clinicians . The policy documented the care plan would be completed within twenty-one days of admission with the input of the IDT. Per the policy, the care plan would meet the residents' immediate care needs including fall prevention needs.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 46678 Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent accidents for 1 (Resident #18) of 6 residents reviewed for accidents hazards/supervision. The facility failed to prevent Resident #18 from eloping from the facility without the staff's knowledge despite the resident wearing a wander guard. The facility failed to ensure the facility exit doors were secured/locked to prevent resident elopement. An Immediate Jeopardy was identified on 02/08/24. The Immediate Jeopardy was lowered on 02/11/24; however, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place residents at risk of serious injuries due to lack of supervision. Findings include: Record review of Resident #18's face sheet dated 2/8/24 revealed a [AGE] year-old man admitted on [DATE]. The face sheet documented his diagnoses included encephalopathy (medical term used to describe a disease that affects brain structure or function. It causes altered mental state and confusion), psychotic disorder (are severe mental disorders that cause abnormal thinking and perceptions) with delusions (fixed, false conviction in something that is not real or shared by other people), cerebral infarction (stroke), history of falling, unspecified lack of coordination, aphasia(an impairment of language, affecting the production or comprehension of speech and the ability to read or write), insomnia (inability to fall and/or stay asleep), recurrent depressive disorders (mental disorder characterized by sustained depression of mood, anhedonia, sleep and appetite disturbances, and feelings of worthlessness, guilt, and hopelessness), anxiety (group of mental illnesses that cause constant fear and worry), ataxic gait (clumsy, staggering movements with a wide-based gait), difficulty in walking, paranoid schizophrenia (mental disorder in which people interpret reality abnormally), and convulsions (a type of seizure consisting of a series of involuntary contractions of the voluntary muscles). Record review of Resident #18's case notes revealed that the resident resided with a family member in the same room. On 1/29/24 he was transferred to a different room due to a Covid positive test which was one room away from the facility exit door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #18's quarterly MDS dated [DATE] revealed a BIMS score of 4 indicating a severe cognitive impairment. The MDS documented he had no potential indicators of psychosis, behaviors affecting others, rejection of care, or wandering behaviors. Per the MDS, Resident #18 had an impairment to one side of his upper and lower extremities, and he used a wheelchair for mobility. The MDS revealed he was administered antipsychotic and antidepressant medications. The MDS documented he received OT services. Record review of Resident #18's care plan dated 2/6/24 revealed a focus on his history of falls with interventions including the use of assistance bars, placing his bed in the lowest position, ensuring fall mats were in place, medication review, use of a scoop mattress, and ensuring the call light was in place. The care plan documented a focus on his behavior plans with interventions including intervention as needed to ensure his and other residents' safety and rights were protected. The care plan included a focus on Resident #18's wander guard elopement device with interventions including frequently monitoring his location, attempts to divert his behaviors, and provision of structured activities. The care plan revealed a focus on his actual falls with interventions including fall cause determinations, education, ensuring the bed was in a low position, and ensuring the room was free of clutter. The care plan documented a focus on his communication problem with interventions including allowing adequate time to respond, referral to speech therapy, and repeating his responses. The care plan included a focus on Resident #18's elopement risk with interventions including fall risk assessment, distraction, provision of structured activities, use of a wander guard elopement reducing device, and completing rounds to ensure his presence. The care plan revealed a focus on his impaired cognitive impairment with interventions including medication administration, use of yes/no questions, cuing and reorienting, and provision of a consistent routine. The care plan revealed a focus on Resident #18's history of seizures with interventions including monitoring for seizures, padded side rails if needed, remaining with the resident during a seizure, and following the facility's seizure protocol. Record review of Resident #18's LVN X's note dated 2/6/24 at 1:30 AM revealed he had left the facility through the back door and was returned to the facility by law enforcement. The note documented that the officer reported Resident #18 was found across the street from the facility. Per the note, Resident #18 reported he had been looking for a man he knew, had left the facility with ketchup to eat, and had left the facility in a jacket and shoes with a blanket. Record review of resident #18's elopement assessments found in the Electronic Health Record (EHR) revealed assessments were completed on 1/7/21, 3/16/22, 4/24/22, 6/14/22, 8/16/22, 11/16/22, 1/26/23, 4/26/23. 7/1/23, 12/15/23, and 2/6/23. All the assessments reported Resident #18 had risk of elopement with the 6/14/22, 8/16/22, 11/16/22, 4/26/23, 7/1/23, 12/15/23, and 2/6/24 indicating he was at a high risk of elopement. Record review of Resident #18's February TAR dated 2/8/24 revealed an order to assess his wander guard for placement and function every shift. The TAR documented this was done every morning shift from 2/1/24 through 2/8/24, and on the night shift on 2/1/24, 2/2/24, 2/4/24, 2/5/24, 2/6/24, and 2/7/24. Per the TAR, Resident #18's wander guard was assessed on 2/5/24 during the night shift by LVN J. Observation and interview on 2/6/24 at 9:10 am, there were no staff in front of Resident #18's door. There was one staff member assisting other residents with their breakfast trays. Resident #18 was lying in bed, he said he did not think he had covid. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and interview on 2/7/24 at 12:20 pm, the Receptionist was sitting in the hallway in front of Resident #18's room. She said she was assigned to sit outside Resident #18's room for the day. She said Resident #18 eloped but was not sure what day that happened. Interview on 2/7/24 at 1:22 pm with Resident #18's family member, he said he got a phone call from the facility at 1:06 am on 2/6/24. The facility informed him Resident #18 eloped from the facility and police brought him back. The family said he did not think the facility was doing anything to keep Resident #18 from escaping the facility. The family said the codes for the front door to get in and out of the facility have not changed in years. The family member said the facility wanted to move Resident #18 to a secure unit. The family member would like Resident #18 to stay because his current roommate is a family member. Interview with the DON on 2/7/24 at 1:45 pm, she said Resident #18 was supposed to be on 1:1 monitoring until Resident #18 can be transferred to a secure unit. She said they did not have enough staff to watch him, so she had staff conduct hourly checks instead. Interview with LVN J on 2/8/24 at 8:31 am, she said on the evening of 2/5/24 she checked Resident #18's wander guard for placement but not for function. LVN J said she did not check for function because Resident #18 was in bed sleeping. Interview with the Director of Plant Operations on 2/8/24 at 8:52 am, he said the front door is the only door that has an alarm for the wander guard, the rest of the exit doors were delayed egress emergency doors (the exit door had to be pushed for 15 seconds before emergency door opened). Observation and interview on 2/8/24 beginning at 9:00 am revealed the Director of Plant Operations tested the alarm for the exit doors on the 100 hall, 200 hall, 300 hall, and 400 hall. All alarms sounded when he pushed on the doors for 15 seconds and opened them. The Director of Plant Operations said once the exit door has been opened, staff must reset the alarm on the keypad by the door, the light on the keypad will turn green when the alarm has been set. The Director of Plant Operations was responsible for ensuring the exit doors were secured. Observation on 2/8/24 at 10:14 am, Resident #18 was in the hallway of the Covid unit, he was trying to get staff's attention because he wanted something to drink, he said his throat was hurting. CNA V was at the end of the hallway moving boxes in a room. CNA U was in a room helping a resident, she shouted at CNA V to make sure Resident #18 was in his room. CNA V approached Resident #18 and told him to go back into his room. Observation a nd interview with Resident #18 on 2/8/24 at 10:16 am, Resident #18 pulled down his sock on his left ankle and revealed a wander guard. Resident #18 said he remembered leaving the facility earlier this week. He said the professor gave him some papers to read for a test. Interview with CNA V on 2/8/24 at 10:19 am, she said she did 1:1 monitoring for Resident #18 on Tuesday morning for her entire shift. CNA V said she did not have any information on Resident #18 when he eloped Tuesday morning. (continued on next page)

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	676204	A. Building B. Wing	02/12/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Administrator on 2/8/24 at 11:32 am, she said Resident #18 went out the back door in the Covid unit. The Administrator said Resident #18 had a history of eloping. The Administrator said she did not think Resident #18 left the property and she needed to get more details from staff that worked that night. On 02/08/24 at 3:03 p.m., the administrator was informed that an Immediate Jeopardy situation was identified due to the above failures. Interview with CNA U on 2/9/24 at 11:10 am she said Resident #18 was on 1:1 checks as of last night. Resident #18 has moved back to the 400 hall, so this may have changed. She said the wander guard is supposed to be checked for placement every shift and the resident must be brought to the front door to check for function. Interview with CNA C on 2/9/24 11:14 am, she said Resident #18 is now on hourly checks and the wander guard had to be checked for placement and function. Interview with LVN S on 2/9/24 at 11:20 am, she said Resident #18 is on hourly checks. The wander guard should be checked by walking him to the front door and checked for placement. Interview with the DON, on 2/9/24 at 11:25 am she said the facility did not have a system in place to check the wander guard for function when residents were placed in the Covid unit. She said the policy should be updated by the charge nurse and either she or the ADON would verify the policy. She said the risk to the resident would be the resident could be harmed if they eloped. Interview with the ADON on 2/9/24 at 11:30 am, she said Resident #18 was back on the hourly checks, she said the wander guard would have to be checked for placement and to checked for function. She said to check for function she would sure the green light is on. Interview with CNA W on 2/9/24 at 12:25 pm, she said Resident #18 left out the side door of Hall 200, she said the door was unlocked that night and she was not sure why. She was not sure what time he left the building and said they did not notice until it was time to take his medications which was around 11:00 pm. She said the police found him across the street and brought him back. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LVN X on 2/9/24 at 1:49 pm she said on 2/5/24 between 11:15 pm and 11:30 pm she saw Resident #18 sitting in his room in his wheelchair . LVN X said Resident #18 was asking for some more pull ups. LVN said she was finishing up taking vitals with other residents in the 200 hall and then went to a different area to get the pull ups. LVN X said when she came back around 11:50 pm, Resident #18 was not in his room. LVN checked Resident #18's bathroom and he was not in there. LVN said she checked the other resident's rooms in the 200 hallway and could not find him. She then went to the Nurse's station located in the center of the building and asked the other staff members if they had seen Resident #18 walk by and they did not see him. LVN X and other staff proceeded to check all the rooms and the restrooms in the building, then went outside to look for him. LVN X said they checked inside and outside the building at least 3 times and then decided to call the police. By the time they got back in the building to call the police, a police officer from the local police department escorted Resident #18 back into the building. LVN X said the police officer found Resident #18 across the street in the hospital parking lot. LVN X said a police report was not filed and she did not get the policeman's name. LVN X said she did not hear a door alarm go off when Resident #18 left the building. LVN X said she went back to check the exit doors for the 200 hallway, and she said the alarms went off when she pushed on the back exit door and the side exit door. LVN X said if staff use any of the exit doors located in the resident hallways, they need to type in a code to exit and enter the building. LVN X said she did not think that Resident #18 knew the code to exit the building. The facility's Plan of Removal was accepted on 02/09/24 at 5:38 p.m., and included: Action: o Conducted audit of all residents who are an elopement risk to ensure appropriate interventions are in place: Completed on 2/9/2024 by DCO. Intervention in place o Reviewed procedure for moving residents to the COVID hall by Admin and DON 2/9/2024 to include identifying placement for residents that are high risk for elopement. o No exit codes are posted next to the exit doors. Confirmed with State Investigator and she removed that statement from her report. Completed on 2/8/2024. o All staff were in-serviced on elopement policy to include checking of wander guard system, interventions to prevent elopement and checking security of emergency exit doors by DCO 2/9/2024 Elopement drills initiated for all staff. Scenario used of a missing resident at the facility by DCO 2/8/2024. o Elopement binder updated completed on 2/8/2024 o All wander guards were checked and working properly 2/6/2024, 2/7/2024 and 2/8/2024 o All exit doors were checked and were working properly 2/6/2024, 2/7/2024 and 2/8/2024 o Head to toe assessment completed on Resident #18 no injuries or adverse effects noted from elopement incident. 2/6/2024 o Reviewed resident care plans. 2/9/24 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Resident remains on one on one until discharged to a secure unit 2/6/2024. o Maintenance Director and/or designee to complete Daily Monitoring of exit doors and wander guard system started on 2/8/2024 o Nursing and/or designee will test wander guard device q shift to ensure that they are properly alarming started on 2/8/2024. o The Medical Director has been notified of the Elopement and reviewed current policy and procedures to keep residents safe from Elopement. Plan of action reviewed with Medical Director with no changes to the current policy. This practice will be reviewed monthly with the QA committee to ensure we are in compliance with Elopement Policy and Procedures completed on 2/8/2024. o All new hires will be trained on Elopement policy and procedure prior to working shift. Started on 2/8/2024. Start Date: 2/8/2024. Completion Date: 2/9/2024 Responsible: EDO and DCO On 02/10/24 and 02/11/24, the surveyor confirmed the plan of removal had been implemented sufficiently to remove the Immediate Jeopardy by: Observation on 2/10/2024 at 9:03 AM of Resident #18 revealed there was no staff in Resident 18's room or outside his door. Staff was observed entering his room to pick up the breakfast trays for him and his roommate. The staff member brought the breakfast trays from the room and exited to other rooms on the hall. Interview on 2/10/2024 at 9:04 AM with LVN S, she said Resident 18 should have a CNA assigned as a one-to-one monitor. LVN S said Resident #18 had a one-to-one monitor during the night shift and a new monitor was assigned that morning. LVN S said the monitor was not in the room. LVN S said the monitor may have gone to the restroom. LVN S said if the monitor had gone to the restroom, she should have informed other staff to ensure continuous coverage for the one-to-one monitoring for Resident #18. LVN S said Resident #18 did not have one-to-one coverage at that moment. LVN S moved to stand in Resident #18's room to provide one-to-one coverage. Interview on 2/10/24 at 9:06 AM with the DON, she said she was aware there was not one-to-one monitoring occurring for Resident #18 at that time. The DON said she had called the monitor's supervisor to locate the monitor. The DON said if the monitor had gone to the restroom, she should have informed other staff to ensure Resident #18 always remained on one-to-one monitoring. The DON said because Resident #18 did not have one-to-one coverage for any amount of time he could have eloped from the facility again. The DON said the staff assigned to provide Resident #18 one-to-one monitoring knew she was assigned to provide him with that monitoring. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #18's Nurse's note dated 2/10/2024 at 9:52 AM revealed he had stayed in his bed for most of the night shift and an elopement monitor was positioned bedside. The note documented Resident #18 would remain on one-to-one elopement monitoring. Record review of Resident #18's Nurse's note dated 2/10/2024 at 10:10 AM revealed he had been in bed and in his wheelchair in his room. The note documented he remained on one-to-one elopement monitoring. Record review of Resident #18's Nurse's note dated 2/9/2024 at 10:59 PM revealed he returned to his original room as he had completed his COVID isolation. The note documented he was on one-to-one elopement monitoring. Observation on 2/10/2024 at 12:31 PM revealed two staff were in Resident #18's room. One staff was standing near the door and the other was seated near his bed. Record review of the facility's elopement binder on 2/10/24 at 12:40 pm revealed it contained information for a total of six residents. The binder included the name, age, sex, weight, race, hair color, eye color, identifying marks or tattoos, mobility devices utilized, physical impairments, language, diagnoses, behavior concerns, and a list of known friends and relatives. The binder contained an area for completion if a resident was determined to be missing with information including the time the resident was discovered missing, the last known location of the resident, a description of the resident's clothing at the time she/he went missing, and medications. The binder included the face sheet for each resident, with a photograph, on the reverse of the missing resident profile. The binder included the information for Resident #'s 18, 25, 45, 53, 66, and 68. Record review of in-service dated 2/8/24 conducted by the DON was about Elopement and Elopement Drill. Record review of in-service dated 2/10/24 conducted by the DON was about one-on-one sitter. Record review of the wander guard daily testing log for February 2024 revealed daily testing on 2/1/24, 2/2/24, 2/3/24, 2/4/24, 2/5/24, 2/6/24, 2/7/24, 2/8/24, 2/9/24, and 2/10/24. Record review of the Elopement Policy dated 11/01/19 read in part .check all offices and any locked doors to ensure none were left unlocked . Interview with LVN K on 2/11/24 at 11:14 AM she said she was in-serviced on restraints and elopement with missing resident drill. Interview with LVN S on 2/11/24 at 11:23 am she said she was in-serviced on resident rights and elopement. She said she was not supposed to put a resident who was at risk of elopement next to exit door. Interview with MA M on 2/11/24 at 11:43 PM she said she was in-serviced on abuse and neglect, pain, medication, and elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with MA H on 2/11/24 at 11:50 PM she said she was in-serviced on pain management and medication, abuse and neglect, elopement. She said when you arrived for your shift, conduct a walk around to make sure all residents are accounted for. She said if a resident was missing, the nurse needed to be notified and the facility needed to be checked. If the resident was not found inside the facility, expand the search outside. She said staff needed to work together to search different areas to find the resident as quickly as possible and adhere to timeline to notify family, doctor, and state. Interview on 2/11/24 at 1:26pm with HK AA, she said 1 on 1 supervision meant that the resident must be supervised 24 hours a day. She said that she was in-serviced on elopement and sitting. She said that she understood if she was monitoring a resident and needed to step away, then she should call someone else to supervise until she returned. The Admin was notified on 2/11/2024 at 1:28 pm, the Immediate Jeopardy was removed. While the IJ was lowered on 2/11/24, 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 continuing education to facility staff.

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47829 Based on observation, interview, record review, the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 7 residents reviewed for pain management. The facility failed to provide medications Hydrocodone-Acetaminophen 10- 325mg per order for Resident #129 when admitted on [DATE] and after Resident #129 complained of continued pain and requested medication. No pain medication was provided until 2/6/24 when MD visited and changed medication orders. An Immediate Jeopardy (IJ) situation was identified on 2/08/2024. The IJ template was provided to the facility on [DATE] at 3:03 PM While the IJ was removed on 2/12/2024, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents on controlled pain medication at risk of not receiving appropriate pain management resulting in pain. Findings included: Record review of Resident #129's Admission Record revealed he was a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included chronic gout (a painful condition in which uric acid builds in the blood and causes inflammation in the joints), metabolic encephalopathy (problem in the brain caused by chemical imbalance in the blood), type 2 diabetes mellitus (the body's impaired used of blood sugar), and stroke (impaired blood flow to the brain). No MDS to review [new admit]. No baseline or comprehensive care plan to review. Record review of the Resident #129's orders revealed that his pain medications ordered upon admission included: Hydrocodone- Acetaminophen Oral Tablet 10-325 MG (Give 1 tablet by mouth every 6 hours as needed for pain)- Ordered by LVN G on 2/4/24 at 3:22 PM. [Resident #129 did not receive this medication prior to 2/08/2024.] Record review of the Nexsys inventory sheet dated 2/7/2024 revealed the electronic dispensing medication device Nexsys (used as e-kit) contained both Eliquis (Position B 3-8) and Hydrocodone 10/325 (Position A-1). Record review of Resident #129 Medication Administration Record dated 2/8/24 revealed: (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #129 did not receive any pain medication of any kind on the following days: 2/4/24-none given 2/5/24-none given 2/6/24- none given in the morning Resident #129 received first dose of pain medication (Acetaminophen-codeine 30mg) on 2/6/24 at 3PM. Resident #129 had no documented pain levels on 2/4/24 or 2/5/24. Record review of progress notes revealed there was no nursing documentation concerning Resident #129's pain. Record review of therapy noted dated 2/5/24 at 12:57 PM by PT M revealed: Patient with significant [NAME] arthritis pain but participated with evaluation. Record review of therapy note dated 2/6/2024 5:21 PM by OT H revealed: Pt required frequent rest breaks d/t pain in BUE (bilateral upper extremities) Record review of therapy note dated 2/6/2024 7:17 PM by SLP C revealed: Pt participated with conversations and cognitive task. He did indicate that he was unhappy and needed additional help. Will continue to monitor. Observation and interview on 2/7/24 at 9:15 AM with Resident #129, he said that he feels his problems are not being addressed: gout flare, lack of therapy. Resident #129 lifted his left arm and showed where he was unable to move his wrist and hand, then said that the pain in his left hand is a 9/10 and the pain in his right thumb is 6/10. He said the pain was due to being in a gout flare. He said that he did not feel enough was being done to get it under control so that he could participate in therapy. He said he had been in bed since Sunday [3 days], and that's just making everything worse. He said that he complained of pain to everyone that came to his room on those days including the therapists. He said that he did ask about the hydrocodone and a different medicine [Eliquis] that he was on prior to facility admit, but he was never given an answer as to why it was not being provided to him. Interview on 2/7/24 at 9:30 AM with PTA N, he said CNA L called him yesterday to see Resident #129 because he was very upset. He said that he went to talk with the Resident #129, and that the resident expressed concerns about desiring therapy but being unable to tolerate due to gout pain. PTA N said, after his encounter with Resident #129, he talked to the OT N to let her know that the resident was in pain before she went to work with him. PTA N said that he also told the nurse aide. He said he was not sure who Resident #129's nurse was but thought the aide would pass along the message. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 2/7/24 at 9:40 AM CNA L, she said that she asked PT N to see Resident #129 because she has seen the resident feed himself but then he asks for help with simple tasks like getting a drink of water or using the remote to change the channels on the television. She said he has complained about some pain, but when he does, she will let the nurse know and the nurse will give him something. Interview on 2/7/23 at 9:45 AM with OTA N, she said that she worked Resident #129 yesterday, but her visit was limited due to him being in pain. She said that she was unable to notify the nurse right away but did notify the ADON when she found her later. Interview on 2/7/24 at 1:57 PM with LVN G. She said that she was the admitting nurse for Resident #129. She said that she reconciled his medications upon admission and notified the physician for review. She said that she only entered the orders and did not follow up with the pharmacy because that's something that would have been done by the oncoming morning nurse, LVN K. She said she was unaware that Resident #129 was in pain. Interview on 2/7/2024 at 2:35 pm with MD R. He said Resident #129 admitted to the facility from the hospital with a prescription for Hydrocodone. He said that he did approve use of this medication for severe pain and sent an order to the pharmacy on 2/4/24. He said that he cannot explain why the medication was not provided to the resident. He said that the Acetaminophen Codeine was added on 2/6/24 as a scheduled medication to address moderate pain . He said he was not made aware that Resident #129's pain was not being managed with Tylenol #3. Attempted to call LVN K on 2/7/24 at 2:55 PM and on 2/8/24 at 8:53 AM, voicemails left requesting a call back. LVN K was Resident #129's nurse on 2/5/24 and 2/6/24. Interview on 2/8/24 at 9:15 AM with the DON. She said residents should be assessed for pain before receiving pain medications and a half an hour to 1 hour after pain medication has been administered. She said this is to ensure that the medication is working. The DON said if a resident experiences pain during therapy, then therapy should communicate that with the resident's nurse immediately. She said the timing of the pain medication can be modified so that the resident receives their medication prior to therapy to keep them resident comfortable. The DON said that failure to follow this process could result in the resident being in pain. The DON said that failure to provide pain management can result in the resident being in pain. Record review and interview on 2/8/24 at 9:15 am, the DON reviewed Resident #129's orders and said that she was able to identify where Resident #129 was ordered Hydrocodone upon admission on 2/4/24 but did not receive it or any alternative pain medication until he was ordered a different one on 2/6/24. She said failure to administer pain medication could result in unnecessary pain. Interview on 2/8/24 at 9:20 AM with the ADON. She said at no point did therapy notify her Resident #129 was experiencing pain on 2/5/24 or 2/6/24. She said if a resident is in pain, they would be assessed by a nurse, then administered pain medication per order. She said failure to do so could result in the resident experiencing pain. Interview on 2/8/24 at 9:50 AM with the Administrator. She said she expected her nursing staff to follow up to the extent necessary to make sure the residents receive their medications. She said failure to receive pain medications in a timely manner can result in the resident being in pain. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's Pain Management Policy dated 8/10/2021 revealed in part: It is the policy of this community that residents experiencing pain will be assessed and pain management provided to the degree possible to provided comfort and enhance the resident's quality of life. 1. Each resident's pain will be assessed using the Pain Tool UDA in PCC upon admission, readmission, the onset, or an increase in pain, quarterly, and whenever there is a significant change in condition that may cause an increase in pain. 2. The community promotes residents self-reporting as the most reliable indicator of pain. 5. The community will treat the resident under the premise that pain is present whenever the resident says that it is. 6. Nursing staff will identify situations or interventions where an increase in the resident's pain may be anticipated (i.e., wound care, ambulation, repositioning). Pain medication will be offered appropriately preceding these identified activities. 7. The resident's pain will be evaluated routinely each shift. Documentation will be done on the EMAR/ETAR. 9. Nursing staff will evaluate how pain is affecting mood, activities of daily living, sleep and the resident's quality of life including complications. (i. e., falls, gait disturbance, social isolation). 10. The physician will order appropriate pain medication intervention both routine and PRN to address the individual's pain. 11. Residents with unrelieved pain will be evaluated by the nurse and the physician notified. Pain interventions will be adjusted accordingly and may include non-pharmacological measures. 13. A care plan will be completed with goals for pain treatment, pharmacological and nonpharmacological interventions. Plan will be updated appropriately. Record review of the facility's Controlled Substance Prescriptions Policy dated 8/2020 revealed in part: (continued on next page)

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	676204	A. Building B. Wing	02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Cedar Bayou	2000 W Baker Rd Baytown, TX 77521

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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A chart order is not equivalent to a prescription for controlled medications. Therefore, the prescriber issuing the chart order must also provide the pharmacy with a valid prescription to ensure delivery of medication. The written prescription may be faxed to the pharmacy for long-term care facility residents. Verbal orders for controlled medications are permitted for Schedule II substances only in emergency situations. Verbal orders for controlled medications received by facility nursing staff should be noted in the resident's medical record and nursing facility staff must confirm that the prescriber or the prescriber's agent has communicated the order to the pharmacy. 2. The prescriber is contacted for direction when the medication is not or will not be available for administration or in accordance with facility policy. An Immediate Jeopardy (IJ) was identified on 2/08/2024. The Administrator, and DON were notified. The IJ template was provided to the administrator via email on 2/08/2024 at 3:03 pm and a POR was requested. The following Plan of Removal was submitted by the facility and accepted on 2/10/2024 at 9:50 AM: On 2/7/2024 an abbreviated survey was initiated. On 2/8/2024 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. The notification of Immediate Jeopardy states as follows: The facility failed to ensure pain management was provided to residents who require such services. F-697 Action: The RDCO will provide education on pain management to the DCO. 2/8/2024 The RDCO provided education to the therapy team on pain management and the need to communicate to nursing when a resident complains of pain. 2/8/2024 In-services on Pain Management Policy and Procedures and use of Nexys machine for first-time medication doses initiated by DCO on 2/8/2024 to all licensed nurses. All licensed nurses expected to be in-serviced prior to the next shift worked. All licensed nurses expected to be in-serviced by 2/9/2024. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Charge nurse were in-serviced on what to do if a resident is in pain and what the charge nurses responsibility is for residents that are in pain 2/9/2024 All residents were assessed for pain to ensure no resident had any unidentified pain issues that were not being addressed by DCO/Designee. No residents were assessed to have any unidentified pain issue. Completed 2/8/2024 Cart audits were completed to ensure physician-ordered pain medications were present in the community by DCO/Designee. No physician-pain medications were not present in the community. Completed 2/8/2024 DCO/Designee to complete new admission chart reviews daily during the clinical meeting to ensure medication availability and pain management is in place. 2/9/2024 Daily Focus Care rounds will be completed by management staff to ensure residents are free from pain through resident interviews and to ensure companies policy and procedures for pain management are being followed. 2/9/2024 The Medical Director has been notified of the allegation and reviewed current policy and procedures for pain management and pharmacy procedures. Plan of action reviewed with Medical Director with no changes to the current policy. This practice will be reviewed monthly with the QA committee to ensure we are in compliance with the pain management and pharmacy procedures policy and procedures. 2/8/2024 Resident #129 was assessed for pain. Physician was notified and ordered Hydrocodone 10/325 1 tab every 6 hours 2/8/2024 Care plans and interventions were reviewed for resident that are high risk for pain 2/9/2024 Start Date: 2/8/2024. Completion Date: 2/9/2024 Responsible: RDCO and DCO/Designee Monitoring: Record review of the In-Service and Education Record dated 2/8/2024 revealed the corporate nurse provided the DON with training on Medication Administration- Routine Meds & Emergency Meds- Use of Nexsys. Record review of the In-Service and Education Record dated 2/8/2024 revealed the DON provided therapists, education on Pain Notification- When a resident complains of pain, you need to immediately let the charge nurse know. Record review of the In-Service and Education Record dated 2/8/2024 revealed the DON provided licensed nursing staff training on Pain Assessment- Administering Pain Medication- Available medication in the Nexsys of not available in community. (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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the In-Service and Education Record dated 2/10/2023 revealed the DON gave licensed nursing staff additional training on Steps to Obtaining Medication from Nexsys when required. Record review of the Pain Assessment Scoring Report dated 2/26/2024 revealed all residents had their pain assessed on 2/8/2024. Record review of Resident #129's pain assessment dated [DATE] revealed that his pain frequency at the time of assessment was occasionally and pain rating was a 5/10. It further revealed that Resident #129 was on a scheduled pain medication regimen of Hydrocodone 10/325 MG 1 PO (by mouth) every 6 hours. Record review of Resident #129's Medication Administration Record [2/11/2024] revealed that Hydrocodone 13/125 had been added as a scheduled medication every 6 hours and his pain was being assessed. Record review of cart audits revealed that this process was overseen by the DON and all medication carts were audited for narcotic pain meds and contained the appropriate medications with orders. Licensed nurses and med aides were interviewed [2/11/2024 between 11:14 AM to 9:35 PM] to verify the training they had received regarding pain management and pharmacy procedures for obtaining controlled pain medications. They were able to verbalize their policy and process for pain management and provision of pain medication. Nurse aides were interviewed [2/11/2024 between 11:14 AM to 9:35 PM] to assess their response to resident complaints of pain. All were able to identify verbal and nonverbal indicators of pain and know to notify the nurse immediately and document on a Stop-and Watch Form. The DON was interviewed on 2/11/2024 at 11:50 AM. She said the regional corporate nurse (RDCO) provided her training on pain management. She said if the resident has pain, then nurses should administer pain medication per physician order. She said if the medication is not readily available from the pharmacy, for instance, if the resident is new, then the nurse should go to the Nexsys to see if the medication is available, get a doctor's order to obtain it from emergency supply, and then follow up with pharmacy to ensure the prescription has been received and there is no issue. If for whatever reason, the medication is not in the Nexsys, the nurse would contact the physician for an alternative medication. She said after receiving her training, she relayed this training to her licensed nurses. The information provided by the DON was verified with the previous interviews of nursing staff. The DON said that on 2/8/2024, she verified that all residents were assessed for pain to ensure no residents had any unidentified pain issues that were not being addressed. Residents on controlled pain medication were interviewed and observed [2/11/24 between 12:30 PM and 1:45 PM]. None had complaints of pain or expressed issues concerning administration of pain medicine. Verbal residents were able to verify that their pain was being assessed per shift by a nurse with pain medication being dispensed as appropriate. They verified that a manager [DON] W daily was providing frequent checks on them . (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #129 was interviewed and observed on 2/11/2024 at 1:30 PM. He said that since Thursday [2/8/2024] he had been receiving his Hydrocodone and was feeling much better. He said the nurses were being very attentive and checking on him frequently to ask if he was in pain, and if he needed pain medication. He said if he needs it, he accepts and if he doesn't then he declines. He said appreciated that it was being offered. Observed resident lift left arm, and he said that he was not hurting at that time. The Admin was notified on 2/12/2024 at 9:20AM, the Immediate Jeopardy was removed. While the IJ was removed on 2/12/24, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing education to facility staff.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety 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** 47829 Based on interview and record review, the facility failed to provide routine and emergency drugs for 1 of 8 residents (Resident #129) reviewed for pharmacy services. -The facility failed to provide Resident #129 with ordered routine medications, Eliquis 5mg (blood thinner) and Hydrocodone-Acetaminophen 10- 325mg (pain medication) upon admission and for two days thereafter resulting in the resident experiencing continued pain. An Immediate Jeopardy (IJ) situation was identified on 2/08/2024. The IJ template was provided to the facility on [DATE] at 3:03 PM. While the IJ was removed on 2/11/2024, the facility remained out of compliance at a severity level of potential harm that was not immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of not receiving their medications as prescribed resulting in decline in health and quality of life. Findings included: Record review of Resident #129's Admission Record revealed he was a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included chronic gout (a painful condition in which uric acid builds in the blood and causes inflammation in the joints), metabolic encephalopathy (problem in the brain caused by chemical imbalance in the blood), type 2 diabetes mellitus (the body's impaired used of blood sugar), and stroke (impaired blood flow to the brain). No MDS to review [new admit]. No baseline or comprehensive care plan to review. Record review of the Resident #129's orders revealed that his medications ordered upon admission included: Hydrocodone- Acetaminophen Oral Tablet 10-325 MG (Give 1 tablet by mouth every 6 hours as needed for pain)- Ordered by LVN G on 2/4/24 at 3:22 PM. Eliquis Oral Tablet 5 MG (Give 1 tablet by mouth twice a day for A-fib (irregular/rapid heart rhythim)- Ordered by LVN G on 2/4/24 at 3:24 PM. Acetaminophen- Codeine Tablet 300-30 mg (Give 1 tablet by mouth every 8 hours for pain)- Ordered by LVN A on 2/6/ 24 at 11:11 AM. Record review of the Nexsys inventory sheet dated2/7/2024 revealed the electronic dispensing medication device Nexsys (used as e-kit) contained both Eliquis (Position B 3-8) and Hydrocodone 10/325 (Position A-1). (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #129 Medication Administration dated 2/8/24 revealed in part: Resident #129 missed 4 doses of Eliquis including: 2/4/24-6 PM dose 2/5/24- 9 AM dose 2/5/24- 6 PM dose 2/6/24- 9 AM dose Resident #129 did not receive any pain medication of any kind on the following days: 2/4/24-none given 2/5/24-none given Resident #129 received first dose of pain medication (Acetaminophen-codeine 30mg) on 2/6/24 at 3PM. Observation and interview on 2/7/24 at 9:15 AM with Resident #129, he said that he feels his problems are not being addressed, and he was not receiving his medications that he was on prior to his admission. Resident #129 lifted his left arm and showed where he was unable to move his wrist and hand, then said that the pain in his left hand is a 9/10 and the pain in his right thumb is 6/10. He said the pain was due to being in a gout flare. He said he took Hydrocodone before he got here [to the facility] to manage that and to his knowledge, it was not taken off his medication list. He said he could not understand why he got here [to the facility] and the nurses were not following his medication routine. Resident #129 said that he was given Tylenol #3 starting on 2/6/24, but it didn't do anything for him. He said prior to that, he was not getting any pain medication at all. Resident #129 also said he was not getting his Eliquis at first, and he has been on that for a while prior to his back when he had a stroke. He said he was in pain and angry because he was paying his money to be here and get therapy but couldn't really do it because they won't give him the right pain medication. Interview on 2/7/24 at 1:57pm with LVN G, she said that she was the admitting nurse for Resident #129 and that she reconciled and entered orders for all of his medications. She said the process for entering meds for a new admit is that the admitting receives a medication list and verifies the medications with the doctor . She said if the doctor is in agreement, the orders are entered. She said pharmacy receives the orders as they are entered, however, certain medications like controlled substances require an e-script directly from the physician. She said if the medication is not received or delayed, then the oncoming nurse should follow up with the pharmacy to address the issue and then follow up with the doctor in the event that an alternate is needed. LVN G said the staff must follow physician's orders because those constituted the only care a resident should receive. LVN G said if a resident was not receiving pain medication that would be concerning. LVN G said if a resident was not receiving pain medication as ordered the resident's pain may not be managed, and he/she may not be able to participate in care services. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 2/7/2024 at 2:35 PM with MD R, he said that he reconciled Resident #129's medications upon admission on 2/04/2024 and sent off scripts for the medications that required them on that same day. He said if the resident did not receive the medications as ordered, that would be on nursing staff and he really cannot answer to why . Observed and interviewed on 2/7/2024 at 3:20 PM, the Nexsys electronic dispensing machine in the locked medication room, accompanied by the DON. She said that she could not physically remove medication from the machine without a pharmacy authorization number, however, the contents of the machine are tracked via the Nexsys Inventory List, list provided and reviewed. Unsuccessfully attempted to interview LVN K (morning nurse for Resident #129 day 1 after admit) by phone 2/7/24 and 2/8/24, voicemails left requesting a call back. Interview on 2/8/24 at 9:15 AM the DON, she said when a resident is admitted into the facility, their medications are reconciled meaning the admitting nurse enters them into the system, the physician is notified and reviews the medication, and the physician will send prescription(s) to the pharmacy. She said if the medication does not come in at the expected time or by the next shift, the oncoming nurse should follow up with the pharmacy to see why the medication has not been sent. The DON said if the problem is that the medication is not available, then the nurse would follow up with the physician to order an alternative medication. She reviewed Resident #129's orders and said that she was able to identify the lapse in medication administration and that it was unacceptable. She said according to the Nexsys Inventory List, both the Eliquis and Hydrocodone were available. She said an oversight occurred in that the Eliquis was simply not given despite being ordered and available. She said the Eliquis would be available to the med aides on the carts, however, they hydrocodone would have to be given by a licensed nurse. She said even if it was not available with the resident's other medications on the nurse's cart, it could have been obtained from the e-kit. She said failure to administer the resident's blood thinner could be dangerous for the resident and missed pain medication could result in unnecessary pain . Interview on 2/8/24 at 9:30 AM with the Administrator, she said if a medication is not here, then the nurse should immediately contact the pharmacy to find out why and contact the doctor . She said failure to provide medication can negatively impact a resident's health condition or cause the resident to be in pain. Interview on 2/8/24 at 12:45 PM with Resident #129, he said that he did notify staff that came to his room on 2/5/24 and 2/6/24 that he was in pain and asked for medication. He said that they started him on Tylenol #3 (Acetaminophen-Codeine) on the 6th, but it doesn't do anything. He said that his pain had been managed with Hydrocodone without a problem prior to his arrival in this facility. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 2/11/2024 at 11:14 AM, LVN K said that she was aware of Resident #129 not receiving his Hydrocodone , but was unaware about the Eliquis. She said there was a drop off on the doctor's end in that the doctor's (MD R) office was saying they sent the prescription, but the pharmacy did not receive it. She said it is the nurses' responsibility to follow up with the physician and the pharmacy when a medication does not arrive. LVN K said that she followed up with doctor and the pharmacy on the morning and afternoon of 2/05/2024 , but did not document it. She said she did not notify the DON that there was an issue with Resident #129's medication. She said she thought she documented in a progress of Resident #129 having an issue with medication, but she must not have saved it. She said she did not have a reason as to why the medication was not accessed from the e-kit, but she has received training on accessing medication from the e-kit and following up with the physician and pharmacy. S he said failure to follow up on unreceived medications can result in residents being in pain or something else depending on the condition being treated. Record review of the facility's policy for Medication and Treatment Orders dated July 2016 revealed in part: Orders for medications and treatments will be consistent with principles of safe and effective order writing. 1. Medications shall be administered only upon the written order upon the written order of a person duly licensed and authorized to prescribe such medications in this state. 2. Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record. 10. Only authorized personnel shall call in orders for prescribed medications to the pharmacy. An Immediate Jeopardy (IJ) was identified on 2/08/2024. The Administrator, and DON were notified. The IJ template was provided to the administrator via email on 2/08/2024 at 3:03 pm. The following Plan of Removal was submitted by the facility and accepted on 2/09/2024 at 2:51 PM: On 2/7/2024 an abbreviated survey was initiated at Focused Care at Cedar Bayou. On 2/8/2024 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. The notification of Immediate Jeopardy states as follows: The facility failed to provide routine and emergency drugs for 1 of 8 residents reviewed for medication administration. F-755 o Action: o The RDCO will provide education on medication administration of routine and emergency medication to the DCO. 2/8/2024 (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 - Immediate jeopardy to resident health or safety Residents Affected - Some	o The RDCO provided education to the therapy team on pain management and the need to communicate to nursing when a resident complains of pain. 2/8/2024 o In-service on the use of Nexsys machine for first-time medication doses initiated by DCO on 2/8/2024 to all licensed nurses. All licensed nurses expected to be in-serviced prior to the next shift worked. All licensed nurses expected to be in-serviced by 2/9/2024. o All residents were assessed for pain to ensure no resident had any unidentified pain issues that were not being addressed by DCO/Designee. No residents were assessed to have any unidentified pain issue. Completed 2/8/2024 o Cart audits were completed to ensure physician-ordered pain medications and anticoagulants were present in the community by DCO/Designee. No physician-pain medications or anticoagulants were not present in the community. Completed 2/8/2024 o DCO/Designee to complete new admission chart reviews daily during the clinical meeting to ensure medication availability and pain management is in place. 2/9/2024 o Daily Focus Care rounds will be completed by management staff to ensure residents are free from pain and receiving their medications through resident interviews and to ensure companies policy and procedures for pain management and anticoagulants are being followed. 2/9/2024 o The Medical Director has been notified of the allegation and reviewed current policy and procedures for pain management and pharmacy procedures. Plan of action reviewed with Medical Director with no changes to the current policy. This practice will be reviewed monthly with the QA committee to ensure we are in compliance with the pain management and pharmacy procedures policy and procedures. 2/8/2024 o DCO or designee will review all new admissions medication orders to ensure that medications are received and administered as ordered during morning clinical meeting 2/9/2024 o DCO or designee will review all new admissions with a controlled medication order to ensure that medication is received and administered as ordered during the morning clinical meeting 2/9/2024 o Resident #129 was assessed for pain and Physician was notified. Physician ordered routine Hydrocodone every 6 hours for pain 2/8/2024 o Admission policy and procedure was reviewed by DCO and EDO 2/9/2024 o Audit of all new admission completed to ensure that medications were administered as ordered. 2/9/2024 Start Date: 2/8/2024. Completion Date: 2/9/2024 Responsible: RDCO and DCO/Designee (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Monitoring: Record review of the In-Service and Education Record dated 2/8/2024 revealed the corporate nurse provided the DON with training on Medication Administration- Routine Meds & Emergency Meds- Use of Nexsys. Record review of the In-Service and Education Record dated 2/8/2024 revealed the DON provided therapists, education on Pain Notification- When a resident complains of pain, you need to immediately let the charge nurse know. Record review of the In-Service and Education Record dated 2/8/2024 revealed the DON provided licensed nursing staff training on Pain Assessment- Administering Pain Medication- Available medication in the Nexsys of not available in community. Record review of the In-Service and Education Record dated 2/10/2023 revealed the DON gave licensed nursing staff additional training on Steps to Obtaining Medication from Nexsys when required. Record review of Resident #129's Medication Administration Record dated 2/26/2024 revealed that Hydrocodone 13/125 was added as a scheduled medication every 6 hours and his pain was being assessed, and medication administered accordingly. It also revealed that the resident did not miss any more doses of Eliquis after 2/6/24 at 6 PM. Record review of cart audits revealed that this process was overseen by the DON and all medication carts were audited for narcotic pain meds and contained the appropriate medications with orders. Licensed nurses and med aides were interviewed [2/11/2024 between 11:14 AM to 9:35 PM] to verify the training they had received regarding pain management and pharmacy procedures for obtaining controlled pain medications. They were able to verbalize their policy and process for pain management and provision of pain medication. Nurse aides were interviewed [2/11/2024 between 11:14 AM to 9:35 PM] to assess their response to resident complaints of pain. All were able to identify verbal and nonverbal indicators of pain and know to notify the nurse immediately and document on a Stop-and Watch Form. The DON was interviewed on 2/11/2024 at 11:50 AM. She said the regional corporate nurse (RDCO) provided her training on pain management. She said if the resident has pain, then nurses should administer pain medication per physician order. She said if the medication is not readily available from the pharmacy, for instance, if the resident is new, then the nurse should go to the Nexsys to see if the medication is available, get a doctor's order to obtain it from emergency supply, and then follow up with pharmacy to ensure the prescription has been received and there is no issue. If for whatever reason, the medication is not in the Nexsys, the nurse would contact the physician for an alternative medication. She said after receiving her training, she relayed this training to her licensed nurses. The information provided by the DON was verified with the previous interviews of nursing staff. The DON said that on 2/8/2024, she verified that all residents were assessed for pain to ensure no residents had any unidentified pain issues that were not being addressed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Cedar Bayou	2000 W Baker Rd Baytown, TX 77521

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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Residents on controlled pain medication were interviewed and observed [2/11/24 between 12:30 PM and 1:45 PM]. None had complaints of pain or expressed issues concerning administration of pain medicine. Verbal residents were able to verify that their pain was being assessed per shift by a nurse with pain medication being dispensed as appropriate. They verified that a manager [DON] W daily was providing frequent checks on them . Resident #129 was interviewed and observed on 2/11/2024 at 1:30 PM. He said that since Thursday [2/8/2024] he had been receiving his Hydrocodone and was feeling much better. He said the nurses were being very attentive and checking on him frequently to ask if he was in pain, and if he needed pain medication. He said if he needs it, he accepts and if he doesn't then he declines. He said appreciated that it was being offered. Observed resident lift left arm, and he said that he was not hurting at that time. He said that he was receiving his Eliquis and all of his medications as he should. The Admin was notified on 2/12/2024 at 8:46 AM, the Immediate Jeopardy was removed. While the IJ was removed on 2/11/24, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing education to facility staff.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27846 Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 6 % based on 2 errors out of 32 opportunities, which involved 1 of 8 residents (Resident #64) reviewed for medication errors, in that: MA Q failed to give Resident #64 her Sevelamer Carbonate (a medication used to lower blood phosphorus levels in patients on dialysis due to kidney disease) as ordered by her physician with meals and Carvedilol (medication used to treat high blood pressure and heart failure) as directed by pharmacy with meals. These failures could place residents at risk of not receiving the desired therapeutic effect of their medications and uncontrolled health conditions. Findings include: Resident #64 Record review of Resident #64's Face Sheet dated 02/08/2024 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included: hypertension (elevated blood pressure blood was pumping with more force than normal through the arteries), chronic kidney disease stage 4 (severe). Record review of Resident #64's care plan dated 05/31/2023 revealed: Focus: Potential for complications, signs and symptoms related to diagnosis of hypertension and risk for side effects; Goal: blood pressure will stay within their normal limits. Resident will not have signs and symptoms of high or low blood pressure; Interventions: Administer high blood pressure medication as ordered. Monitor blood pressure and for side effects of low blood pressure and increased heart rate. Record review of Resident #64's care plan dated 05/31/2023 revealed: Focus: Resident #64 needed dialysis related to renal failure; Goal: Resident #64 will have no signs or symptoms of complications from dialysis; Intervention: Monitor labs and report to doctor as needed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #64's quarterly MDS dated [DATE] revealed, Resident #64's cognition was intact indicated by her BIMS score of 15 out of 15. Section I Active Diagnoses: revealed the resident had end stage renal dialysis, renal failure (kidney failure) and hypertension (high blood pressure). Section O: Special treatments revealed the resident was on dialysis (the process of removing excess water and toxins from the blood for people whose kidneys no longer work). Record review of Resident #64's Order Summary Report dated as of 02/08/2024 revealed Renvela oral tablet 800 Mg (Sevelamer Carbonate) Give one tablet by mouth with meals for supplement/binder. Order dated 06/16/2023. Record review of Resident #64's Order Summary Report dated as of 02/08/2024 revealed Carvedilol oral tablet 25 Mg. Give one tablet by mouth two times a day for hypertension. Blood pressure less than 110/60 hold. Order dated 05/06/2023. Record review of Resident #64's medication administration record dated 02/01/2024-02/29/2024 revealed MA Q administered Renvela oral tablet (Sevelamer Carbonate) in the morning of 2/3, 2/4, 2/7. Record review of Resident #64's medication administration record dated 02/01/2024-02/29/2024 revealed MA Q administered Carvedilol in the morning of 2/3, 2/4, 2/7. In an observation on 02/07/2024 at 7:34AM revealed Resident #64 sitting in a chair in her room awake alert and oriented. The resident's over bed table was sitting next to her. There was no food, snack or supplement in the room. MA Q dispensed one Sevelamer Carbonate 800 Mg. MA Q administered the medication to the resident. Observation of resident taking the medication. Observation of the medication container read with meals supplement binder. In an interview on 02/07/2024 at 7:42 AM Resident #64 stated she had not eaten yet today. Resident #64 stated this was the normal time she received the medication. Resident #64 stated she did not know how long she had received the medication. In an observation on 02/07/2024 at 8:08AM MA Q dispensed Carvedilol 25Mg. Observation of the medication container revealed take with food. No food or snacks were provided to the resident. In an observation on 02/07/2024 at 8:22AM breakfast tray was delivered to Resident #64. As the observation continued Resident #64 began to eat breakfast at 8:23AM. In an interview on 02/07/2024 at 1:20 PM MA Q stated the medication packets both read to give with meals or food. MA Q stated the physician's order for the Sevelamer also read give with meals. MA Q stated they should have been given with food . MA Q stated she did not know how long or how many times the medications have been given without food. MA Q stated she gave the medications normally at this time. MA Q stated she thought she had an hour before and an hour after the time scheduled to give the medications. MA Q stated now she could see the medications were to be given with food. MA Q stated one medication was a binder and needed the food. MA Q stated the risk also was nausea due to giving on an empty stomach. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/07/2024 at 3:08 PM the DON stated she expected the medication administration record and the physicians' orders were checked to make sure the orders were followed. The DON stated any parameters or special administration orders were to be followed such as give with food. The DON stated the risk of giving medication without food could be an upset stomach. The DON stated to prevent this in the future we would in-service to make sure the staff were reviewing the orders and instructions. In a phone interview on 02/07/2024 at 3:32 PM the facility Quality Assurance Pharmacist stated the purpose for the Sevelamer to be given with food was not clear. The pharmacist stated it could be to prevent stomach upset. The Pharmacist stated the medication was also a phosphorus binder. As the interview continued, the pharmacist stated the Carvedilol needed to be given with food to help slow absorption. He stated on an empty stomach the Carvedilol may cause the blood pressure to drop too fast. In an interview on 02/08/2024 at 9:20 AM the Admin stated she expected the staff to read the physician's orders and instructions to be followed when medications were administered. The Admin stated if the pharmacy recommend the medications to be given with food then it was to be given with food. The Admin stated the risk could be upset stomach or absorption of the medication. The Admin stated the pharmacist conducted random medication administration observations monthly. She stated the DON and ADON did observations randomly. The Admin stated they will increase the frequency of the observations. The Admin stated they would do in-services on the procedures for medication administration. In an interview on 02/08/2024 at 12:34 PM Dialysis RN R stated it was important for the Sevelamer to be administered with food. As the interview continued the RN stated the medication helped control the phosphorous levels in the blood by binding with the food. RN R stated Sevelamer needed the food in the stomach to work. The medication was to be given with every meal and snack. RN R stated if the blood phosphorus levels are high the calcium will be pulled from the bones resulting in weak bones. Record review of the facility policy titled Oral Medication Administration revision dated 08/2020 revealed . Policy medication will be administered in a safe and effective manner. The guidelines in this policy refer to oral medications. Special Considerations 2. Refer to medication reference text for administration of any medication when added to any substance such as applesauce, juice, milk or confirm with a pharmacist .

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 47829 Based on observation and interview the facility failed to dispose of garbage and refuse properly for 1 of 1 dumpster reviewed for Food and Nutrition Services: -The facility failed to ensure the dumpster lids and doors were secured. This failure could place residents at risk of infection from improperly disposed garbage. Findings included: Observation on 02/09/2024 at 8:02 AM, revealed the facility's dumpster area, which was in the lot on back side of the facility had a commercial -size with top lid completely open. Interview on 2/12/2024 at 8:45 AM DA BB said that kitchen and housekeeping staff are usually the ones that take trash to the dumpster. DA BB said the dumpster should be closed when not throwing away trash, but sometimes it is not. Interview on 2/12/24 at 9:03 AM HKM said the dumpster should be closed to prevent trash from coming out and to keep anything that shouldn't be, there out. 2/12/24 9:30 AM The Administrator said that she expects the dumpster to be completely closed, and if it is found open, then it should be closed. She said failure to close the lid could attract unwanted pests. Requested a copy of facility policy and procedure for Waste Disposal/Dumpster. Facility did not provide the requested copy before exit .