STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676225	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mitchell County Nursing and Rehabilitation Center	971 W I 20 Colorado City, TX 79512

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305 Based on observations, interviews, and record review, the facility failed to ensure each resident was treated with respect, dignity, and care for each resident in a manner and in an environment that promoted the maintenance or enhancement of their quality of life, recognizing each resident's individuality. The facility failed to protect and promote the rights of the resident for 2 of 14 residents (Resident #35 and Resident #41) reviewed for resident rights. The facility failed to ensure RN C provided privacy during wound care for Resident #35 and Resident #41. This failure could place residents at risk for diminished quality of life and loss of dignity and self-worth. Findings included: Resident #35 Record review of Resident 35's face sheet, dated 02/18/25, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include adult failure to thrive (a syndrome of weight loss, poor nutrition, and inactivity that affects older adults), anxiety, dementia (memory loss that interferes with daily life), stage 2 pressure ulcer to left buttock, and hypertension (high blood pressure). Record review of Resident #35's current physician's orders, with a start date of 01/21/25, revealed an order to cleanse stage II pressure ulcer to left buttock with wound cleanser and apply zinc daily. Record review of Resident #35's admission MDS, dated [DATE], revealed a BIMS score of 12, which indicated the resident's cognition was mildly impaired. Section M-Skin Conditions revealed a stage 2 pressure ulcer that was present upon admission. Record review of Resident #35's comprehensive care plan dated 02/10/25 revealed the resident was admitted to the facility with a Stage II pressure injury to the left buttock. Interventions included: Administer treatments as ordered and monitor for effectiveness. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a wound care observation on 02/18/25 at 12:33 PM for Resident #35, RN C failed to fully pull the privacy curtain and close the window blind before performing wound care to the resident's left buttock, which placed the resident at risk of bodily exposure to the hallway and facility exterior. Resident #35's bed position was nearest the window and there was a roommate occupying the other bed in the room. During an interview on 02/20/25 at 11:33 AM, RN C stated she did not completely pull the curtain or close the window blind prior to performing wound care for Resident #35. She stated blinds and curtains should always be closed during personal care to provide privacy to the resident. RN C stated she just didn't see that the blind was open and stated staff attempt to work in a timely manner when providing personal care to Resident #35 because he gets agitated if we take too long. She stated she had been trained by nursing administration to provide privacy during personal care. RN C stated a potential negative outcome for failure to provide privacy during personal care would be that the resident's mental health could be negatively affected, the resident could suffer shame or lose trust in staff. Resident #41 Record review of Resident 41's face sheet, dated 02/18/25, revealed an [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include age-related cognitive decline, chronic kidney disease, weakness, macular degeneration (an eye disease that causes vision loss), and hypertension (high blood pressure). Record review of Resident #41's significant change MDS, dated [DATE], revealed a BIMS score of 06, which indicated the resident's cognition was moderately impaired. Section M-Skin Conditions revealed a stage 2 pressure ulcer that was present upon admission. Record review of Resident #41's current physician's orders, with a start date of 12/14/24, revealed an order to cleanse stage II wound to the sacrum (area above the tailbone) with wound cleanser and apply ordered treatment and dressing daily. During a wound care observation on 02/18/25 at 12:56 PM for Resident #41, RN C failed to fully pull the privacy curtain and close the window blind before performing wound care to the resident's sacrum, which placed the resident at risk of bodily exposure to the hallway and facility exterior. Resident #41's bed position was nearest the window and there was a roommate occupying the other bed in the room. During an interview on 02/20/25 at 11:35 AM, RN C stated she did not completely pull the curtain or close the window blind prior to performing wound care for Resident #41. She stated she should have closed the curtain and window blind before she began wound care for Resident #41, but she was concentrating on the steps of proper wound care and forgot. She stated she had been trained by nursing administration to provide privacy during personal care. RN C stated a potential negative outcome for failure to provide privacy during personal care would be that the resident's mental health could be negatively affected, the resident could suffer shame or lose trust in staff. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/25/25 at 11:38 AM with the ADM, she stated she was not aware that staff were not providing privacy to residents during personal care. She stated the door, privacy curtain and window blinds should be closed during personal care to provide as much privacy as possible to the resident. She stated her expectation of staff was that they always provide privacy to residents during personal care by following the facility policies for dignity and privacy and closing doors, curtains, and blinds. The ADM stated a potential negative outcome for failure to provide privacy during care was that the resident would not have the privacy they desire. Record review of the facility's policy titled; Dignity, date revised February 2021 revealed: Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation: 1. Residents are always treated with dignity and respect. . 11. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on interviews, and record review, the facility failed to inform residents in advance of the risks and benefits of proposed care and treatment for 1 of 14 residents (Resident #39) reviewed for resident rights. The facility failed to obtain a signed consent for antipsychotic medication, Trazadone, administered to Resident #39 for depressive episodes. The failure affected residents who received psychoactive medications without informed consents and placed them at risk of receiving treatments without informed consent. Finding included: Record review of Resident #39's face sheet, dated 02/19/25, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include depressive episodes, dysphasia (swallowing difficulties), cognitive communication deficit (a difficulty in communication that arises from an impairment in cognitive functions), reduced mobility, and aphasia difficulty in communicating). Record review of Resident #39's Comprehensive MDS, dated [DATE], revealed: Section C BIMS score revealed a score of 06, which indicated the resident's cognition was severely impaired. Section N-Medications [N0415] High Risk Drug Classes: Use and Indication revealed Resident #39 was taking an antidepressant. Record review of Resident #39's care plan, dated 09/12/24, revealed Resident #39 received antidepressant medications with the potential for drug-related adverse side effects like nausea, dizziness, drowsiness, dizziness, dry mouth, diarrhea, upset stomach, or trouble sleeping. Record review of Resident #39's Physician Order's, dates 02/18/25, revealed: Trazadone 100 MG; give 1 tablet by mouth one time a day for depressive episodes (Order date 08/25/23; Start date 10/01/24) Record review of Resident #39's Medication administration Record, February 2025, revealed: Resident #39 received Trazadone 100 MG; give 1 tablet by mouth one time a day for depressive episodes from 02/01/25-02/17/25. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/19/25 at 3:00 PM, the MDS Coordinator, stated she was familiar with the facility policy regarding medication consent. She stated the PNO was the facility could get sued. She stated the residents or family could allege that a medication was given that was not effective. She stated the purpose was to receive consent to administer the medication. She stated that consent should be obtained before then. The MDS Coordinator stated she was unaware of any residents missing medication consents. She stated the system to monitor medication consents was as soon as a doctor gave an order, the nurse should do the paperwork immediately. She stated there were instances where they will get verbal consent from the resident or the family, but they get all consents in writing as soon as possible. She stated if verbal consent had been obtained, it would be documented in the resident's EMR. The MDS Coordinator stated she expected all consents (written/verbal) should be obtained as soon as the doctor order was given. She stated all the nurses who receive orders were responsible. She stated if there were any missed medication consents, she did not have a reason it was not obtained. During an interview on 02/19/25 at 3:22 PM, the DON stated regarding medication consents, she was familiar with the facility policy and the purpose of medication consents was to make sure that everyone (resident and their family) was aware of the medication and that they were permitted to receive it. She said the PNO of not obtaining medication consent was that staff could end up giving the resident a medication that they do not want or may even receive medication to which they were allergic. The DON stated she was unaware of any residents who did not have medication consent for psychotropic medications. She stated the system to monitor medication consents was that the ADON or the MDS Coordinator will go through and ensure everything is up to date for all residents. She stated she, as the DON, would follow up. She stated she would also go through the resident medication consents when she is thinning their physical charts. She stated that she had been trained that all psychotropic medications required a consent before administering the medication. She stated she expected all appropriate medications to have the required consents. She stated she did not have a reason for the missing medication consents. She stated the nurse present when the medication is ordered was responsible for ensuring that the consents were obtained. During an interview on 02/19/25 at 3:55 PM, the ADM stated she was familiar with the facility's policy regarding medication consents. She stated the purpose of medication consent was if staff were going to administer psychotropic medications, they would have permission/consent from the resident and family. She said the PNO of not obtaining medication consent before administration was the facility would be liable if the resident could not make decisions. She stated it could be detrimental if the resident does not get the correct medication. She stated she was unaware of any residents who did not have the appropriate medication consent. She stated her system to monitor medication consent for psychotropic medications was that she relied on the DON. She stated she had not had specific training on obtaining medication consent because she is the administrator. She stated the nursing staff was responsible and did not have a reason it was not done if it was not done. She stated that she expected all appropriate psychotropic medications to have consents before administration. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/19/25 at 4:48 PM, the ADON stated she was familiar with the facility's policy on medication consents for psychotropic medications. She stated the purpose of obtaining consent was to ensure families and the residents knew what they were getting and the potential side effects. She stated the PNO was something bad could happen to the resident, or they could have a decline in health. She stated she was unaware of any residents not having medication consent until it was brought to her attention by the investigator. She stated the system to monitor consent for psychotropic medications was the nurse that receives the order would get the consent. She stated if the resident came into the facility with the medication, the admission nurse would obtain the consent. She stated she had been trained to obtain written consent before the administration of psychotropic medications. She stated she expected all appropriate medications to have an appropriate consent if applicable. She stated the nurses were responsible for getting consent and that she did not have a reason any resident consent was not obtained. During an interview on 02/20/25 at 9:10 AM, Resident #39 could not speak. He could not provide any information regarding administration of psychotropic medications. Record review of facility policy, Psychotropic Medication Use, dated July 2022, revealed: Policy Statement Residents will not receive medications that are not clinically indicated to treat a specific condition. Policy Interpretation and Implementation A Psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: Anti psychotics Anti-anxiety medications Residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes: Indications for use Dose Duration Adequate monitoring for efficacy and adverse consequences Preventing, identifying and responding to adverse consequences (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents (and/or representatives) have the right to decline treatment with psychotropic medications. The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives. Record review of facility policy, Resident Rights, revised February 2021, revealed: Policy Statement Employees shall treat all residents with kindness, respect, and dignity. Be informed of, and participate in, his or her care planning and treatment

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43344 Based on record review and interview, the facility failed to ensure residents have the right to formulate an advance directive and determine the choice to receive or not receive CPR (cardiopulmonary resuscitation) for 1 of 14 residents (Resident #27) whose records were reviewed for code status. The facility failed to obtain a DNR order and update the EMR for Resident #27 based on his completed DNR, dated [DATE]. This failure could place residents at risk for having their end of life wishes dishonored, and of having CPR performed against their wishes. Findings included: Record review of Resident #27's face sheet, dated [DATE], revealed an [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include Parkinson's (brain disorder that worsens), constipation (infrequent or uncomfortable bowel movements) and lack of coordination. Resident #27's face sheet revealed that his code status was full code. Record review of Resident #27's Comprehensive MDS, dated [DATE], revealed: Section C BIMS score revealed a score of 09, which indicated the resident's cognition was moderately impaired. Section V Care Area Assessment (CAA) Summary: CAA Results: (List the CAA that triggered and not Care Planned) 03. Visual Function 06. Urinary Incontinence Section B1000. Vision - coded 1 = impaired - sees large print, but not regular print in newspapers/books. B1000. Corrective Lenses: Yes. Section H-Bowel and Bladder. H0300. Urinary Continence Coded 3=Always incontinent (no episodes of continent voiding). H0400. Bowel Continence Coded 3=Always incontinent (no episodes of continent Bowel Movement) Record review of Resident #27's care plan, dated [DATE], revealed no care plan for visual function or urinary incontinence. Resident #27 had a care plan stating he did not want CPR and a goal of having an order for no CPR accepted/followed daily for the next 90 days. The intervention included to ensure all of Resident #27's needs are being met, ensure that all staff understand his no CPR status and having a OOH-DNR on file. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #27's OOH-DNR, dated [DATE], revealed that Family Member D declared as an agent in a Medical Power of Attorney on [DATE] that on the behalf of Resident #27 that she did not want any resuscitation measures to be initiated or continued. The OOH-DNR was valid with the medical power of attorney, notary and doctor's signature. During an interview on [DATE] at 9:23 AM, Resident #27 stated he knew what a DNR was. He said it was tough to answer the question about his preference. He was unable to report if he had a DNR in place. During an interview on [DATE] at 9:34 AM, LVN A stated regarding if a resident code (the resident was experiencing a cardiac arrest, where their heart had stopped beating, requiring immediate life-saving measures like CPR from a medical team) they would call for assistance from other staff. She stated that they had not had anyone code in a while. She stated whether a resident wanted CPR or was a DNR status, they, as the nurses, should know. She stated the first place that she would look was the computer. She stated there was a list of residents who wished to receive CPR at the nurse's station, but it had been moved. She stated Resident #27 was a full code and would require CPR. Observed LVN A on [DATE] at 9:35 AM, looked in Resident #27 EMR and reported he was a resident listed as full code status. No observation of a list of residents who wished to be a DNR was observed at the nurses' station on [DATE]. During an interview on [DATE] at 9:48 AM, RN B stated if someone coded, it is their duty to determine their code status. She said there was a list of residents wishing to receive CPR at the nurses' station. She stated that she had been a nurse at the facility since [DATE], and no one had coded. She said staff could find residents' code status on the computer and the list at the nurses' station. She stated Resident #27's code status was full, which meant they would perform CPR. Observed RN B on [DATE] at 9:49 AM, look in Resident #27's EMR and report that his code status was full code. During an interview on [DATE] at 9:56 AM, the MDS Coordinator stated if a resident codes, they will immediately check to see their code status. She stated the first place would be the computer. She stated if they did not have the information on the computer, she was unsure where the second place would be. She said the PNO for the resident, if the correct code status were not administered, was they, as the staff, may give the resident CPR, and this could make the family mad. She stated there could be many issues. She stated they could bring the resident back, which may not be what they wanted. She stated it was a violation of the resident's rights. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:27 AM, RN C stated if a resident coded, they immediately check to see if they were full code (Required CPR). She stated they would check the computer first and then the grey physical charts. She stated if those two do not coincide or the information was inconsistent, trying to find the correct answer could delay treatment. She stated the staff would have to have the correct information to start the correct code. She stated the PNO was the facility could receive a lawsuit. She stated the resident and or the family would not be happy. She stated if it were her, she would not be happy if the incorrect treatment was performed. She stated the computer was the first place to look, and the charge nurse was responsible for relaying the information on the code status. During an interview on [DATE] at 10:27 AM, Family Member D stated she still wanted the DNR in place. She stated she could not remember who helped her complete the paperwork, but that is a wish and desire of hers and her family. She said she had medical power of attorney, and it states no matter the capacity of his mental status, she could make medical decisions for Resident #27. She stated Resident #27 thinks he can walk and cannot, and his mental status fluctuates. During an interview on [DATE] at 3:22 PM, the DON stated she if a resident codes, and they have DNR code status, she does not expect CPR to be administered. She stated if the resident is a full code, she expected CPR to be administered. She stated the code status in the physical chart and the computer (EMR). She stated that the charge nurse would typically go to the physical chart, but all information should be consistent. Regarding DNR documentation, she was familiar with the facility policy. She stated not having consistent information in the EMR, physical charts, and care plan could affect all involved. She said the PNO of not having the correct code status was if it is not consistent or accurate, a resident could receive the wrong treatment. She said she was unaware of any residents who did not have the correct code status. She stated the system to monitor consistency in code status information was to check all residents' information every quarter. She stated by doing this, they had not identified any inconsistencies. She stated that she expected all information regarding code status to be consistent and accurate. She stated she did not have a reason Resident #27 EMR reflected he was a full code, and the remainder of his information reflected that he was a DNR. She said she was responsible for ensuring that this information was correct. During an interview on [DATE] at 3:55 PM, the ADM stated if a resident codes, she expected her staff to know the resident's code status. She stated each resident's code status was in the EMR. She stated after the staff checks the EMR, they should be able to provide appropriate care. She stated the code status should also be kept in the hard chart. She stated the information should be consistent and accurate. The ADM stated she was familiar with the policy regarding DNR and the accuracy of information regarding code status. She stated the PNO of if code status was inaccurate or inconsistent across platforms, the resident's health and life could be affected. She stated the purpose of having consistent information across facility platforms was that, potentially, the resident's wishes may not be met. She stated she was unaware of residents whose code status was inconsistent across all facility platforms, such as the EMR, care plan, and physical charts. She stated she had been trained that code status should be updated and accurate. She stated the ADON was responsible for updating the resident's EMR and maintaining DNR accuracy. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 4:48 PM, the ADON stated that the nurse should get a crash cart if a resident coded. She stated the nurse could look in the computer in the resident's EMR to determine their code status. She stated that if there is an advance directive, the attached DNR should be there for staff viewing. She stated she expected all code status information to be consistent across facility platforms, such as the EMR, care plan, and physical chart. She stated the DON was responsible for ensuring that all information across the facility platforms was consistent regarding resident code status. She stated she did not have a reason the information was not consistent for Resident #27. Record review of facility policy, Advance Directives, dated [DATE], revealed: Policy Statement The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Definitions Do Not Resuscitate (DNR) - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used. Determining Existence of Advance Directive If the Resident Has an Advance Directive If the resident or the residents representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff. The director of nursing services (DNS) or designee notifies the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the residents medical record and plan of care. The attending physician is not required to write orders for which he or she has an ethical or conscientious objection. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The residents wishes are communicated to the residents direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the residents wishes in care planning meetings. The plan of care for each resident is consistent with his or her documented treatment preferences and/or advance directive. Facility staff are not required to provide care that conflicts with an advance directive. If advance directive documents were developed in another state, the resident must have such documents reviewed and revised (as necessary) by his/her legal counsel in this state before the facility may honor such directives. Changes or revocations of a directive must be submitted in writing to the administrator. The administrator may require new documents if changes are extensive. The interdisciplinary team will be informed of changes and/or revocations so that appropriate changes can be made in the resident medical record and care plan.

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Mitchell County Nursing and Rehabilitation Center	971 W I 20 Colorado City, TX 79512

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150 43344 Based on observation, interview and record review, the facility failed to develop a comprehensive care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs, as well as describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 6 of 14 residents (Resident #10, #24, #27, #34, #36 and #39) reviewed for care plans in that: The facility failed to ensure that Resident #10's care plan was revised, updated and individualized with interventions and goals to address Resident #10's vison and communication. The facility failed to ensure that Resident #24's care plan was revised, updated and individualized with interventions and goals to address Resident #24's vision and communication. The facility failed to ensure that Resident #27's care plan was revised, updated and individualized with interventions and goals to address Resident #27's vision and urinary incontinence. The facility failed to ensure that Resident #34's care plan was revised, updated and individualized with interventions and goals to address Resident #34's vision. The facility failed to ensure that Resident #36's care plan was revised, updated and individualized with interventions and goals to address Resident #36's vision. The facility failed to ensure that Resident #39's care plan was revised, updated and individualized with interventions and goals to address Resident #39's vison, communication, urinary incontinence and psychosocial wellbeing. This deficient practice could place residents in the facility at risk of not being provided with the necessary care or services and not having personalized or individualized plans developed to address specific needs or concerns. Findings included: Resident #10 Record review of Resident #10's face sheet, dated 02/19/25, revealed an [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss), . Record review of Resident #10's Comprehensive MDS, dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 4, which indicated the resident's cognition was severely impaired. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section V Care Area Assessment (CAA) Summary: CAA Results: 03. Visual Function 04. Communication Section B0200. Hearing Coded 1= Minimal difficulty= difficulty in some environments. B0800 Ability to understand others- Coded 1= Usually understands= misses some part/intent of message but comprehends most conversation. B1000. Vision - coded 1 =impaired - sees large print, but not regular print in newspapers/books. B1200 Corrective Lenses: Yes. Record review of Resident #10's care plan, dated 07/15/24, revealed no care plan for visual function or communication. Record review of Resident #10's Physician Order's, dates 02/18/25, revealed: Influenza Vaccination intramuscular solution Prefilled Syringe .5 ML (Order date 07/02/24 Start Date 10/01/24) During an interview on 02/20/25 at 9:17 AM, LVN A stated when talking to Resident #10, staff must speak to her in her right ear and speak loudly. She said she learned this through trial and error. She also stated that Resident #10 wears glasses. During an interview on 02/20/25 at 9:18 AM, RN C stated staff must speak in Resident #10's right ear. She said she learned this through trial and error. She noticed Resident #10 would answer more questions on her right side. During an interview on 02/20/25 at 9:19 AM, Resident #10 could not provide any information regarding her vision and communication ability. Observed on 02/20/25 at 9:19 AM, Resident #10 had her glasses on and had a puzzle book in her lap. Resident #24 Record review of Resident #24's face sheet, dated 02/19/25, revealed an [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include Alzheimer (memory loss) and schizophrenia (chronic mental illness). Record review of Resident #24's Comprehensive MDS, dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 5, which indicated the resident's cognition was severely impaired. Section V Care Area Assessment (CAA) Summary: CAA Results: (List the CAA that triggered and not Care Planned) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03. Visual Function 04. Communication Section B0200. Hearing Coded 1= Minimal difficulty= difficulty in some environments. B0700. Ability to understands others. Coded 1= Usually understands- misses some part. intent of message but comprehends most conversation. B1000. Vision - coded 1 = impaired - sees large print, but not regular print in newspapers/books. B1000. Corrective Lenses: No Record review of Resident #24's care plan, dated 07/19/24, revealed no care plan for visual function and communication. During an interview on 02/20/25 at 10:34 AM, Resident #24 did not provide any additional information regarding his ability to communicate and vision. He stated he could communicate and see. During an interview on 02/20/25 at 10:35 AM, CNA L stated Resident #24 can be demanding and usually communicates in a demanding manner. She also stated Resident #24 can be hostile. She said she practices asking him politely, which usually works even if he was communicating in a demanding manner. She stated that she knew this by working with him but did not know what a care plan was. She said that she believes Resident #24 can see well. Resident #27 Record review of Resident #27's face sheet, dated 02/19/25, revealed an [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include Parkinson's (brain disorder that worsens), constipation (infrequent or uncomfortable bowel movements) and lack of coordination. Resident #27's face sheet revealed that his code status was full code. Record review of Resident #27's Comprehensive Minimum Data Set (MDS), dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 09, which indicated the resident's cognition was moderately impaired. Section V Care Area Assessment (CAA) Summary: CAA Results: (List the CAA that triggered and not Care Planned) 03. Visual Function 06. Urinary Incontinence Section B1000. Vision - coded 1 = impaired - sees large print, but not regular print in newspapers/books. B1000. Corrective Lenses: Yes. Section H-Bowel and Bladder. H0300. Urinary Continence Coded 3=Always incontinent (no episodes of continent voiding). H0400. Bowel Continence Coded 3=Always incontinent (no episodes of continent Bowel Movement) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #27's care plan, dated 01/06/25, revealed no care plan for visual function or urinary incontinence. During an interview on 02/20/25 at 10:30 AM, Resident #27 stated he wore glasses and needed them. He stated he could clean them, but preferred staff do so because they do a better job than he does. He stated that he had three pairs of glasses. He stated he can go to the restroom by himself and does not need any help but likes to have help sometimes when he goes to the restroom. During an interview on 02/20/25 at 11:10 AM, CNA K stated regarding Resident #27, they must assist him in the restroom all the time. She said he used his briefs most of the time but can assist when standing. She stated Resident #27 had dementia, but she typically goes by what the resident says if they tell her any information about themselves. She stated Resident #27 wears glasses, and he cleans his glasses. Resident #34 Record review of Resident #34's face sheet, dated 02/20/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include anxiety, dementia, hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), depression, muscle weakness, pain, heart disease, and hypertension (high blood pressure). Record review of Resident #34's Admission's Minimum Data Set (MDS), dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 7, which indicated the resident's cognition was impaired. Section V Care Area Assessment (CAA) Summary: CAA Results: (List the CAA that triggered and not Care Planned) 03. Visual Function Section B1000. Vision - coded 1 = impaired - sees large print, but not regular print in newspapers/books. Record review of Resident #5's care plan, dated 11/24/24, revealed no care plan for visual function. Record review of Resident #34's Care Plan on 02/19/2025 at 9:50 AM, revealed: Resident #34 was at risk for injuries due to falls due to confusion and weakness. I have impaired vision and wear glasses. I require moderate assist for transfers. I use a walker when ambulating. The goals indicated that Resident #34 would not have injuries due to falls in the next 90 days. The interventions stated: ensure that Resident #34 is wearing glasses, and they are clean, provide a well-lit room to enhance vision. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident #34 on 2/20/2025 at 11:32 AM. Resident #34 stated that she had not been to the eye doctor in a while but does not remember how long it had been. Resident #34 stated that she can see out of her glasses. Resident #34 stated that she can clean her own glasses. Resident #34 stated that she had brought her glasses from home. Resident #34 stated Resident #36 Record review of Resident #36's face sheet, dated 02/19/25, revealed an [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include major depressive disorder, headache, and dizziness. Record review of Resident #36's Comprehensive Minimum Data Set (MDS), dated [DATE], revealed: Section C score revealed a score of 14, which indicated the resident's cognition was not impaired. Section V Care Area Assessment (CAA) Summary: CAA Results: 03. Visual Function Section B1000. Vision - coded 1 = impaired - sees large print, but not regular print in newspapers/books. B1200. Corrective Lenses: Yes Record review of Resident #36's care plan, dated 05/27/24, revealed no care plan for visual function. During an interview on 02/20/25 at 9:13 AM, Resident #36 stated she wore glasses only when she completed her puzzles. She said that she was independent and can clean her glasses. She stated she had multiple pairs and liked to have them match her clothing. Resident #36 stated that when she does not wear her glasses and attempts to do puzzles or read, she gets a headache. Resident #39 Record review of Resident #39's face sheet, dated 02/19/25, revealed an [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include depressive episodes, dysphasia (swallowing difficulties), cognitive communication deficit (a difficulty in communication that arises from an impairment in cognitive functions), reduced mobility, and aphasia difficulty in communicating). Record review of Resident #39's Comprehensive Minimum Data Set (MDS), dated [DATE], revealed: Section C BIMS revealed a score of 06, which indicated the resident's cognition was severely impaired. Section V Care Area Assessment (CAA) Summary: CAA Results: (List the CAA that triggered and not Care Planned) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03. Visual Function 04. Communication 06. Urinary Incontinence 07. Psychosocial Well-Being Section B0600. Speech Clarity Coded 1 Unclear Speech- slurred or mumbled words. B0700 Makes self understood Coded 3= Rarely/never understood. B0800 Ability to Understand Others Coded 1 Usually understands= misses some part/intent of message but comprehends most conversation. B1000. Vision - coded 2 = Moderately impaired - limited vision; not able to see newspaper headlines but can identify objects. B1200 Corrective lenses: No. Section H-Bowel and Bladder. H0300. Urinary Continence Coded 3=Always incontinent (no episodes of continent voiding). H0400. Bowel Continence Coded 3=Always incontinent (no episodes of continent Bowel Movement) Record review of Resident #39's care plan, dated 09/12/24, revealed no care plan for visual function, communication, urinary incontinence, and psychosocial wellbeing. Record review of Resident #39's Physician Order's, dates 02/18/25, revealed: Influenza Vaccination intramuscular solution Prefilled Syringe .5 ML (Order date 08/25/23 Start Date 10/01/24). During an interview on 02/20/25 at 9:08 AM, CNA K stated regarding Resident #39, they figured it out regarding communicating with him. She stated when he gets mad because they do not understand him, she returns and tries again later. She stated she knows to do this because of her certified nurse aide experience. She stated not many staff can communicate with him. She stated Resident #39 used briefs and required total assistance from the staff. She stated Resident #39 does not get sad but gets angry often and does not want to do activities. She stated the staff had to tread lightly with Resident #39. During an interview on 02/20/25 at 9:10 AM, Resident #39 could not speak. He pointed at his TV and his nightstand. During an interview on 02/18/25 at 11:42 AM, Resident #39 could not answer any questions. He had a tough time communicating. After a few attempts to communicate with Resident #39, he became frustrated and waved the investigator out of his room. Resident #39 could not answer questions about his communication preference, vision, psychosocial well-being, and urinary. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/19/25 at 3:00 PM, the MDS Coordinator, stated she was familiar with the care plan policy regarding missing care plans. She stated that a care plan was when there was an identified problem or things that the resident needed to work on. The MDS Coordinator stated there was a goal set and then they (staff and resident) would see if the resident could meet the goal. She stated the PNO of the care plan was not accurate or up to date because the resident could not get proper care. She stated the PNO for a resident who required a vision care plan, and they did not have it, was that the resident could lose their vision if they were not receiving the proper treatment. She stated the PNO for a resident who required a urinary care plan and did not have it was that they could have issues with skin integrity. She stated the PNO for a resident that required a communication care plan, and they did not have it, the resident may be overlooked. Staff would not know to take their time and wait for the resident to communicate if that was the case. She stated the resident's communication could get worse, and the resident could become depressed. She stated the PNO for a resident that required a psychosocial well-being care plan, and they did not have it, so there may not be adequate monitoring for the resident. The MDS Coordinator stated she was unaware of any missing care plans. She stated that the system to monitor care plans was she would put the assessment date on the calendar as the MDS Coordinator. She stated after she completed the MDS assessment she is unsure what happened with the resident care plans. She stated she did not collaborate with the DON regarding the creation/revision and did not know how the care plan connected to the MDS assessment. She stated she had been trained on how to do the MDS assessment but had no training regarding care plans. She said she expected all resident care plans to be updated and accurate. She stated the DON was responsible for the care plans. She stated she was responsible for the MDS assessment, and if there were missing care plans, she did not have a reason. She stated she believed the MDS assessment pulled information from the care plan. She stated the DON creates the CAAs, and she does not deal with section V (CAAs) of the MDS assessment. During an interview on 02/19/25 at 3:22 PM, the DON stated she had been trained on the care plan policy. She stated that the resident plan's purpose was to provide continuous care, so all staff knew what was happening with the resident. She stated if there were any missing care plans, then the PNO, which is the resident, may not get the care they need. She stated the care plan is created based on what was triggered on the MDS assessment (section V). She stated the PNO for a resident who required a vision care plan, and if they did not have it, it could impact their falls. She stated the PNO for a resident who required a urinary care plan, and they did not have it, was that the resident could have skin breakdown. She stated the PNO for a resident that required a communication care plan, and they did not have it, the resident will not be able to be understood and may not understand who is speaking with them. She stated the PNO for a resident that required a psychosocial well-being care plan, and they did not have it, the resident may feel down and may not get out of their room, and it could lead to depression. She stated she was unaware of any missing resident care plans. She stated her system to monitor care plans was that she sometimes would combine triggered care areas to ensure that she had them all care planned. She stated she had been trained on how to complete care plans. She stated that she expected all care plans to be updated and accurate. She stated that as the DON, she was responsible for resident care plans. She stated she did not have a reason for missing care plans as she believed all care plans had been created according to Section V of the MDS assessment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/19/25 at 3:55 PM, the ADM stated regarding the accuracy and creation of resident care plans, she was familiar with the facility policy. She stated the resident care was to inform staff about the resident care and family information. She said the PNO of not having accurate and triggered care plans was the resident may not receive the care they should be receiving. She stated the PNO for a resident who required a urinary care plan, and they did not have the staff would not know if the resident was incontinent. She stated the PNO for a resident that required a communication care plan, and they did not have it was the staff may not know if they had any assistive devices to help them communicate. She stated the PNO for a resident who required a psychosocial well-being care plan and did not have it, the staff may not know if there were any services the resident will need to attend or if there were medications they were required to have. The staff may not know if the resident is acting out of character. She stated she was unaware of any residents missing care plan. She stated the system to monitor resident care plans was they were discussed in morning meetings and that it may be on the dashboard in the EMR (PCC). She stated since she is not a nurse, she may not have access to this information. She stated she had not had specific training on resident care plans but had always consulted with the DON. She stated she expected all care plans to be updated and accurate. She stated the DON was responsible, and the only reason she could think of why there were missing care plans was that they were transitioning from one EMR to another. During an interview on 02/19/25 at 4:48 PM, the ADON stated she was familiar with the facility policy regarding resident care plans. She stated that the purpose of resident care plans was that they were detailed plans of care. Ashe stated that the resident's care plan was tailored to each resident. She stated that everyone used the care plan to provide care. She stated that the PNO was if the care plan was not updated and accurate, the resident may not receive the care they need. She stated the PNO for a resident that required a vision care plan, and they did not have it the resident would not get the care that they needed. She stated the PNO for a resident who required a communication care plan and did not have it, staff would be unable to communicate with the resident or provide the communication devices they may need. She stated the PNO for a resident who required a urinary care plan and did not have it then placed the resident at risk for skin breakdown. She stated the PNO for a resident that needed a psychosocial well-being care plan, and they did not have it she was unsure what the negative outcome would be for the resident. She stated she was unaware of any residents missing any triggered care plans. She stated she did not know the system they used to monitor the care plans. She stated she had not been trained on how to create care plans. She stated the DON was responsible for care plans and was unsure why there would be any missing ones. Record review of facility policy, Care Area Assessments, dated November 2019, revealed: Policy Statement Care area assessments (CAAs) are used to help analyze data obtained from the MDS and to develop individualized care plans. Triggered care areas are evaluated by the interdisciplinary team to determine the underlying causes, potential consequences and relationships to other triggered care areas. Document interventions on the care plan: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include specific interventions, including those that address common causes of multiple issues; and Include recommendations for monitoring and follow-up timeframes CAA documentation explains the basis for the care plan. This documentation should include: causes and contributing factors for the triggered care areas; the nature of the condition or issue (i.e., What exactly is the problem and why is it a problem?); complications contributing to (or caused by) the care area; risk factors related to the condition; Record review of facility policy, Care Planning, dated March 2022, revealed: Policy Statement The interdisciplinary team is responsible for the development of resident care plans. Resident care plans are developed according to the timeframes and criteria established by S483.21. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). Record review of facility policy, Comprehensive Assessments, dated March 2022, revealed: Policy Statement Comprehensive assessments are conducted to assist in developing person-centered care plans. Annual Assessment: Its completion dates (MDS/CAA(s)/ care plan) depend on the most recent comprehensive and past assessments ' ARDs and completion dates. Completed assessments are maintained in the residents active record for a minimum of 15 months. These assessments are used to develop, review and revise the residents comprehensive care plan. Record review of facility policy, Goals and Objectives, Care Plans, dated April 2009, revealed: Record review of facility policy, , date/revised, revealed: Policy Statement (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 43344 Based on interviews and record review, the facility failed to utilize the services of a registered nurse for at least eight consecutive hours per day, seven days per week for 4 days out of 33 days (1/25/25, 1/26/25, 2/8/25 and 2/9/25) reviewed for nursing services. The facility failed to ensure a registered nurse was scheduled for eight consecutive hours per day, seven days per week on the following dates: 1/25/25, 1/26/25, 2/8/25 and 2/9/25. This deficient practice could place residents at risk of not receiving adequate care. Findings included: During an interview on 02/19/25 at 9:48 AM, RN B stated she was an RN. She said she worked every other weekend. As an RN, she had the ability to pronounce death. She stated they were also in the facility if the LVN needs guidance. She said there were times when an LVN may not be able to get a catheter in but will ask for assistance. During an interview on 02/19/25 at 10:27 AM, RN C stated occasionally, she worked the weekends. She stated she had not in a while, but if she did, she clocked in. She stated as an RN, she could pronounce death. She stated if there was an IV, the RN would start them. She stated she does not believe that they did IVs in their facility. She stated the RN assists the LVN with decision-making in critical situations. She stated LVNs could not complete or create a care plan for the residents. She stated if the resident did not feel comfortable the RN could help comfort and be available to the residents. During an interview on 02/19/25 at 3:22 PM, the DON stated she had been trained on the RN coverage policy. The DON stated the purpose of having an RN in the facility was to provide continuous daily care. She stated the RN was there so that they could oversee the shift. She stated the RN could pronounce death if someone passed away. She stated the RN can oversee the care the LVN and CNAs provide. She said the PNO of not having an RN in the facility, according to the policy, was that if something went wrong, they would not be present to give professional oversight. She stated she was unaware of any uncovered days. She stated the system to monitor RN coverage was the ADON ensured it was covered. If there is no coverage, the ADON needed to get an agency and find someone to cover. The DON stated if the ADON could not find coverage and she (the DON) was available, she would come in. She stated she was not available to come in on the days identified. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mitchell County Nursing and Rehabilitation Center	971 W I 20 Colorado City, TX 79512

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 02/19/25 at 3:55 PM, the ADM stated she was familiar with the facility policy regarding RN coverage. She stated the purpose was that it was a state requirement. She stated the PNO of not following the state requirement regarding RN coverage was they would be out of compliance. She stated the LVN can do only so much. She stated the RN could pronounce death. She stated the RN can guide LVNs in the decision-making process. She stated she was unaware of any uncovered days until 02/19/25 when she looked at the time sheets. She stated her system to monitor RN coverage relied on the DON. She stated she had not been trained on the expectations but had read the policy. She stated she expected the policy to be followed. She stated the DON was responsible for ensuring that the facility had the appropriate RN coverage. She stated there was no RN coverage because an RN volunteered to help but then called in. She did not specify the date. She stated if they did not have coverage, they could call agency help. During an interview on 02/19/25 at 4:48 PM, the ADON stated she was familiar with the RN coverage policy. She stated she was unsure of the purpose of having an RN every day for 8 consecutive hours. She stated she was unsure what additional duties or assessments an RN can do vs what an LVN can do outside of pronouncing death. She stated she was unaware of multiple days that were uncovered. She stated she was aware of just one day. She stated she had a volunteer, but the volunteer called in. She stated as a result of the call in, she did not think she made any additional effort to cover the shift. She said they needed to call the agency nurses if they could not find RN coverage. She stated this had been mentioned before but when the volunteer did not come in, she did not think of calling agency. She stated it is typically unsuccessful when they attempt to get an RN at the last minute. She stated the system she used to monitor RN coverage was that every other weekend was always covered, and she typically had no issues covering the alternate weekend. She stated if it is not covered then they attempt to find coverage. She stated she had been trained that the facility had to have RN coverage 7 days a week for 8 consecutive hours. She stated she expected the facility to have RN coverage 7 days a week for 8 consecutive hours. She sated she was responsible for making the schedule. She stated she did not have a reason the four days did not have RN coverage for 8 consecutive hours. Record review of RNB, C, P and Q time sheets for the time period of 1/17/25-02/18/25 revealed there was no RN coverage for 1/25/25, 1/26/25, 2/8/25 and 2/9/25. Record review of facility policy, Director of Nursing Services, dated August 2022, revealed: Policy Statement The nursing services department is under the direct supervision of a registered nurse. Policy Interpretation and Implementation The director is employed full-time (40-hours per week) and is responsible for, but is not necessarily limited to: overseeing standards of nursing practice; coordinating nursing services with other resident services; (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	recruiting and retaining the number and skill levels of nursing personnel necessary to meet the nursing care needs of each resident; Record review of facility policy, Departmental Supervision, dated August 2022, revealed: Policy Statement The nursing services department shall be under the direct supervision of a registered or licensed practical/vocational nurse at all times. Policy Interpretation and Implementation A licensed nurse (RN/LPN/LVN) is on duty twenty-four hours per day, seven (7) days per week, to provide resident care services and supervise the nursing services activities provided by unlicensed staff. A licensed nurse is designated as a charge nurse on each shift. A licensed nurse may be a licensed practical nurse (LPN), licensed vocational nurse (LVN), or registered nurse (RN). A charge nurse is a licensed nurse with designated responsibilities that may include staff supervision, emergency coordination, provider or physician support and direct resident care. The director of nursing services (DNS) may serve as the charge nurse only when the average daily occupancy of the facility is 60 or fewer residents. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled more than eight (8) hours depending on the acuity needs of the resident. A registered nurse (RN) is employed as the director of nursing services (DNS). The DNS is on duty a minimum of 40 hours per week. Record review of facility policy, Staffing, Sufficient and Competent Nursing, dated August 2022, revealed: Policy Statement (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and facility assessment. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49305 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident on 1 of 1 medication cart (cart for hall 100) reviewed for pharmaceutical services. The facility failed to ensure the medication cart for hall 100 did not contain expired medication. This failure could place residents at risk of not receiving prescribed medications as ordered and receiving medications that are less effective or have altered composition. The findings included: An observation 02/19/25 at 9:11 AM of the medication cart for hall 100 with RN B revealed a bottle of expired over-the-counter medication. The medication was labeled: Acetaminophen 500 mg/Diphenhydramine HCl 25 mg and had an expiration date of 11/2024. RN B confirmed that the date of the medication was past the manufacturer's expiration date. During an interview on 02/19/25 at 9:20 AM, RN B stated there should not be expired medication on the medication cart. She stated she did not know why the medication cart contained expired medication. She stated it was the responsibility of the nursing staff to check the cart for expired medications. RN B stated she had only been employed by the facility for a couple of months and was not sure how often the carts were audited by nursing administration for proper medication storage. RN B stated a potential negative outcome for expired medication on the cart would be that a resident could have an adverse reaction or may not receive the therapeutic effect of the ordered medication. During an interview on 02/20/25 at 10:05 AM the DON stated she was not aware that the medication cart contained expired medication. She stated it was the responsibility of the nursing staff on duty to assure expired medications were removed from the medication cart. The DON stated staff were trained and carts were monitored through periodic cart audits conducted by the pharmacy consultant and nursing administration. She stated her expectation of staff was to monitor carts and assure expired medications were removed from the medication cart for destruction. The DON stated a potential negative outcome for expired medication on the cart was that medications may lose potency and the resident would not get the full effect of the medication. During an interview on 02/20/25 at 10:51 AM the ADM stated she was not aware that there was an expired medication on the medication cart. She stated nursing staff and nursing administration were responsible to assure expired medications were removed from the cart. She stated her expectation of staff was to monitor expiration dates of medications and to follow policy at all times. The ADM stated a potential negative outcome of expired medication on the cart was that a resident's health could be negatively affected if an expired medication were administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility-provided policy titled, Medication Labeling and Storage; revised February 2023 revealed: Policy Interpretation and Implementation Medication Storage . 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 3. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49305 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored properly for 1 of 1 medication carts (medication cart for Hall 100), reviewed for medication storage. The medication cart assigned to Hall 100 contained loose pills. This failure could place residents at risk of not receiving prescribed medications as ordered, receiving medications that are less effective or have altered composition, and drug diversions. The findings included: On 2/19/25 at 9:11 AM an observation of the medication cart for Hall 100 was conducted with RN B. Two loose pills were found in the drawer of the medication cart. RN B placed the pills in a dispensing cup and the ADON identified the medications as Furosemide 40 mg (1 tablet) and Cyclobenzaprine 10 mg (1 tablet). RN B destroyed the loose pills by placing them in the sharps container on the medication cart. During an interview on 02/19/25 at 9:20 AM, RN B stated there should not be loose pills on the medication cart. She stated she was not sure why the medication cart contained loose pills. She stated it was her responsibility to check the cart for proper medication storage each time when reporting for duty. RN B stated she received training on proper medication storage through her nursing education. She stated she had only been employed by the facility for a couple of months and was not aware of how often training on proper medication storage was provided by the facility. RN B stated she was trained by nursing administration to assure medication blister packs were kept in hard plastic sleeves in the drawers of the cart to reduce the risk of loose medications. RN B stated a potential negative outcome of loose medications on the cart would be that a resident may miss a scheduled dose of medication. During an interview on 02/20/25 at 10:05 AM the DON stated she was not aware that there were loose pills on the medication cart. She stated it was the responsibility of the nurse on duty as well as nursing administration to assure medications were stored properly on the medication cart. The DON stated staff were trained and carts were monitored through periodic cart audits conducted by the pharmacy consultant and nursing administration. She stated her expectation of staff was to keep medications secured by monitoring carts and assuring pill packs were in protective plastic covers to prevent medications from falling out of blister packs. The DON stated a potential negative outcome for loose pills on the cart was that medications may lose potency and the resident would not get the full effect of the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/20/25 at 10:51 AM the ADM stated she was not aware that there were loose pills on the medication cart. She stated the nurse on duty and nursing administration were responsible to assure medications were stored properly on the cart. She stated her expectation of staff for proper storage of medications was to follow policy at all times. The ADM stated a potential negative outcome for failure to properly store medications was that medications could be more easily accessed, placing the facility at risk of drug diversions and residents could receive the wrong medications. Record review of the facility-provided policy titled, Medication Labeling and Storage; revised February 2023 revealed: Policy Interpretation and Implementation Medication Storage 1. Medications and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received . 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. . 5. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43150 Based on observation, interview, and record review, the facility must store, prepare, and serve food under sanitary conditions, as required by the Texas Department of State Health Services food service sanitation requirements. in 1 of 1 kitchen reviewed for dietary services, in that: 1. The facility failed to ensure canned foods were not expired and dented. 2. The kitchen staff member failed to use proper hand washing while preparing eating utensils. 3. The facility failed to label and properly date foods. These failures could place residents at risk for food contamination and foodborne illness. The findings included: The following observations were made on [DATE] beginning at 09:07 AM during initial observation of the kitchen: Observed the following in the storage panty: 1. 1 can Sweetened Condensed milk (14 oz) with a dent. 2. 2 cans Velvet Evaporated milk; vitamin added (12 oz) dented 3. 4 boxes of Ritz crackers (3.4 oz.) with an expiration of [DATE]. 4. 3 bags (1 lbs.) of Fritos (chips) with an expiration date [DATE]. 5. 2 boxes of white chocolate pudding with an expiration date of [DATE]. 6. 1 zip top sandwich baggie with contents that looked like quarter baggie of coffee grounds, with no label with a date as ,d+[DATE] but no year. 7. 2 packages of Ranch Dressing with an expiration date of [DATE]. 8. 1 can of green chili peppers with the expiration date of [DATE]. During an observation on [DATE] at 10:15 AM, revealed the Dishwasher was observed wrapping silverware in napkins while touching the forks and spoons on the end that went in the mouth without washing her hands and they had no gloves on. During an observation on [DATE] at 9:22 AM, revealed a quarter amount of butter was left out on the counter unwrapped and unattended, for approximately thirty-minutes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on [DATE] at 10:34 AM, revealed the Dishwasher was observed again wrapping silverware in napkins while touching the forks and spoons on the end that went in the mouth without washing her hands and had no gloves on. During an interview on [DATE] at 10:41 AM, the dishwasher stated that she did not know why she was not wearing gloves or did not wash her hands to wrap the silverware and stated that she just did. The dishwasher stated that she had been trained to wash her hands and wear gloves prior to wrapping the silverware. She stated that the manager was responsible for overseeing the training. The dishwasher stated that their training consisted of in-services every couple of weeks. The dishwasher stated that by not wearing gloves or washing her hands while wrapping the utensils it could spread germs and infections. During an interview on [DATE] at 11:10 AM, the Kitchen Manager stated that he was responsible for the training of the staff and had just recently trained on washing hands, last week. The Kitchen Manager stated that he had not realized that there were expired foods in the storage room. He stated that all staff were responsible for helping to clear out the expired foods, but mainly it was his responsibility to make sure that all expired foods are cleared out of the pantry. He stated that staff were to bring the expired foods to his office so he can properly waste them. The Kitchen Manager stated that for the butter that was left out unattended it should have been put up in the refrigerator as soon as it was done being used. The Kitchen Manager stated that the Dishwasher that was observed wrapping the silverware, should have washed her hands and put on gloves. He stated that all staff had been trained through in-services and meetings. He stated that he had covered those topics with the staff several times and he would now resort to disciplinary actions. The Kitchen Manager stated that the negative potential outcome would have been the spread of germs, food poisoning, cross contamination, and foodborne illnesses. During an interview on [DATE] at 11:21 AM the he Dietary Manager stated that she would expect food to be properly disposed if they were outside of the expirations date because it could cause illnesses. The Dietary Manager stated that anyone handling silverware or utensils should properly wash their hands and use gloves because it could cause germs to spread to residents and cause a decline in their health. The Dietician Manager stated that she could be in-serviced on these particular topics. During an interview on [DATE] at 11:43 AM the Administrator stated that she expected staff to follow the policy for all situations especially handling foods and utensils. The Administrator stated that the dietary manager was responsible for training. The Administrator stated that the negative outcome was that it could have affected residents' health. During an interview on [DATE] at 11:50 AM the Administrator stated that she could not find a policy related to expired canned goods. Record review of the FDA Food Code 2022, revised [DATE] reflected the following: Food Codes: ,d+[DATE].11-Personal Cleanliness: FOOD EMPLOYEES shall keep their hands and exposed portions of their arms clean. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	,d+[DATE].12 (A) Cleaning Procedure: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound in a HANDWASHING SINK that is equipped as specified under S ,d+[DATE].12 and Subpart ,d+[DATE]. ,d+[DATE].14 When to wash: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms. (D) After coughing, sneezing, using a handkerchief or disposable tissue, using Tobacco Products, eating, or drinking. (E) After handling soiled Equipment or Utensils. (H) Before donning gloves to initiate a task that involves working with Food. ,d+[DATE] Food Labeling: (A) Food Packaged in a Food Establishment, shall be labeled as specified in Law, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) The common name of the Food, or absent a common name, an adequately descriptive identity statement. Record review of the facility policy, titled Food Receiving and Food Storage, revised [DATE] reflected the following: Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Dry Food Storage: 4. Dry foods that are stored in bins are removed from original packaging, labeled, and dated (use by date) such foods are rotated using a first in-first out system. Record review of the facility policy, titled Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, revised [DATE] reflected the following: Policy Statement: Food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illnesses. Policy Interpretation: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	All employees who handle, prepares, or serves food are trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food to residents. Hand Washing/ Hand Hygiene: a. after personal body functions (i.e., toileting, blowing/wiping nose, coughing, sneezing, etc.). c. whenever entering or re-entering the kitchen. d. before coming in contact with any food surfaces. f. after handling soiled equipment or utensils. Gloves and Direct Food Contact: 9. Gloves are considered single-use items and must be discarded after completing the task for which they are used. Gloves are removed, hands are washed, and gloves are replaced. a. after direct contact with resident. d. between handling soiled and clean dishes. 10. The use of disposable gloves does not substitute for proper handwashing. 12. Gloves are used when serving residents who are on transmission-based precautions. 14. Food service employees are trained in the proper use of utensils such as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of communicable diseases for 2 of 4 residents (Residents #35, and Resident #151) and 2 of 4 staff (RN C and CNA E) reviewed for infection control. RN C failed to sanitize her hands between gloves changes during wound care for Resident #35. CNA E failed to wear PPE during catheter care for Resident #151 who was on EBP. These failures could place residents at risk for spread of infection and cross contamination. Findings included: Resident #35 Record review of Resident 35's face sheet, dated 02/18/25, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include adult failure to thrive (a syndrome of weight loss, poor nutrition, and inactivity that affects older adults), anxiety, dementia (memory loss that interferes with daily life), stage 2 pressure ulcer to left buttock, and hypertension (high blood pressure). Record review of Resident #35's current physician's orders, with a start date of 01/21/25, revealed an order to cleanse stage 2 (partial thickness skin loss) pressure ulcer to left buttock with wound cleanser and apply zinc daily. Record review of Resident #35's admission MDS, dated [DATE], revealed a BIMS score of 12, which indicated the resident's cognition was mildly impaired. Section M-Skin Conditions revealed a stage 2 pressure ulcer that was present upon admission. Record review of Resident #35's comprehensive care plan dated 02/10/25 revealed the resident was admitted to the facility with a stage 2 pressure injury to the left buttock. Interventions included: Administer treatments as ordered and monitor for effectiveness. During a wound care observation on 02/18/25 at 12:33 PM for Resident #35, revealed RN C entered the room, washed her hands, and put on a gown and gloves. RN C explained the procedure to Resident #35 then assisted him to roll to his left side. RN C removed the dressing to the resident's left buttock and placed it in the trash. RN C then removed her gloves, put on new gloves and cleansed the resident's wound, according to the physician's orders. RN C placed a new dressing to the wound and repositioned the resident for comfort. RN C did not sanitize her hands between the glove change. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/18/25 at 1:19 PM, RN C stated she did not sanitize her hands between the glove change. She stated hand hygiene should be performed each time gloves were changed during wound care. RN C stated she realized she failed to sanitize her hands after she had already changed her gloves and continued with wound care. She stated she forgot to set her bottle of hand sanitizer on the prepped table, which would have reminded her to sanitize her hands. RN C stated she was trained on hand hygiene through in-services conducted by nursing administration annually and as needed. RN C stated a potential negative outcome of failure to sanitize hands between glove changes was that bacteria could be spread from resident to resident and wounds could become infected. Resident #151 Record review of Resident 151's face sheet, dated 02/18/25, revealed an [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include Parkinson's Disease (a disorder of the central nervous system that affects movement), dementia, hypertension (high blood pressure), anxiety, and overactive bladder (a disorder of bladder function that causes the sudden need to urinate). Record review of Resident #151's current physician's orders, with a start date of 02/03/25, revealed an order to change Foley catheter monthly and provide catheter care daily on each shift. Record review of Resident #151's admission MDS, dated [DATE], Section H-Bowel and Bladder revealed the resident had an indwelling catheter. During a perineal care and catheter care observation on 02/18/25 at 1:36 PM for Resident #151, revealed CNA E entered the room, washed her hands, and put on gloves. CNA E explained the procedure to Resident #151 then performed female perineal care and catheter care. CNA E repositioned the resident in bed, removed her gloves and washed her hands. CNA E did not put a gown on prior to performing care for the resident. A sign was observed above Resident #151's bed which reflected a gown and gloves were required while performing direct care for the resident. During an interview on 02/18/25 at 1:54 PM, CNA E stated she did not put a gown on prior to performing perineal care and catheter care for Resident #151. She stated she should have worn a gown while performing care because the resident had a catheter. CNA E stated a resident on EBP would require staff to wear a gown and gloves while performing care in order to prevent bacteria from entering wounds and catheters. She stated staff were informed of a resident being on EBP through the report given at shift change. She stated, Most of the time, there is a sign in the room that tells us if we need to put on a gown. CNA E stated she had been trained on EBP through in-services conducted by the ADON. CNA E stated a potential negative outcome for failure to use proper PPE on a resident on EBP would be that the resident could get an infection. During an interview on 02/20/25 at 10:05 AM the DON stated she was not aware that staff were not following proper hand hygiene and EBP protocol. She stated hand hygiene should be performed after each glove change and a gown and gloves should be used when caring for a resident on EBP. She stated it was the responsibility of nursing administration to assure staff were properly trained on hand hygiene and EBP through in-services conducted periodically at the facility. The DON stated her expectation of staff was to follow protocol for hand hygiene and EBP at all times. The DON stated a potential negative outcome for failure to observe proper hand hygiene and EBP protocol would be cross-contamination and the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/20/25 at 10:51 AM the ADM stated she was not aware that staff were not following proper hand hygiene and EBP protocol. She stated it was the responsibility of nursing administration to assure staff were properly trained on hand hygiene and EBP. The ADM stated her expectation of staff was to always follow protocol for hand hygiene and EBP by sanitizing hands and wearing proper EBP when necessary. The ADM stated a potential negative outcome for failure to observe proper hand hygiene and EBP protocol would be that residents and employees were at higher risk of infection. Record review of the facility-provided in-service, dated 03/27/24, revealed: Subject: New State Guidelines for Residents with wounds, feeding tubes and catheters. The document was signed by 28 staff members and had a memorandum attached from the Centers for Medicare and Medicaid Services with a subject of Enhanced Barrier Precautions in Nursing Homes. Record review of the facility-provided policy, date revised March 2024, titled Enhanced Barrier Precautions revealed: Policy Statement Enhanced Barrier Precautions (EBP's) are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment {PPE} is changed before caring for another resident. . 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. wound care (any skin opening requiring a dressing).

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49305 Based on the interview and record review the facility failed to provide each resident or the resident's representative education regarding pneumococcal immunization and failed to document evidence of receiving, refusal, or education regarding pneumococcal immunization, for 2 of 14 residents (Residents #10 and #39). The facility failed to document the influenza immunization status for Resident #10 The facility failed to document the influenza immunization status for Resident #39 This failure placed residents who wanted but did not receive the pneumococcal vaccine, who are at risk for infections and decreased quality of life. Findings included: Resident #10 Record review of Resident #10's face sheet, dated 02/19/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include dementia (memory loss). Record review of Resident #10's Comprehensive Minimum Data Set (MDS), dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 4, which indicated the resident's cognition was severely impaired. Section O [O0250] Influenza Vaccine revealed Resident #10 did not receive the influenza vaccine in the facility because she was not in the facility. Record review of Resident #10's Physician Order's, dated 02/18/25, revealed: Influenza Vaccination intramuscular solution Prefilled Syringe .5 ML (Order date 07/02/24 Start Date 10/01/24). Record review of Resident #10's progress notes dated 10/01/24-02/18/25, did not reveal any documentation indicating that the resident had received or refused the influenza vaccination. During an interview on 02/20/25 at 9:19 AM, Resident #10 could not provide any information regarding whether the flu immunization had been offered or refused. Resident #39 Record review of Resident #39's face sheet, dated 02/19/25, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include depressive episodes, dysphasia (swallowing difficulties), cognitive communication deficit (a difficulty in communication that arises from an impairment in cognitive functions), reduced mobility, and aphasia difficulty in communicating). (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #39's Comprehensive Minimum Data Set (MDS), dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 06, which indicated the resident's cognition was severely impaired. Section O [O0250] Influenza Vaccine revealed Resident #39 did not receive the influenza vaccine in the facility and no reason was given. Record review of Resident #39's Physician Order's, dates 02/18/25, revealed: Influenza Vaccination intramuscular solution Prefilled Syringe .5 ML (Order date 08/25/23 Start Date 10/01/24). Record review of Resident #39's progress notes dated 10/01/24-02/18/25, did not reveal any documentation indicating that the resident had received or refused the influenza vaccination. During an interview on 02/18/25 at 11:42 AM, Resident #39 could not answer any questions. Resident #39 could not answer questions about whether he had been offered or refused immunizations. During an interview on 02/19/25 at 3:00 PM, the MDS Coordinator stated she was familiar with the facility's immunization policy. She stated the purpose of offering immunizations to residents was so they could fight illnesses. The MDS Coordinator said the PNO of not offering necessary immunizations was the residents could get sick and pass illnesses to other residents. The MDS Coordinator stated she was unaware of residents not being offered the influenza (flu) immunization. She stated the system to monitor immunizations was that the ADON headed the process. She stated they were provided a list of names and then went down the list. She stated they do the flu shots in October or November. She stated she had been trained that all immunizations were offered upon admission and during the applicable seasons. She stated she expected all residents to be offered immunizations. She stated she did not have a reason if any immunizations were not offered but that the ADON was responsible. During an interview on 02/19/25 at 3:22 PM, the DON stated regarding resident immunizations she was familiar with the facility policy. She stated the purpose for offering and administering resident immunizations was that it helped prevent the flu. She stated she was unaware of any resident missing immunizations or not being offered until 2/19/25. She stated the system to monitor resident immunizations was the ADON normally kept up with it since she was the infection prevention nurse. She stated she had been trained to offer all applicable immunizations, such as flu, TB, and COVID-19. She stated she did not have a reason the flu immunization was not offered to Resident #10 and Resident #39. She stated she and the ADON were responsible for resident immunizations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/19/25 at 3:55 PM, the ADM stated regarding resident immunizations she was familiar with the policy but only a little. She stated she read the policy. She stated the purpose of offering residents immunizations was to give them a choice of what they want regarding preventative care. She stated it was the resident's right to choose. She stated the PNO of not offering or administering their choice in preventative care was the residents would not be able to decide what they wanted for preventative care. She stated she was unaware of residents who had not been offered or received their flu shot. She stated the system to monitor resident immunizations was the ADON kept up with it. She stated she had not had specific training but read the policy. She stated the ADON was responsible for resident immunizations. The ADM stated she did not know why resident immunizations were not offered or administered. During an interview on 02/19/25 at 4:48 PM, the ADON stated she was familiar with the resident immunization policy. She stated the purpose of offering or administering immunizations was so that residents could receive their immunizations if they wanted them. She stated the PNO for not offering or administering the flu immunization was so the resident would not get the flu. She stated she was unaware that Residents #10 and #39 had no flu vaccines. She stated the system that she used to monitor resident immunizations was that she would make a list. She said she would then give it to the nurses so they could offer and administer the immunization. She stated they offered upon admission, and starting in October, they began with flu immunizations. She stated last year (2024), most residents received their flu immunizations in November and late December because of a wave of sickness that occurred in October. She stated even if the resident was admitted after December 2024, the resident would have still been offered the flu shot. She stated she had been trained on resident immunizations and expected all residents to be offered immunizations upon admission and in the appropriate seasons. She stated she, as the ADON, was responsible, and there was no reason the two residents (Resident #10 and #39) had not received their flu shot or been offered. Record review of facility policy, Director of Nursing Services, dated August 2022, revealed: Policy Statement The nursing services department is under the direct supervision of a registered nurse. Policy Interpretation and Implementation The director is employed full-time (40-hours per week) and is responsible for, but is not necessarily limited to: overseeing standards of nursing practice; coordinating nursing services with other resident services; recruiting and retaining the number and skill levels of nursing personnel necessary to meet the nursing care needs of each resident; Record review of facility policy, Resident Rights , revised February 2021, revealed: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Statement Employees shall treat all residents with kindness, respect, and dignity. Be informed of, and participate in, his or her care planning and treatment Record review of facility policy, Influenza Vaccine , dated March 2022, revealed: Policy Statement All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents (or residents' legal representatives) Policy Interpretation Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident has already been immunized. Residents admitted between October 1st and March 31st shall be offered the vaccine within 5 working days of the resident admission to the facility. A resident refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record. Administration of the influenza vaccine will be made in accordance with current Centers for Disease Control and Prevention recommendations at the time of the vaccination.