STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676274	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Remarkable Healthcare of Seguin	1339 Eastwood Dr Seguin, TX 78155

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observation, interview, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 19 residents (Residents #34) reviewed for accommodation of needs. The facility failed to ensure Resident #34's call light was within reach while he was positioned in her wheelchair. This failure could place residents at risk for delay in care and services, and increased risk of falls and injuries. The findings included: Record review of Resident #34's face sheet, dated 12/04/2024, revealed the resident was [AGE] years old male and an original admitted [DATE] and re-admitted [DATE] with diagnoses that included: Dementia (loss of cognitive function), hemiplegia and hemiparesis (weakness and loss of strength on one side of the body), muscle weakness, muscle wasting and atrophy (muscles to decrease in size and strength), and rhinitis (nasal congestion, sneezing, and itching). Record review of Resident #34's quarterly MDS assessment, dated 11/08/2024, indicated his BIMS score was 99 reflecting he chooses not to participate or gave a nonsensical response. Further record review indicated the resident was dependent (Helper does all of the effort) to toilet hygiene, dressing, personal hygiene, and chair-to-bed transfer. Record review of Resident #34's comprehensive care plan, dated 11/29/2021, reflected [Resident #34] am at risk for falls related to unsteady gait/balance, weakness, and hemiplegia. For intervention - keep call light within reached and encourage to ask for assistance. Observation on 12/02/2024 at 9:16 a.m. revealed Resident #34 was on his wheelchair located in front of his bed in his room, and the call light was on the bed, which was behind him. At 9:18 a.m. revealed Resident #34 said on his wheelchair in his room, Help! Help! However, the resident's voice was very low, so most of staff could not hear the resident's voice. On at 9:25 a.m., CNA-I heard the resident's voice and entered to the resident room to help the resident. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/02/2024 at 9:25 a.m. CNA-I stated Resident #34 was on his wheelchair located in front of his bed in his room, and the call light was on the bed, which was behind him. Resident #34 could not reach his call light. The call light should have been within reached all the time. Resident #34 could use the call light to get help. CNA-I did not know what reason the call light was on the bed. CNAs probably forgot putting the call light on him after transferring the resident from the bed to the wheelchair. Interview on 12/02/2024 at 9:38 a.m. with LVN-J stated Resident #34 could use the call light to get help. The call light should have been within reached all the time. Interview on 12/02/2024 at 4:16 p.m. with DON stated Resident #34 could use the call light to get help. The call light should have been within reached all the time per the facility policy, and if Resident #34 could not use the call light because it was not within reached, the resident's care might be delayed. Record review of the facility policy, titled Answering the call light, revised 09/2003, revealed Be sure that the call light is plugged in at all times. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, and record reviews, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 19 residents (Residents #34) whose assessments were reviewed, in that: The facility failed to ensure Resident #34's quarterly MDS, dated [DATE], correctly assessed the resident's functional limitation in range of motion status as evidence by coding No impairment to upper extremity. However, Resident #34 had impairment regarding function limitation in range of motion to his left arm. These failures could place residents at-risk for inadequate care and services. The findings were: Record review of Resident #34's face sheet, dated 12/04/2024, revealed the resident was [AGE] years old male and an original admitted [DATE] and re-admitted [DATE] with diagnoses that included: Dementia (loss of cognitive function), hemiplegia and hemiparesis (weakness and loss of strength on one side of the body), muscle weakness, muscle wasting and atrophy (muscles to decrease in size and strength), and rhinitis (nasal congestion, sneezing, and itching). Record review of Resident #34's quarterly MDS assessment, dated 11/08/2024, indicated his BIMS score was 99 reflecting he chooses not to participate or gave a nonsensical response. Further record review indicated GG0115: Functional limitation in range of motion in the Section GG (function abilities and goals) was answered No impairment to upper extremity (shoulder, elbow, wrist, and hand). Record review of Resident #34's comprehensive care plan, dated 11/29/2021, reflected [Resident #34] have an alteration in neurological status related to of stroke with left hemiplegia, pseudobulbar affect, and the intervention was physical therapy and occupational therapy evaluated and treat as ordered. Record review of Resident #34's mobility assessment, dated 08/01/2024, reflected Resident #34's upper extremity (shoulder, elbow, wrist, and hand) had impairment on one side. Observation on 12/02/2024 at 9:28 a.m. indicated Resident #34 was on the bed and had contracture (condition of shortening and hardening of muscle) and limitation in range of motion to his left arm. Interview on 12/03/2024 at 5:17 p.m. the Director of Rehab stated Resident #34 had limitation in range of motion to his left arm due to left arm's contracture since the resident was admitted to the facility on [DATE], and the resident was receiving physical therapy including body stretching and range of motion exercise five times a week since 10/30/2024. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/03/2024 at 5:19 p.m. the DON stated Resident #34's quarterly MDS, dated [DATE], was inaccurate regarding No impairment to upper extremity in range of motion because the resident had limitation in range of motion to his left arm. MDS nurse had responsibility to assess the resident accurately. The facility used contracted MDS nurse until hiring full-time MDS nurse, and the contracted MDS nurse should have coded impairment on one side to the resident's function limitation in range of motion to upper extremity. Further interview with the DON stated she did not know what reason the MDS nurses coded it inaccurately, and the inaccurate MDS assessment might cause inaccurate care to the resident. On 12/04/2024 at 1:35 p.m., the surveyor called to the MDS a voice message was left . The MDS nurse did not return phone call prior to exit. Record review of the facility policy, titled Resident assessment instrument, revised 01/2017, revealed The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. Record review of the CMS MDS 3.0 Manual dated October 2023 revealed in part, . The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. The MDS 3. 0 is part of that assessment process and is required by CMS .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 44020 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that are identified in the comprehensive assessment, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 11 residents (Resident #6, Resident #22 and Resident #62) reviewed for care plans. 1. The facility failed to ensure Resident #6's care plan reflected his receiving hospice services and did not have an active care plan. 2. The facility failed to ensure Resident #22's care plan reflected his pain management. 3. The facility filed to ensure Resident #62's care plan reflected his full code status, need for assistance with ADLs (activities of daily living), and only communicating in Spanish. These deficient practices place residents at risk for not receiving proper care and services due to inaccurate care plans. The findings included: 1. Record review of Resident #6's face sheet, dated 12/04/2024, revealed Resident #6 was admitted on [DATE] with a readmitted on 08/22/2024 with diagnoses which included: acute diastolic (congestive) heart failure, chronic atrial fibrillation, unspecified dementia, moderate, without behavioral disturbance, heart failure, hypothyroidism, and hypertension. Record review of Resident #6's Significant change MDS assessment, dated 08/26/2024, revealed Resident #6's BIMS score was 5 for severe cognitive impairment and coded as receiving hospice services while a resident at the facility. Record review of Resident #6's physician order summary report, dated 12/04/2024, read, ADMIT TO [name of hospice service], with an order date of 08/23/2024. Record review of Resident #6's care plan with a closed date of 08/30/2024 and a targeted date 09/04/2024, revealed the care plan was closed and did not have a care plan addressing Resident #6 receiving hospice services. During an interview on 12/03/2024 at 3:32 p.m. with the SW stated the DON would care plan when a resident goes on hospice services. (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 12/03/2024 at 3:55 p.m. the DON stated Resident #6's care plan had been deactivated, did not have a care plan for hospice and did not have an active care plan. The DON further stated Resident #6 not having an active care plan would cause the staff to not be aware of his wishes or how they were to care for him correctly. 2.Record review of Resident #22's face sheet, dated 12/04/2024, revealed the resident was [AGE] years old male and an original admitted [DATE] and re-admitted [DATE] with diagnoses that included pain in left shoulder and muscle wasting and atrophy (muscles to decrease in size and strength). Record review of Resident #22's quarterly MDS, dated [DATE], revealed Resident #22's BIMS score was 15 reflecting his cognitive function was intact. Further record review indicated J0100: Pain Management in the Section J (Health Conditions) was answered the resident received scheduled pain medication as ordered. Record review of Resident #22's physician order, dated 10/31/2024, revealed the resident had the order of Norco (Hydrocodone-Acetaminophen) oral tablet 10-325 mg. Give one tablet by mouth every 6 hours as needed for pain, referral for out-patient rehab for occupational therapy due to shoulder pain, and Monitor level of pain every shift using the following scale: 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain every shift. Record review of Resident #22's nursing note, dated 10/28/2024 and 11/18/2024, revealed the resident was transferred to the local acute hospital due to his shoulder pain per the resident's request. Record review of Resident #22's comprehensive care plan, dated 08/16/2024, revealed there were no care plan regarding pain management. Interview on 12/03/2024 at 1:53 p.m. the DON stated Resident #22 had pain to his left shoulder, and for the pain management, the resident had medications and out-patient therapy, and transferred the resident to the local acute hospital because the resident requested it. IDT discussed the resident's pain. However, the facility did not develop the care plan for pain. Interview on 12/03/2024 at 2:47 p.m. the DON said developing care plans was her responsibility, and forgetting to develop Resident #22's care plan for pain, might cause lack of pain management. 3. Record review of Resident #62's face sheet, dated 12/04/2024, revealed Resident #62 was admitted on [DATE] with a readmitted on 10/19/2024 with diagnoses which included: encounter for orthopedic aftercare following surgical amputation, type 2 diabetes mellitus without complications, polyneuropathy, unspecified, hypertension, acquired absence of right leg below knee, end stage renal disease, unsteadiness of feet, difficulty in walking, not elsewhere classified, and dependence on renal dialysis. Record review of Resident #62's Quarterly MDS assessment, dated 10/26/2024, revealed Resident #62's BIMS score was 11 for moderate cognitive impairment and substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathing self, lower body dressing, sit to lying (the ability to move from sitting on side of bed to lying flat on the bed), and lying to sitting on the side of bed (the ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor and with no back support). (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 #62's physician order summary report, dated 12/04/2024, read, FULLCODE, with an order date of 09/28/2024. Record review of Resident #62's care plan with a target date of 10/09/2024, revealed the care plan did not address Resident #62's need for assistance with ADLs, code status and only communicating in Spanish. During an interview on 12/01/2024 at 10:52 a.m. Family Member A of Resident #62 stated when she is visiting, she would translate for Resident #62 due to him only speaking Spanish. Family Member A further stated Resident #62's Family Member B was present daily, but she also only spoke Spanish. During an interview and observation on 12/03/2024 at 3:32 p.m. with the SW revealed care plans are done by the DON and if she needs assistance the ADON will help with care plans. The SW further stated the SW was responsible for completing the code status, behaviors and communication in the care plan. The SW stated she would typically care plan a resident speaking only Spanish and code status. The SW was observed reviewing Resident #62's care plan on her computer when she stated Resident #62's care plan did not address his Spanish speaking only nor his code status being full code. The SW stated the importance of the care plan was to show the resident's diagnoses, the nursing he gets, any behaviors he has, and what the staff need to look for when caring for him. The SW stated the importance of the code status being care planned was for staff to know what to do and the resident's wishes for resuscitation or not to be resuscitated. She further stated the importance of care planning his communication would make staff aware of the need possibly for a translator. During an interview on 12/03/2024 at 3:55 p.m. the DON reviewed Resident #62/s care plan on her computer of which she revealed ADLs (activities of daily living), communication and code status were not care planned. The DON further stated ADLs, communication and code status were things that would be care planned. The DON stated the ADLs were not care planned which she felt was odd due to the admission care plan when completed usually triggers them in the comprehensive care plan. The DON further stated Resident #62 only speaking Spanish should have been care planned. The DON stated Resident #62 was Spanish speaking mostly. The DON stated the importance of a care plan was to inform the staff of the needs of the resident, how to care for them and what their wishes were. During an interview on 12/04/2024 at 1:55 p.m. with the ADM revealed the DON, a nurse the facility contracts had been doing the care plans. He further stated when they took over in July it was found the care plans had not been done for residents and the issue was part of QA with the goal of completing them being within 90 days. The ADM further stated he believed they were behind on meeting the 90-day goal. (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 facility's Care Plans - Comprehensive policy, revision date April 2010, read, Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation: 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor) develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problems areas; b. Incorporate risk factors associated with identified problems; c. Build on the resident's strengths; d. Reflect resident's expressed wishes regarding care and treatment goals; e. Reflect treatment goals, timetables and objectives in measurable outcomes; f. Identify the professional services that are responsible for each element of care; g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; h. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and i. Reflects currently recognized standards of practice for problem areas and conditions. 4. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 42031 44020 Based on interview and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments person-centered care plan to reflect the current condition for 4 of 19 residents (Resident #4, Resident #25, Resident #30 and Resident #39) reviewed for care plan revisions. 1. The facility failed to ensure Resident #4's care plan was revised quarterly. 2. The facility failed to ensure Resident #25 care plan was revised after Significant Change in condition and when resident returned from the hospital. 3. The facility failed to ensure Resident #30's care plan was revised or reviewed after the quarterly MDS was completed on 09/25/2024. 4. The facility failed to ensure Resident #39's care plan was revised after revised after re-entry to facility and Significant Change in condition. These deficient practices could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included: 1. Record review of Resident #4's face sheet dated 12/4/2024 revealed the resident was admitted to the facility on [DATE], with readmissions on 8/3/2017, and 5/17/2024. Resident #4's diagnoses included secondary parkinsonism, unspecified (any condition that involves the types of movement problems seen in Parkinson disease but is not Parkinson's disease), chronic kidney disease (chronic progressive loss of kidney function), and repeated falls. Record review of Resident #4's quarterly MDS assessment dated [DATE] revealed the resident had a BIMS score of 7 indicating the resident was severely cognitively impaired. The resident was totally dependent on staff for dressing and footwear, and required partial assistance for eating, showering, and personal hygiene. The resident was always incontinent of urine and frequently incontinent of bowel and was at risk of developing pressure ulcers. Record review of Resident #4's EHR (Electronic Health Record) revealed under the care plan tab there was no current care plan for the resident. Under this care plan tab there were three care plans under history, with the newest care plan with a date initiated on 8/3/2022 with a next review date of 6/9/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/03/2024 at 2:30 p.m. the DON stated she was responsible for updating the care plans and she had a PRN (as needed) RN that assisted her. The DON stated she was not sure why Resident #4 had no current care plan and they must have missed revising it in June of 2024. During an interview on 12/4/2024 at 2:00 p.m. the DON stated it was important for the resident's care plans to be revised and current to ensure they received any needed services. 2. Record review of Resident #25's face sheet, dated 12/04/2024, revealed Resident #25 was originally admitted on [DATE] with an admitted [DATE] with diagnoses which included: acute respiratory failure with hypoxia, end stage renal disease, parkinsonism, major depressive disorder, hyperlipidemia, anxiety disorder, and dependence on renal dialysis. Record review of Resident #25's Significant change MDS assessment, dated 10/18/2024, revealed Resident 25 unable to complete the BIMS interview with long- and short-term memory loss. Record review of Resident #25's care plan revealed a start date of 08/18/2024, target date 11/27/2024 and next review date 09/01/2024 without a review having been completed. During an interview on 12/04/2024 at 1:36 p.m. the DON stated regarding the revision of Resident #25's care plan 08/18/2024 it looked like there were some nursing items updated however, the care plan had not been reviewed or revised for the quarter. The DON further stated the facility had been trying to go through all the care plans because they were not getting done before she came to the facility. The DON stated the importance of revision was to be up to date on the care of the resident for the staff to know how to care for the resident. 3. Record review of Resident #30's face sheet, dated 12/04/2024, revealed the resident was [AGE] years old male and an original admitted [DATE] and re-admitted [DATE] with diagnoses that included: displaced intertrochanteric fracture of left femur (fracture to hip area), heart failure (does not pump enough blood for the body's need), muscle wasting and atrophy (muscles to decrease in size and strength), hypertension (high blood pressure), and chronic obstructive pulmonary disease (restricted airflow and breathing problems). Record review of Resident #30's quarterly MDS, dated [DATE], revealed Resident #30's BIMS score was 15 reflecting his cognitive function was intact. Record review of Resident #30's comprehensive care plan revealed the care plan's start date was 03/24/2024, and next review date for the care plan was 06/04/2024. However, there was no reviewed or revised care plan since 06/04/2024. Interview on 12/03/2024 at 11:07 a.m. the DON stated Resident #30's care plan was not revised or reviewed after the resident's quarterly MDS was completed on 09/25/2024. The facility generally had IDT meeting after completion of quarterly MDS, but the DON did not know what reason she did not revise the resident's care plan. Updating or revising the care plan was IDT and DON's responsibility, and not revising care plan after comprehensive assessment might cause incorrect care to the resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of Resident #39's face sheet, dated 12/04/2024, revealed Resident #39 was originally admitted on [DATE] with an admitted [DATE] with diagnoses which included: other cerebral infarction, unspecified atrial fibrillation, hemiplegia, unspecified affecting right nondominant side, aphasia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and traumatic subdural hemorrhage without loss of consciousness subsequent encounter. Record review of Resident #39's MDS assessments indicated the following: *Entry MDS completed 09/07/2024 *5-day MDS dated [DATE] *Significant Change MDS assessment, dated 10/18/2024 The Significant Change MDS assessment revealed Resident #39 unable to complete the BIMS interview with long- and short-term memory loss. Record review of Resident #39's care plan revealed a start date of 12/01/2024, target completion date 03/20/2025 without a review having been completed after her return form the hospital. During an interview 12/03/2024 at 3:55 p.m. the DON revealed when Resident #39 returned from the hospital they should have reviewed his care plan. DON further stated they just didn't catch it which was why the care plan had not been revised. Record review of facility's Care Plans - Comprehensive policy, revision date April 2010, read, Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation: 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor) develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problems areas; b. Incorporate risk factors associated with identified problems; c. Build on the resident's strengths; d. Reflect resident's expressed wishes regarding care and treatment goals; e. Reflect treatment goals, timetables and objectives in measurable outcomes; f. Identify the professional services that are responsible for each element of care; g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; h. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and i. Reflects currently recognized standards of practice for problem areas and conditions. 4. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). 5. The Care Planning/Interdisciplinary Team is responsible for the periodic review and updating of care plans: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; When the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the CMS MDS 3.0 Manual dated October 2023 revealed in section 2-44, Care plan completion based on the CAA process is required for OBRA-required comprehensive assessments. It is not required for non-comprehensive assessments (Quarterly, SCQA), PPS assessments, Discharge assessments, or Tracking records. However, the resident's care plan must be reviewed after each assessment, as required by S483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observation, interviews, and record review, the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice for 1 of 3 (Resident #30) reviewed for respiratory care. Resident #30's physician order indicated the resident had oxygen via nasal cannular on 2 liter per minute, but the resident was observed on 12/01/2024 at 3:10 p.m. receiving oxygen 2.5 liter per minutes and on 12/03/2024 at 11:30 p.m. receiving 3.5 liter per minutes. This failure could affect residents with oxygen therapy and could lead to care as ordered by the physician. The findings included: Record review of Resident #30's face sheet, dated 12/04/2024, revealed the resident was [AGE] years old male and an original admitted [DATE] and re-admitted [DATE] with diagnosis of chronic obstructive pulmonary disease (restricted airflow and breathing problems). Record review of Resident #30's quarterly MDS, dated [DATE], revealed Resident #30's BIMS score was 15 reflecting his cognitive function was intact, and Section O (Special treatment and program indicated the resident was receiving oxygen therapy. Record review of Resident #30's physician order, dated 02/08/2023, revealed the resident had the order of oxygen at 2 liter per minute via nasal cannular continuously for chronic obstructive pulmonary disease. Observation on 12/01/2024 at 3:10 p.m. revealed the resident was on the bed and receiving oxygen via nasal cannula, and the oxygen rate was setting on 2.5 liter per minutes. Observation on 12/03/2024 at 11:30 p.m. revealed the resident was receiving oxygen with rate of 3.5 liter per minutes. Interview on 12/03/2024 at 11:39 a.m. with RN-E stated Resident #30 was receiving oxygen via nasal cannula with the rate above 2 liter per minutes. RN-E stated when the nurse checked the resident's oxygen rate as the beginning of shift, the oxygen rate was 2 liter per minutes. The nurse did not know what reason the oxygen rate was above 2 liter per minutes. The nurse had responsibility to check oxygen rate, and the resident might be over oxygenated. Interview on 12/04/2024 at 1:16 p.m. with DON stated the facility nurses should have followed physician order for oxygen rate, and for Resident #30, it was 2 liter per minute. Record review of the facility policy, titled Oxygen Administration, revised 03/2012, revealed Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

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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. 39049 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 for 1 of 2 medication room (Recovery Medication Room) and 1 of 4 medication carts (Recovery Nursing Cart) reviewed for pharmacy services. 1. There was one bottle of medication (Ocular Vitamins for eye) expired on 09/2024 found inside the Recovery medication room on 12/04/2024. 2. There was one gel of medication (antimicrobial skin and wound gel hospital and professional use only) expired on 08/01/2024 found inside the Recovery nursing cart on 12/04/2024. These failures could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. The findings included: 1. Observation on 12/04/2024 at 10:14 a.m. revealed there was one bottle of medication (Ocular Vitamins for eye) expired on 09/2024 found inside the Recovery medication room. Interview on 12/04/2024 at 10:14 a.m. the ADON stated there was one bottle of medication (Ocular Vitamins for eye) expired on 09/2024 found inside the Recovery medication room. The ADON stated she did not know why the expired medication was in the medication room. The facility medication aides usually reviewed the medication room weekly, and the facility nurses had responsibility to remove all expired medications from the medication room. Using expired mediation to residents might cause incorrect therapeutic effects. 2. Observation on 12/04/2024 at 10:26 a.m. revealed there was one gel of medication (antimicrobial skin and wound gel hospital and professional use only) expired on 08/01/2024 found inside the Recovery nursing cart. Interview on 12/04/2024 at 10:29 a.m. the ADON stated there was one gel of medication (antimicrobial skin and wound gel hospital and professional use only) expired on 08/01/2024 found inside the Recovery nursing cart, and per the facility policy all expired medications could not be inside the nursing and medication aide carts. The Recovery nurse had responsibility to review their carts and removed all expired medications. Using expired mediation to residents might cause incorrect therapeutic effects. Interview on 12/04/2024 at 10:31 a.m. with Recovery nurse LVN-F stated he did not know why the medication (antimicrobial skin and wound gel hospital and professional use only) was in the cart. LVN-F said he did not use the medication, but it should have been removed from the cart because it was already expired. (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 policy, titled Administering Medications, revised 04/2011, revealed The expiration date on the medication label must be checked.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on interview and record review, the facility failed to ensure each resident's drug regimen be free from unnecessary drugs without adequate indications for its use for 1 of 5 (Resident #30) reviewed for unnecessary medications. The facility failed to discontinue Resident #30's Melatonin 5 mg for sleep after the resident's primary care physician agreed on 09/18/2024 to the pharmacist's recommendation on 08/21/2024, which was for Resident #30, melatonin 5 mg due for gradual dose reduction, consider as needed for 14 days, then discontinue. This failure could lead to residents being prescribed medications without indication and place residents at risk of unnecessary side effects and a decline in overall health. Findings included: Record review of Resident #30's face sheet, dated 12/04/2024, revealed the resident was [AGE] years old male and an original admitted [DATE] and re-admitted [DATE] a diagnosis of insomnia (difficulty of sleeping). Record review of Resident #30's quarterly MDS, dated [DATE], revealed Resident #30's BIMS score was 15 reflecting his cognitive function was intact. Record review of Resident #30's pharmacy review, dated 08/21/2024, revealed the pharmacist recommended Melatonin 5 mg at hours at sleep due to for gradual dose reduction, consider as needed for 14 days then discontinue. Record review of Resident #30's Note to attending physician, dated 09-18-2024, revealed Resident #30's primary care physician agreed to the pharmacist recommendation (Melatonin 5 mg at hours at sleep due to for gradual dose reduction, consider as needed for 14 days then discontinue). Record review of Resident #30's physician order, start dated 10/31/2023, revealed the resident had the order of Melatonin oral tablet 5 mg give one tablet by mouth at bedtime for insomnia (difficulty of sleeping). Record review of Resident #30's medication administration record, dated from 12/01/2024 to 12/31/2024 revealed the resident was still receiving his Melatonin oral tablet 5 mg by mouth at bedtime for insomnia. Interview on 12/03/2024 at 3:44 p.m. the DON stated Resident #30 was still taking his Melatonin 5 mg one tablet by mouth at bedtime, and the pharmacist recommended on 08/21/2024 For Resident #30 Melatonin 5 mg at hours at sleep due to for gradual dose reduction, consider as needed for 14 days then discontinue. The DON notified it to the resident's primary care physician, and the physician agreed it on 09/18/2024. However, the DON forgot discontinuing Resident #30's melatonin. It was DON's responsibility to make sure following pharmacist recommendations and physician orders. The resident did not have gradual dose reduction trials. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, titled Pharmacy Services, revised 12/2010, revealed Collaborate with the staff and practitioners to address and resolve medication-related needs or problems; Help establish procedures for conducting the monthly medication regimen review (MRR) for each resident in the facility; Help the facility establish procedures related to medication regimen reviews for individuals who are anticipated to stay less than 30 days or when residents experience acute changes of condition; Help develop procedures and guidance regarding when to contact a prescriber about a medication issue.

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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. 39049 Based on observation, interview, and record review, the facility failed to ensure all drugs and biological were stored in locked compartments for 1 of 4 nursing carts (treatment cart) reviewed for storage, in that: The facility failed to ensure the Treatment Cart was locked when left unattended. This failure could place residents at risk of misappropriation of medications or harm due to accidental ingestion of unprescribed mediations. The findings were: During an observation on 12/02/2024 at 11:57 a.m. revealed the treatment cart was found unlocked and unattended on the 200 hall. This surveyor was able to open all drawers revealing multiple creams, scissors, and bottles of medications. Interview on 12/02/2024 at 11:58 p.m. with Wound care nurse RN-G stated the treatment cart was unlocked and unattended on the 200 hall. The wound care nurse RN-G stated he did not realize he left the treatment cart unlocked. The wound care nurse RN-G stated it was important the treatment cart was locked at all times due to resident, visitor, and staff safety. The wound care nurse RN-G stated by the treatment cart being unlocked, anyone could get into the cart and take medications or scissors from the cart. Interview on 12/02/2024 at 4:16 p.m. the DON stated the treatment cart should not have been unlocked as it would not be safe for residents and visitors. The DON stated if the treatment cart was not locked someone other than the nurse, like a resident with dementia, could open the medication cart, take out the medications and take them. The wound care nurse was responsible for overseeing this and monitored if or not the treatment cart was locked sometimes. Record review of the facility's policy, titled Administering Medications, revised 04/2011, revealed . 11. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 44020 Based on observation, record review, and interviews, the facility failed to ensure resident received food prepared in a from designed to meet individual needs for 1 of 2 meals, reviewed for nutrition services. The facility failed to ensure the breakfast meal served on 12/03/2024 had the appropriate consistency for the meat serving for the puree textured diet. This deficient practice could affect residents who received pureed meals from the kitchen by contributing to choking, poor intake, and/or weight loss. The findings included: Observation on 12/03/2024 at 8:40 a.m. revealed [NAME] D preparing breakfast plates for puree residents with meat (sausage) that appeared grainy, closer to a fine ground meat consistency than a pudding consistency. [NAME] D put gravy over the meat as he served the plates. [NAME] D placed a scoop of the puree meat on a plate when asked about the texture of the meat. The DM then took a plastic spoon and mashed the puree meat. The DM after mashing the meat with a plastic spoon then removed from the serving line and pureed the meat. [NAME] D only had 2 tray tickets remaining when the puree meat was removed from the serving table to be processed more by the DM. Observation, record review and interview on 12/03/2024 at 11:12 a.m. revealed [NAME] D preparing puree chicken fried steak with gravy for the lunch meal using microwave warmed milk as the liquid to assist with the processing of the pureed chicken fried steak. Review of the recipe book read gravy to be used when pureeing the chicken fried steak. [NAME] D stated he did not know to use the recipe book and had been instructed to use milk when preparing the chicken fried steak. During an interview on 12/04/2024 at 12:43 p.m. the DM stated the facility had 9 residents who received puree diets. The DM further stated they are served last. The DM could not recall if any purees had been served however, stated there may be some residents who received a puree diet may have eaten in their room, she was not sure who was present the day before in the dining room for the breakfast meal. During an interview on 12/04/2024 at 12:47 p.m. the DM stated she has not had any in-services regarding training meal texture preparation. The DM stated they had had in-services to follow the recipe when preparing diets. The DM further stated the sausage did look to dry to be pureed consistency. The DM stated puree diets are for residents with swallowing issues. She stated the resident could be at risk of chocking or aspiration by receiving non-puree food. During an interview on 12/04/2024 at 1:40 p.m. the DON stated if the diet was not right consistency a resident could choke on it, and possibly get aspiration pneumonia. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/04/2024 at 1:42 p.m. the DM and DON revealed the facility did not have a policy regarding diet textures and preparation. The DM stated the recipe told staff how to make the puree. During an interview on 12/04/2024 at 1:45 p.m. the ADM stated food consistencies should reflect the order when served. The ADM stated pureed diets should have a pudding consistency. The ADM further stated they do not want residents to suffer aspiration pneumonia if served the wrong diet.

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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** 44020 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen observed for kitchen sanitation. 1. The facility failed to ensure 4 pitchers of beverages were covered and dated when prepared. 2. The facility failed to ensure box of powder sugar was dated with open date. 3. The facility failed to ensure opened bag of spaghetti was properly sealed with an opened date. 4. The facility failed to ensure opened bag of elbow noodles was dated with an opened date. 5. The facility failed to ensure food temperatures were taken in a sanitary fashion. 6. The facility failed to ensure staff with facial hair was covered by a hair restraint. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: Observation on [DATE] at 9:24 a.m. during the initial tour of the kitchen revealed in the standing refrigerator 3 pitchers of beverages not dated with what looked to be apple juice, orange juice and milk all were approximately ,d+[DATE]th emptied and a large pitcher toward the back with what looked to be a juice with no lid and no date. Further observation during the initial tour of the kitchen revealed in the pantry an opened box of powder sugar half empty with no date as to when it was opened, a 10-pound bag of spaghetti in a zip lock bag with top of bag opened to air not dated as to when it was opened, and a quarter of a bag of elbow macaroni noodles with the open end tied off not dated when opened. During an interview on [DATE] at 9:31 a.m. [NAME] A stated she did not know when the spaghetti and elbow pasta were opened and didnot know when it was used. [NAME] A further stated it should have been dated. [NAME] A stated it was important to date items due to it could be dangerous to serve them not knowing when it was opened, and it could cause sickness. [NAME] A stated she did not prep the juices. During an interview and observation on [DATE]at 9:40 a.m. the DA B stated the drinks should be dated when they were prepared. DA B further stated it could make people sick if they did not know when the juice had been prepared. DA B stated he was not there when juices were prepared, but when he came to work there were already there. DA B removed the beverages from the refrigerator and threw them out. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE] at 4:14 p.m. revealed [NAME] C taking the food temperatures. [NAME] C was observed while taking temperatures of ground meat, beans, and rice would place the digital thermometer in iced water and wipe with napkin then place in the next item to take temperature of the food item. Observation on [DATE] at 4:20 p.m. revealed when the DM when asked how staff typically took the temperature of food, she gathered the items from the table including alcohol swabs, pieces of napkin and the digital thermometer. The DM used the digital thermometer after wiping with alcohol swab took the temperature of puree beans. During an interview on [DATE] at 4:26 p.m. with the DM and [NAME] C the DM stated alcohol swabs should be used when taking temperatures of items due to it would not being sanitary going from one item to another. [NAME] C stated the digital thermometer should be sanitized stating by not sanitizing it could cause contamination of the food. [NAME] C further stated by not sanitizing the thermometer could make residents sick. Observation on [DATE] at 8:30 a.m. revealed [NAME] D not wearing a beard restraint (hair net) with a mustache, beard to his chin and hair along the jaw line while preparing breakfast plates. During an interview and observation on [DATE] at 8:45 a.m. [NAME] D stated he did not normally have facial hair so he does not usually need a beard net. [NAME] D further stated beard nets were worn so hair would not go in the food. [NAME] D was not able to explain the risk of hair going into the food. [NAME] D upset by questions regarding beard restraint, stated he wasn't stupid as he was observed to continue to prepare plates and did not put on beard restraint. [NAME] D finished preparing plates. The DM was observed to then provide [NAME] D with a beard restraint. During an interview on [DATE] at 8:50 a.m. the DM stated the purpose of the beard restraints were to prevent hair from going into the food. The DM further stated they prevent cross contamination of the food. The DM stated by hair getting into the food it could cause residents to get sick or even choke on the hair. During an interview on [DATE] at 3:55 p.m. the DON stated beard restraints were used so hair did not fall in the food. The DON further stated if hair was to get in the food it could cause food contamination and the resident could get sick. During an interview on [DATE] at 12:47 p.m. the DM stated pasta noodles should be stored in a zip lock bag, sealed properly, dated with the opened date. The DM stated sealing dried items prevented contamination and by ensuring the opened date was on items ensued staff knew when it was opened. The DM stated beverages should have lids or be covered with a date it was put in the pitcher. The DM further stated beverages could be in the refrigerator for 3 days from the poor date. She stated by not knowing the date it was poured it could be contaminated and make someone sick. (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 interview on [DATE] at 1:45 p.m. with the ADM revealed dried food items should be in a resealable container or in a sealable package with a date. The ADM further stated by dating items when opened was for staff to know it was fresh and not expired. The ADM stated by sealing items keep them from getting pest in them and it would stay fresh. The ADM stated beard guards kept hair from getting in the food. He further stated staff were to wear beard restraints any time they were in the kitchen just like a hair net. The ADM stated beard restraints keep hair out of the food and was important due to the hygiene issue. The ADM stated food temperatures should be taken with a digital thermometer, and an alcohol wipe should be used between food items. Review of facility's policy, Food Receiving and Storage, date revised [DATE], read, Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation: 6. Dry foods that are stored in bins will be removed from original packaging, labeled, and dated (use by date). Such food will be rotated using a first in - first out system. 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). Review of facility's policy, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, Policy Statement: Food Services employees shall follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness., Policy Interpretation and implementation: 12. Hair nets or [NAME] and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, ,d+[DATE].11, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposited to splash, dust, or other contamination. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, ,d+[DATE] Hair Restraints, ,d+[DATE].11, Effectiveness., (A) Except as provided in paragraph (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.

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	676274	A. Building B. Wing	12/04/2024

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Remarkable Healthcare of Seguin	1339 Eastwood Dr Seguin, TX 78155

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42031 Based on observation, interview and record review the facility failed to ensure that the hospice services met professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services for 1 of 3 residents (Resident #27) reviewed for administration: There were no hospice nursing notes, records of visits or care available for Resident #27 at the facility. This failure could place residents receiving hospice services at risk of not receiving their needed services and care, and a decreased continuity of care between facility staff and hospice staff. The findings were: Record review of Resident #27's face sheet dated 12/4/24 revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #27's diagnoses included heart failure (the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen.), age related cognitive decline (refers to the concern of or difficulty with a person's thinking, memory, concentration, and other brain functions beyond what is typically expected due to aging), muscle wasting, and atrophy not elsewhere classified multiple sites (wasting or loss of muscle tissue). Record review of Resident #27's annual MDS assessment dated [DATE] indicated the resident's BIMS was blank and staff assessment of cognitive skills indicated the resident was moderately impaired cognitively. The resident was always incontinent of urine and bowel and had medically complex conditions. The resident was on hospice care. Record review of Resident #27's care plan with a print date of 12/4/24 sent by the facility revealed the resident was admitted to hospice services on 10/27/24. There were no interventions listed for hospice services. There were no dates of focus initiation, goals, or revisions on this care plan for any problems listed. Record review of Resident #27's EHR on 12/2/24, 12/3/24, and 12/4/24 revealed no documentation from hospice nurse visits or hospice care staff. Record review of Resident #27's hospice notes that were faxed to the DON on 12/2/24 at 4:03 p.m. revealed 15 pages of hospice nursing communication notes detailing resident observations, vital signs, and interviews with the resident and family including phone calls and requests from the resident's family. Documentation dates were 10/27/24, 10/28/24, 10/29/24, 10/30/24, 10/31/24, 11/1/24, 11/2/24, 11/5/24, 11/7/24, 11/8/24, 11/12/24, 11/18/24, 11/19/24, 11/20/24, 11/26/24, 12/1/24, and 12/2/24. During an observation on 12/02/24 at 12:10 p.m. hospice staff X2 arrived and entered Resident #27's room and were speaking with the resident and family and were about to provide a bed bath. The resident's family was updating hospice staff that the hospice nurse changed her medications because when they would move the resident she would holler out as if in pain. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations on 12/2/24 at 12:25 p.m., 12/3/24 at 3:00 p.m., and 12/4/24 at 11:30 a.m. Resident #27's hospice services binder located at the nursing station revealed handwritten orders to admit the resident to hospice dated 10/27/24, a hospice visit note dated 10/27/24, and a visitation log with one visit logged on 10/27/24. There was no other documentation and no nursing visit notes. In an interview on 12/2/24 at 12:20 p.m. RN E stated the hospice service binder should have all the hospice notes for resident #27 and further stated all hospice residents had their own binders and she had not seen any hospice notes in the EHR as their systems are different. RN E was unsure who was responsible for putting the notes in the binder. RN E stated the hospice nurses give the facility nurses a verbal report on their visits. In an interview on 12/2/24 at 12:45 p.m. the DON stated all hospice visits and notes from hospice nurses should be in the hospice binder at the nurses' station. The DON further stated that was the only place the hospice nursing notes were kept and she would contact them immediately. The DON stated hospice was responsible for getting their notes to the facility. In an interview on 12/02/24 at 4:30 p.m. hospice RN S stated she was the on-call nurse and she had visited the resident on 12/1/24 and had put new orders in for the resident. RN S further stated they have their own computer system that they document on and she was unsure of when or how their notes get to the resident's record. RN S stated she was not the resident's regular hospice nurse and RN T was her regular hospice nurse. In an attempted interview on 12/4/24 at 11:26 a.m. a call was placed to hospice RN T and a message left. Did not receive a return call. In an interview on 12/04/24 at 2:00 p.m. the DON stated it was important that hospice notes be available so that the facility knows what services were provided by hospice and to ensure continuity of care and to know what was going on with the resident. The facility hospice documentation policy was requested from the DON on 12/4/24 at 12:35 p.m. and was never received.

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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** 39049 Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 2 residents (Residents #48 and #59) of 19 residents reviewed for infection control. 1. The facility failed to Resident #48's suction tube Yankauer (oral suction tool used in medical procedure) to be covered in a plastic bag when it was not used on 12/01/2024. The Yankauer was connected to the suction machine and hanging without a plastic bag. 2. When CNA-H was providing incontinence care to Resident #59, the CNA-H had multiple pass with one wipe and touched new and clean brief with old and dirty gloves on 12/03/2024 at 2:07 PM. These deficient practices could place residents at risk for cross contamination and infections. The findings included: 1. Record review of Resident #48's face sheet, dated 12/04/2024, revealed the resident was [AGE] years old female and admitted [DATE] and readmitted to the facility on [DATE] with the diagnosis of encephalopathy (brain dysfunction), muscle wasting and atrophy (muscles to decrease in size and strength), hypertension (high blood pressures), Acute upper respiratory infection (runny nose, sore throat, and cough), and hypothyroidism (not enough thyroid hormone in the body). Record review of Resident #48's significant change MDS, dated [DATE], revealed her BIMS score was 0 of 15 reflecting she had severe cognitive impairment, and the resident required supervision or touching assistance (Helper provides verbal cues or touching/steadying assistance as resident completes activity) to oral hygiene. Record review of Resident #48's care plan, date initiated 08/30/2024, revealed [Resident #48] has a significant weight loss related to swallowing impairment, poor intake, and aging process - Intervention: Staff to assist neighbor as necessary. Observation on 12/01/2024 at 11:50 a.m. revealed a suction tube Yankauer was connecting to the suction machine and hanging on Resident #48's nightstand. The Yankauer was not covered in a plastic bag. Interview on 12/01/2024 at 11:54 a.m. with RN-E stated Resident #48's Yankauer was not covered in the plastic bag connected to the suction machine was on Resident #48's nightstand, and the Yankauer was hanging. Further interview with the RN-E said nurses should have covered the Yankauer in a plastic bag when not using it to prevent infection. The nurse did not know what reason the Yankauer was not covered in a plastic bag when not using it. The potential harm was the resident could have infection. Interview on 12/02/2024 at 4:16 p.m. with the DON stated nurses should have covered the Yankauer in a plastic bag when they did not use it to prevent infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #59's face sheet, dated 12/04/2024, revealed the resident was [AGE] years old male and admitted [DATE] to the facility with the diagnosis of malignant neoplasm of prostate (prostate cancer), dementia (loss of cognitive function), repeated falls, muscle wasting and atrophy (muscles to decrease in size and strength), and need for assistance with personal care. Record review of Resident #59's significant change MDS, dated [DATE], revealed his BIMS score was 2 of 15 reflecting he had severe cognitive impairment, the resident required partial/moderate assistance (Helper does less than half the effort) to toilet hygiene and chair-to-bed transfer, and the resident was occasionally incontinent to bowel and bladder. Record review of Resident #59's comprehensive care plan, initiated dated 06/05/2024, revealed I [Resident #59] have activities of daily living self-care performance deficit - intervention: required assistance to use toilet. Observation on 12/03/2024 at 2:07 p.m. revealed CNA-H was cleaning Resident #59's genital area with wipe, and the CNA-H was cleaning the area with multiple pass by one wipe, then turned the resident to right side. CNA-H was cleaning the resident's buttock area and put the new and clean brief under the resident's buttock area with the old and dirty gloves, then CNA-H closed the brief. Interview on 12/03/2024 at 2:30 p.m. CNA-H stated she cleaned Resident #59's genital area with multiple pass by one wipe and touched the new and clean brief with the old and dirty gloves. Further interview with the CNA-H stated she should have cleaned the resident's genital area with only one pass by one wipe and touched the new and clean brief with new and clean gloves by changing the CNA-H's gloves after sanitizing her hands to prevent possible infection. The CNA-H forgot them because she was nervous. Interview on 12/04/2024 at 1:16 p.m. the DON said the CNA-H should clean Resident #59's genital area with one pass by one wipe and touched the new and clean brief with the new and clean gloves. Clean to clean and dirty to dirty to prevent possible infection. The DON had responsibility to monitor and provide training CNAs for infection control, and DON provided a lot of training for infection control in 2024 but did not know what reason the CNA did not follow the instructions. The CNA might be very nervous. Record review of the facility policy, titled Hand washing/Hand hygiene, revised 04/2010, revealed Hand washing - After handling soiled or used linens, dressings, bedpans, catheters and urinals; After handling soiled equipment or utensils; After performing your personal hygiene (hand washing with soap and water); After removing gloves or aprons; and After completing duty.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 39049 Based on interview and record review, the facility failed to ensure Quality Assurance Performance Improvement (QAPI) Training that outlines and informs staff of the elements and goals of the facility's QAPI program for 10 of 19 staff (CNA-K, CMA-L, CMA-M, CMA-N, CNA-O, Hospitality-P, CNA-Q, Hospitality-R, Dietary Manger, and Activity Director) reviewed for training, in that: The facility failed to ensure that CNA-K, CMA-L, CMA-M, CMA-N, CNA-O, Hospitality-P, CNA-Q, Hospitality-R, Dietary Manger, and Activity Director had completed their mandatory QAPI annual training. This failure could place residents at risk for care by staff who had been insufficiently trained while working in the facility. The findings included: Record review of the annual staff training information revealed the following staff had not completed their mandatory QAPI annual training requirement: *CNA-K (hired 11/02/2023), *CMA-L (hired 05/09/2023), *CMA-M (hired 11/14/2019), *CMA-N (hired 01/18/2021), *CNA-O (hired01/13/2021), *Hospitality-P (hired09/23/2023), *CNA-Q (hired08/07/2023), *Hospitality-R (hired11/22/2022), *Dietary Manger (02/26/2024), and *Activity Director (hired 11/12/2024). Interview on 12/04/2024 at 1:07 p.m. with Administrator and DON stated CNA-K, CMA-L, CMA-M, CMA-N, CNA-O, Hospitality-P, CNA-Q, Hospitality-R, Dietary Manger, and Activity Director did not complete their mandatory QAPI annual training. Further interview with DON stated because the facility Human Resources staff was on vacation at this time, the facility did not know what reason the staff did not take the QAPI annual training. It was Human Resources staff's responsibility, but the staff had just promotion recently to Human Resources from CNA position. The staff might be catching all missing trainings. The possible negative outcome was that they might not know what QAPI was.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. 39049 Based on interview and record review, the facility failed to ensure compliance and ethics training was completed for 10 of 19 employees (CNA-K, CMA-L, CMA-M, CMA-N, CNA-O, Hospitality-P, CNA-Q, Hospitality-R, Dietary Manger, and Activity Director) reviewed for orientation training. The facility failed to ensure that CNA-K, CMA-L, CMA-M, CMA-N, CNA-O, Hospitality-P, CNA-Q, Hospitality-R, Dietary Manger, and Activity Director had completed their mandatory ethics training. This failure could affect residents and place them at risk of poor care or victimization due to lack of staff training. Findings included: Record review of the annual staff training information revealed the following staff had not completed their mandatory ethics annual training requirement t: *CNA-K (hired 11/02/2023), *CMA-L (hired 05/09/2023), *CMA-M (hired 11/14/2019), *CMA-N (hired 01/18/2021), *CNA-O (hired01/13/2021), *Hospitality-P (hired09/23/2023), *CNA-Q (hired08/07/2023), *Hospitality-R (hired11/22/2022), *Dietary Manger (02/26/2024), and *Activity Director (hired 11/12/2024). Interview on 12/04/2024 at 1:07 p.m. with Administrator and DON stated CNA-K, CMA-L, CMA-M, CMA-N, CNA-O, Hospitality-P, CNA-Q, Hospitality-R, Dietary Manger, and Activity Director did not complete their mandatory ethics annual training. Further interview with DON stated because the facility Human Resources staff was on vacation at this time, the facility did not know what reason the staff did not take the ethics annual training. It was Human Resources staff's responsibility, but the staff had just promotion recently to Human Resources from CNA position. The staff might be catching all missing trainings. The possible negative outcome was that they might not know the procedures for resolving issues in the facility or how to deal with residents in an appropriate manner.