STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676278	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pecan Bayou Nursing and Rehabilitation	2700 Memorial Park Dr Brownwood, TX 76801

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on interviews and record review, the facility failed to immediately consult with the physician of a significant change in the resident's physical, mental, psychosocial status; or a need to alter treatment significantly for 1 (Resident #63) of 4 residents reviewed for physician notification. The facility failed to notify the physician of change of condition which led to Resident #63 going into respiratory and cardiac arrest and was pronounced dead after transfer to the hospital on [DATE]. An Immediate Jeopardy was identified on [DATE] at 2:40 pm. The IJ template was provided to the facility on [DATE] at 2:40 pm. While the IJ was removed on [DATE] at 3:18 pm, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm due to the facility's need to continue to monitor the implementation and effectiveness of their corrective systems. This failure placed residents at risk for not receiving emergency care and further life-saving treatments as desired, that could lead to serious illness, hospitalization , and/or death. Findings Include: Review of Resident #63's electronic face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included: fractured femur, breast cancer, and muscle weakness. Further review of the electronic face sheet revealed discharged [DATE] to acute care hospital. Review of Resident #63's Quarterly MDS assessment, dated [DATE], revealed a BIMS score of 15 which indicated no impaired cognition. Section I Active Diagnosis revealed Resident #63 had cancer and high blood pressure. Further review revealed no cardio or respiratory diagnosis. Review of Resident #63's care plan, initiated [DATE], revealed: Focus: Resident has a code status of Full Code/CPR. Goal: Resident wishes to be a Full Code/CPR will be honored. Interventions: If resident arrest CPR will be performed, 911/EMS called, MD/RP informed. Further review of care plan revealed no evidence of respiratory or cardiac issues and no evidence of the use of oxygen. Review of Resident #63's electronic physicians orders from [DATE] to [DATE], revealed no evidence of any oxygen orders. (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #63's electronic nurse's progress notes dated [DATE] at 9:00 pm, signed by LVN A, revealed: resident c/o feeling weak, pain to extremities, VS 97.8, 64, 20, ,d+[DATE], SPO2 81%@ RA, applied O2 @ 2lpm/NC, SPO2 up to 94%, respirations unlabored, administered PRN APAP#3 (Tylenol #3), resident drank approximately 240cc of H20, resident then vomited, VS remain 97.7,71, 20, ,d+[DATE], SpO2 93%@2lpm/NC. Review of Resident #63's electronic record from [DATE]-[DATE], revealed no evidence of any respiratory or lung assessments completed. Further review of Resident #63's record revealed no evidence of physician notification or change or condition. Review of Resident #63's electronic nurse's progress notes from [DATE] to [DATE] revealed no evidence of follow up assessments or monitoring after oxygen was administered. Review of Resident #63's electronic nurse's progress notes dated [DATE] at 05:00 am, signed by LVN A, revealed: resident has had no further Nausea/vomiting this shift, continues to c/o pain to BLE, VS remain stable, SpO2 ,d+[DATE]%@2lpm/NC, has drank approximately ,d+[DATE]cc of fluids this shift, alert, oriented, able to make needs known. Review of Resident #63's electronic nurse's progress notes dated [DATE] at 07:30 am, signed by RN B, revealed: CNA came to nurse stating resident not responding-this nurse entered room resident not breathing-not responding to verbal or tactile stimulation-RN call for help CPR initiated and LVN called 911-7:35 ems arrived, and CPR continued - MD/[family member] notified-8am ems departed with resident cpr still in progress. Review of Resident #63's electronic nurse's progress notes dated [DATE] at 10:43 am, signed by RN B revealed: Hospital notified states resident expired. Review of Resident #63's hospital clinical record dated [DATE], revealed: 8:21 am CPR was continued on arrival to emergency room without any change. 8:32 am expired due to cardiac and respiratory arrest During an interview on [DATE] at 3:30 pm, the DON stated the physician, and the family should have been notified on [DATE] at 9:00 pm when Resident #63 had a change of condition requiring oxygen placement. She stated a change of condition assessment should have been completed. The DON stated Residents #63 should have been monitored closely throughout the night. She stated she did not feel that it was a significant enough change for her to have been notified. The DON stated she felt that the nurse had probably notified the doctor and just forgot to document it. She stated it was probably just a hectic night and the nurse forgot to document her assessments and any further monitoring throughout the night. The DON stated CNA F no longer worked at the facility. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 4:00 pm, the Physician stated she was notified on [DATE] that Resident #63 had coded and was sent to the emergency room . She stated she was not notified the night before of the resident change in condition and requiring oxygen. The physician stated she expected to be notified of any change of condition and that any resident who previously did not require oxygen and then does was considered a significant change in condition. She said she would have sent Resident #63 to the emergency room or at least started treatment on the night of ,d+[DATE] had she been notified because she had already discussed this with Resident #63 and the resident wanted aggressive treatment. The Physician stated it was a delay in care and she could have been treated 10 hours earlier possibly preventing the code and the death. During an interview on [DATE] at 4:45 PM, LVN A stated Resident #63 had a low blood pressure and low oxygen saturation on ,d+[DATE] at 9:00 pm. She stated she applied oxygen, and that Resident #63 had a prn oxygen order. She stated she texted the physician but did not get a reply, but she was not concerned because she did not feel that anything was wrong with Resident #63. She stated she did not perform a lung assessment because the resident did not seem distressed. She stated she did not consider it a change in condition and did not complete a change in condition assessment. She stated she and her CNA did check on the resident throughout the night, but she just forgot to document it. During an interview on [DATE] at 5:02 PM, RN B stated she was notified of nurse aides that Resident #63 was found unresponsive at the time of shift change. During an interview on [DATE] at 5:04 PM, CNA H stated she walked into Resident #63's room, found resident non-responsive, and notified RN B immediately. She stated this occurred at shift change. During an interview on [DATE] at 1:56 PM, the ADMN stated her expectation was to call the physician with any change of condition. She stated if a residents oxygen level decreased and staff was having to address that, staff should have contacted the physician and the DON, but only if the resident needed orders outside of resident's parameter orders. Attempted interview on [DATE] at 11:09 AM with CNA F who worked on the night of [DATE] and she did not answer. During an interview on [DATE] at 01:00 PM, CNA G stated she worked the night of [DATE] and was aware of Resident #63's episode at 9:00 pm. She stated she notified LVN A that the resident was having difficulty breathing and the nurse applied oxygen to the resident. She stated she was not in charge of care for that resident and was unaware of her status the rest of the night. She stated CNAs did not document every 2 hours. She stated they complete once a shift documentation. CNA stated there was no way to prove that residents were rounded on every 2 hours. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the policy titled, Change in a Resident's Condition or Status, last revised [DATE] read in part: Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status. Policy Interpretation and Implementation: 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a (an): .d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly .2. A significant change of condition is a major decline or improvement in the resident's statue that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions .3. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provide, including information prompted by the Interact SBAR Communication Form. Record review of the policy titled, Oxygen Administration, last revised [DATE] read in part: Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident . Assessment: Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 1. Signs or symptoms of cyanosis; 2. Signs or symptoms of hypoxia; .4. Vital signs; 5. Lung sounds .Procedure .13. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated . This was determined to be an Immediate Jeopardy on [DATE] at 2:40 PM. The ADMIN was notified. The ADMIN was provided with the IJ template on [DATE] at 2:40 PM. The following Plan of Removal was submitted by the facility was accepted on [DATE]at 1:06 PM: Impact Statement: On [DATE] an abbreviated survey was initiated. On [DATE] the facility was provided notification that the Survey Agency has determined that the conditions at the center constitute Immediate Jeopardy to resident health due to failure to identify and provide treatment and care to resident #1. How were other residents at risk to be affected by this deficient practice identified? The facility DON and nurse management team completed an audit to address potential change of conditions on all residents using the ,d+[DATE]-hour report on [DATE]. All residents had the potential to be affected by this deficient practice, no other residents were identified as being affected. What corrective actions have been implemented for the identified resident? Resident #1 no longer resides in the building as of [DATE]. What corrective actions were taken? 1. The following actions were initiated immediately on [DATE] (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	g. Newly hired staff, agency, and PRN staff will be trained on the stop and watch tools, changes in condition, verification of orders, notification to physician during orientation by the DON or designee. Staff unable to come to receive training will be required to completed training before their next scheduled shift. The physician will be notified via telephone, if no response the nurse will call the DON and/or Administrator and the Medical Director will be notified. The notification will be documented in the resident medical record. Quality Assurance An impromptu Quality Assurance and Performance Improvement review of the plan of removal was completed on [DATE] with the Medical Director. The Medical Director has reviewed and agrees with this plan. Monitoring of the facility's Plan of Removal through interviews and record reviews from [DATE] at 1:06 pm through [DATE] at 3:00 pm revealed: During an interview on [DATE] at 01:51 PM, the DON stated she ran 24-hour report and ran an order listing report that would encompass all new orders. She stated looked at all residents' vital signs including weight and nurses' documentation to identify residents who were at risk. She stated that any change of condition including administering O2, staff would have to contact MD with changes and then anything that was not normal had to be documented as MD notified. The DON stated if there was not an answer from doctor then they would continue to try to contact and if they could not get ahold of the physician then nurses will contact DON or ADMN to notify the Medical Director. She stated the Medical Directors had been notified of POR and the Medical Directors have been notified that if staff were unable to reach attending, then she would be notified. The DON stated changes in condition would be discussed in morning meeting and be documented on a 24-hour report with VS, falls, and new orders in the clinical meeting and everything from previous day would be reviewed. The DON stated she would monitor that the in-services were effective by looking at the dashboard on PCC to see if alerts have been cleared out. She stated she would monitor that physicians were being notified by monitoring nurses notes to verify that change in condition was followed up on. The DON stated she had remote access to PCC. She stated the weekend supervisor would be the DON and ADON every weekend and that one of them would look at the reports and monitor/review ,d+[DATE]-hour report from PCC. During random interviews via phone on [DATE] at 1:15 PM, revealed 2 Licensed Nurse and 1 Registered Nurse who worked the 12-hour night shift had been educated regarding change of condition and notifying the physician of changes. During random interviews on [DATE] at 2:15 PM, revealed 1 Licensed Nurse and 1 Registered Nurse who worked the 12-hour day shift had been educated regarding change of condition and notifying the physician of changes. Review of written in-service initiated on [DATE] about Change of Condition - Administering O2 - Contacting MD & RP's with changes - Stop n watch - Monitoring after the change of condition - documentation ensure change is on 24 hour report - care planning - monitor nurse alerts require monitoring & documentation. Notify the MD - call - if no answer the nurse will notify DON and/or Administrator and the Medical Director will be notified - Must be documented in the Medical Record. Verified all nurses' signatures on in-service. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During random interviews via phone on [DATE] at 1:15 PM, revealed 3 CNAs, who worked the 12-hour night shift had been educated regarding the importance of completing stop and watch forms when there are changes of condition noticed in residents. During random interviews on [DATE] at 2:15 PM revealed 2 CNAs, who worked the 12-hour night shift had been educated regarding the importance of completing stop and watch forms when there are changes of condition noticed in residents. Review of written in-service initiated on [DATE] with CNAs titled Change of condition- Stop N Watch, with 27 signatures. Review on [DATE] at 01:51 PM, revealed QAPI Signature page with: ADMN and MD signatures on [DATE] and DON, ADON, Payroll, BOM, Housekeeping, Maintenance Director, Medical Records, Nutrition Services, Rehab Services Director, Social Service, and Activity Director signatures on [DATE]. The ADMIN was informed that the Immediate Jeopardy was removed on [DATE] at 3:18 PM. The facility remained out of compliance at a scope of isolated with no actual harm, due to the facility's need to continue to monitor the implementation and effectiveness of their corrective systems that were put into place.

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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** 44728 Based on observation, interview, and record review the facility failed to review and revise resident's comprehensive care plancs by the interdiscplianry team after each assessment 3 (Residents #13, #22 and #33) of 16 residents reviewed for comprehensive care plans. The interdisciplinary team failed to review and revise the plan of care for Residents #13, #22 and #33. These failures could affect residents by placing them at risk for not having their individual needs met. Findings included: Resident #13 Record review of Resident #13's Face sheet dated 07/24/2024 revealed an [AGE] year-old female, with an initial admitted to the facility on [DATE]. Resident #13 had a diagnoses of obstructive sleep apnea and anxiety. Record review of Resident #13's Physician orders dated 05/13/2024 revealed: O2 sats every shift and as needed. O2 at 2-4 liter/minute via nasal cannula. Record review of Resident #13's MDS dated [DATE], Section C under Cognitive Patterns revealed a BIMS score of 00 (severely impaired). Record review of Resident #13's Care Plan with the last review dated 07/18/2024 revealed, no evidence of Oxygen use via nasal cannula. During an observation on 07/23/2024 at 8:42 AM, Resident #13 had Oxygen on via nasal cannula. Resident #22 Record review of Resident #22's Face sheet dated 07/24/2024 revealed an [AGE] year-old male, with an initial admitted to the facility on [DATE]. Resident #22 had a diagnoses of muscle weakness, person injured in collision between other specified motor vehicle, displaced fracture of olecranon process without intraarticular extension of left ulna (elbow fracture) and unsteadiness on feet. Record review of Resident #22's Physician orders dated 07/24/2024 revealed: WBAT to LLE with fx boot and WBAT to LUE with a start date of 07/08/2024. Record review of Resident #22's MDS dated [DATE] Section C under Cognitive Patterns revealed a BIMS score of 14 (cognitively intact). (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 Resident #22's Care Plan initiated 06/11/2024 revealed there were no splints or braces Care Planned. During on observation and interview on 07/23/24 at 04:24 PM, Resident #22 had a back brace and left ankle boot on. The resident stated he only wore his brace and boot when he was out of bed. Resident #33 Record review of Resident #33's Face sheet dated 07/24/2024 revealed a [AGE] year-old female, with an initial admitted to the facility on [DATE] and a most recent admitted [DATE]. Resident #33 had a diagnoses of acute and chronic respiratory failure and congestive heart failure. Record review of Resident #33's Physician orders dated 07/24/2024 revealed: O2 at 2 liters/minute via nasal cannula continuously with a start date of 05/18/2023. Record review of Resident #33's MDS dated , 06/13/2024 Section C under Cognitive Patterns revealed a BIMS score of 15 (cognitively intact). Record review of Resident #33's Care Plan date initiated 11/06/2019 and a revision date of 12/20/2023 revealed: Focus-The resident has altered respiratory status/difficulty breathing r/t heart failure. Goal- the resident will maintain normal breathing pattern as evidenced by normal skin color, and regular respiratory rate/pattern through the review date. Interventions O2 saturation every shift, apply as needed O2 if > (greater) or = (equal) to 90 % (percent) every shift. During an observation on 07/22/2024 at 4:02 PM, Resident #33 was wearing O2 via nasal cannula. During an interview on 07/25/24 at 8:30 AM the DON stated, if there were an order for O2 and braces, they should have been care planned as well as being measurable. She stated Resident #33's Care Plan was not person centered or measurable and was a typo and could be corrected. The DON stated the DON, MDS, and ADON was in charge of monitoring the care plans although the ADON and the MDS were new to the facility. She stated there was no negative impact or outcome for residents not having the O2 in their care plan as well as the braces. The DON stated the residents were still getting the proper care they needed and was only the paperwork that was not correct. She stated she would have to look at each case to if there were a failure, but if it were late at night, the failure would have been the residents nurse that failed to update the care plan. The DON stated her expectations were for all care plans to be updated when needed. During an interview 07/25/24 at 10:38 AM, the previous facility MDS Coordinator stated If there were an order for O2 or braces it should have been care planned as well have been resident centered. During an interview on 07/25/24 at 11:23 AM, LVN-E stated the nurses looked at care plans in the EMR and if it needed to be updated, they could have done that. She stated they then would have always notified the DON for any and all changes they made. (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 07/25/24 at 3:14 PM LVN-D stated she still worked on resident care plans and felt it was still her responsibility to keep them up to date. She stated she had been out of the facility for two weeks and could log into the resident EMR from her home, but she had been too busy to do so. LVN-D stated if she were still full time at the facility, the protocols and policies were to review the MDS's and then updated the care plans as needed or with significant change. LVN-D stated staff had morning meetings as well and if there were any changes voiced, the care plans would need to be reviewed and updated. During an interview on 07/25/24 at 3:39 PM the MDS Corporate Consultant stated the care plans were to be reviewed quarterly and updated as needed. She stated if there were an order for O2 and/or braces, those orders should have been care planned. The MDS Corporate Consultant stated the staff as a whole should have monitored the residents care plans. She stated she felt there was no negative impact for residents if not care planned as the nurses went by the resident orders and not the care plans. She stated she had no idea what the failure might have been. The MDS Corporate Consultants expectations were that the care plans should be reviewed upon admission, quarterly and as needed. Review of facility Policy titled Care Plans, Comprehensive Person-Centered dated December 2016 revealed: Policy: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is develop and implemented for each resident. Policy Interpretation and Implementation: 8. the comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; e. Include the resident's stated goals upon admission and desired outcomes; . 13. Care plans are revised as information about the residents and the residents' conditions change.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on interview, and record review the facility failed to ensure a resident received the necessary treatment and services, consistent with professional standards of practice for 1 of 4 residents (Resident #63) reviewed for hospitalization s. LVN A failed to recognize Resident #63 was having a change in condition when her oxygen saturation was low, she required supplemental oxygen, she vomited, and complained of pain, and no additional assessments of her condition were provided including follow-up assessments of her vital signs. The facility failed to provide basic quality of care to prevent Resident #63 from going into respiratory and cardiac arrest. The resident was pronounced dead after transfer to the hospital on [DATE]. An Immediate Jeopardy (IJ) situation was identified on [DATE] at 2:40 PM. While the IJ was removed on [DATE] at 3:18 PM, the facility remained out of compliance at a scope of isolated with actual harm that is not immediate jeopardy, due to the facility's need to continue to monitor the implementation and effectiveness of their corrective systems. This failure placed residents at risk for not receiving emergency care and further life-saving treatments as desired, that could lead to serious illness, hospitalization , and/or death. Findings Include: Review of Resident #63's electronic face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included: fractured femur, breast cancer, and muscle weakness. Further review of electronic face sheet revealed discharged [DATE] to acute care hospital. Review of Resident #63's Quarterly MDS assessment, dated [DATE], revealed a BIMS score of 15 which indicated no impaired cognition. Section I Active Diagnosis revealed Resident #63 had cancer and high blood pressure. Further review revealed no cardio or respiratory diagnosis. Review of Resident #63's care plan, initiated [DATE], revealed: Focus: Resident has a code status of Full Code/CPR. Goal: Resident wishes to be a Full Code/CPR will be honored. Interventions: If resident arrest CPR will be performed, 911/EMS called, MD/RP informed. Further review of care plan revealed no evidence of respiratory or cardiac issues and no evidence of the use of oxygen. Review of Resident #63's electronic physicians orders from [DATE] to [DATE], revealed no evidence of any oxygen orders. Review of Resident #63's electronic nurse's progress notes dated [DATE] at 9:00 pm, signed by LVN A, revealed: resident c/o feeling weak, pain to extremities, VS 97.8, 64, 20, ,d+[DATE], SPO2 81%@ RA, applied O2 @ 2lpm/NC, SPO2 up to 94%, respirations unlabored, administered PRN APAP#3 (Tylenol #3), resident drank approximately 240cc of H20, resident then vomited, VS remain 97.7,71, 20, ,d+[DATE], SpO2 93%@2lpm/NC. (continued on next page)

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	676278	A. Building B. Wing	07/26/2024

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #63's electronic record from [DATE]-[DATE], revealed no evidence of any respiratory or lung assessments completed. Further review of Resident #63's record revealed no evidence of physician notification or change or condition. Review of Resident #63's electronic nurse's progress notes from [DATE] to [DATE] revealed no evidence of follow up assessments or monitoring after oxygen was administered. Review of Resident #63's electronic nurse's progress notes dated [DATE] at 05:00 am, signed by LVN A, revealed: resident has had no further Nausea/vomiting this shift, continues to c/o pain to BLE, VS remain stable, SpO2 ,d+[DATE]%@2lpm/NC, has drank approximately ,d+[DATE]cc of fluids this shift, alert, oriented, able to make needs known. Review of Resident #63's electronic nurse's progress notes dated [DATE] at 07:30 am, signed by RN B, revealed: CNA came to nurse stating resident not responding-this nurse entered room resident not breathing-not responding to verbal or tactile stimulation-RN call for help CPR initiated and LVN called 911-7:35 ems arrived, and CPR continued - MD/[family member] notified-8am ems departed with resident cpr still in progress. Review of Resident #63's electronic nurse's progress notes dated [DATE] at 10:43, signed by RN B revealed: Hospital notified states resident expired. Review of Resident #63's hospital clinical record dated [DATE], revealed: 8:21 am CPR was continued on arrival to emergency room without any change. 8:32 am expired due to cardiac and respiratory arrest During an interview on [DATE] at 3:30 pm, the DON stated the physician, and the family should have been notified on [DATE] at 21:00 when Resident #63 had a change of condition requiring oxygen placement. She stated a change of condition assessment should have been completed. DON stated Residents #63 should have been monitored closely throughout the night. She stated she did not feel that it was a significant enough change for her to have been notified. DON stated she felt that the nurse had probably notified the doctor and just forgot to document it. She stated it was probably just a hectic night and the nurse forgot to document her assessments and any further monitoring throughout the night. DON stated CNA F no longer worked at the facility. During an interview on [DATE] at 4:00 pm, the Physician stated she was notified on [DATE] that Resident #63 had coded and was sent to the emergency room . She stated she was not notified the night before of the resident change in condition and requiring oxygen. The physician stated she expected to be notified of any change of condition and that any resident who previously did not require oxygen and then does is considered a significant change in condition. She said she would have sent Resident #63 to the emergency room or at least started treatment on the night of ,d+[DATE] had she been notified because she had already discussed this with Resident #63 and the resident wanted aggressive treatment. Physician stated it was a delay in care and she could have been treated 10 hours earlier possibly preventing the code and the death. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 4:45 PM, LVN A stated Resident #63 had a low blood pressure and low oxygen saturation on ,d+[DATE] at 9:00 pm. She stated she applied oxygen, and that Resident #63 had a prn oxygen order. She stated she texted the physician but did not get a reply, but she was not concerned because she did not feel that anything was wrong with Resident #63. She stated she did not perform a lung assessment because the resident did not seem distressed. She stated she did not consider it a change in condition and did not complete a change in condition assessment. She stated she and her CNA did check on the resident throughout the night, but she just forgot to document it. During an interview on [DATE] at 5:02 PM, RN B stated she was notified of nurse aides that Resident #63 was found unresponsive at the time of shift change. During an interview on [DATE] at 5:04 PM, CNA H stated she walked into Resident #63's room, found resident non-responsive, and notified RN B immediately. She stated this occurred at shift change. During an interview on [DATE] at 1:56 PM, the ADMN stated her expectation was to call the physician with any change of condition. She stated if a residents oxygen level decreased and staff was having to address that, staff should have contacted the physician and the DON, but only if the resident needed orders outside of resident's parameter orders. Attempted interview on [DATE] at 11:09 AM with CNA F who worked on the night of [DATE] and she did not answer. During an interview on [DATE] at 01:00 PM, CNA G stated she worked the night of [DATE] and was aware of Resident #63's episode at 9:00 pm. She stated she notified the nurse that the resident was having difficulty breathing and the nurse applied oxygen to the resident. She stated she was not in charge of care for that resident and was unaware of her status the rest of the night. She stated CNAs did not document every 2 hours. She stated they complete once a shift documentation. CNA stated there is no way to prove that residents were rounded on every 2 hours. Record review of policy titled, Change in a Resident's Condition or Status, last revised [DATE] read in part: Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status. Policy Interpretation and Implementation: 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a (an): .d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly .2. A significant change of condition is a major decline or improvement in the resident's statue that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions .3. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provide, including information prompted by the Interact SBAR Communication Form. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of policy titled, Oxygen Administration, last revised [DATE] read in part: Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident . Assessment: Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 1. Signs or symptoms of cyanosis; 2. Signs or symptoms of hypoxia; .4. Vital signs; 5. Lung sounds .Procedure .13. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated . This was determined to be an Immediate Jeopardy on [DATE] at 2:40 PM. The ADMIN was notified. The ADMIN was provided with the IJ template on [DATE] at 2:40 PM. The following Plan of Removal was submitted by the facility was accepted on [DATE] at 1:06 PM: Impact Statement: On [DATE] an abbreviated survey was initiated. On [DATE] the facility was provided notification that the Survey Agency has determined that the conditions at the center constitute Immediate Jeopardy to resident health due to failure to identify and provide treatment and care to resident #1. How were other residents at risk to be affected by this deficient practice identified? The facility DON and nurse management team completed an audit to address potential change of conditions on all residents using the ,d+[DATE]-hour report on [DATE]. All residents had the potential to be affected by this deficient practice, no other residents were identified as being affected. What corrective actions have been implemented for the identified resident? Resident #1 no longer resides in the building as of [DATE]. What corrective actions were taken? 3. The following actions were initiated immediately on [DATE] h. On [DATE] an audit was completed by the DON and/or designee to identify all residents who were at risk for having a change in condition in last 30days related to their disease process including reviewing all Oxygen orders in last 30days. No residents were identified to be affected. DON and ADON were educated on [DATE] by CSD (Clinical Service Director) on identification of change of condition, e-interact stop and watch tool, and notification to physician when changes of condition are observed in residents. Change in condition will be reported/monitored with the Stop and Watch tool and SBAR. When a change in condition has been identified it will be placed on the shift-to-shift charge nurse report and also reported in the morning clinical meeting by the charge nurse. The physician will be notified via telephone, if no response the nurse will call the DON and/or Administrator and the Medical Director will be notified. The notification will be documented in the resident medical record. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	i. On [DATE] an in-service was initiated for all Licensed Nurses, on change of condition, notifying the physician of changes. All staff who are unable to attend will be required to complete training before their next scheduled shift. Inservice was completed on [DATE] and will be monitored and review for effectiveness by DON During QAPI. The physician will be notified via telephone, if no response the nurse will call the DON and/or Administrator and the Medical Director will be notified. The notification will be documented in the resident medical record. j. On [DATE] an in-service was initiated for all staff by the DON and/or designee on the importance of completing stop and watch forms when there are changes of condition noticed in residents. All nursing staff unable to attend will be required to complete training before their next scheduled shift. Inservice was completed on [DATE] and will be monitored and review for effectiveness by DON During QAPI. 4. How will the system be monitored to ensure compliance? k. The ADON, DON and/or designee will review the facilities ,d+[DATE]-hour summary report in PCC 5 days per week in the morning clinical meeting starting on [DATE] for 4 weeks and then ongoing to identify any resident who has had a change in condition or has symptoms that may trigger an acute decline requiring medical attention. Licensed and trained nursing staff will ensure the physician has been notified and interventions implemented. Any identified concerns will be addressed immediately, and additional training will be provided as needed. The physician will be notified via telephone, if no response the nurse will call the DON and/or Administrator and the Medical Director will be notified. The notification will be documented in the resident medical record. l. The DON and Nurse Manager will review all stop and watch forms completed by all staff in morning meetings to help identify observed changes in condition and to ensure the physician has been notified. Starting on [DATE] and will be ongoing. The physician will be notified via telephone, if no response the nurse will call the DON and/or Administrator and the Medical Director will be notified. The notification will be documented in the resident medical record. m. The weekend supervisor and/or designee was in-serviced on [DATE] by DON on how to review the , d+[DATE]-hour report from PCC and the stop and watch tools on Saturdays and Sundays to ensure that any residents with a change in condition are identified. Nursing staff will contact the physician and ensure appropriate orders and interventions are in place. The physician will be notified via telephone, if no response the nurse will call the DON and/or Administrator and the Medical Director will be notified. The notification will be documented in the resident medical record. n. Newly hired staff, agency, and PRN staff will be trained on the stop and watch tools, changes in condition, verification of orders, notification to physician during orientation by the DON or designee. Staff unable to come to receive training will be required to completed training before their next scheduled shift. The physician will be notified via telephone, if no response the nurse will call the DON and/or Administrator and the Medical Director will be notified. The notification will be documented in the resident medical record. Quality Assurance (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review on [DATE] at 01:51 PM, revealed QAPI Signature page with: ADMN and MD signatures on [DATE] and DON, ADON, Payroll, BOM, Housekeeping, Maintenance Director, Medical Records, Nutrition Services, Rehab Services Director, Social Service, and Activity Director signatures on [DATE]. The ADMIN was informed that the Immediate Jeopardy was removed on [DATE] at 3:18 PM. The facility remained out of compliance at a scope of isolated with no actual harm, due to the facility's need to continue to monitor the implementation and effectiveness of their corrective systems that were put into place.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of 1 of 16 resident (Resident #118) reviewed for expired medications. The B Hall medication cart contained Promethazine cream with an expiration date of 06/28/2024 for Resident #118 who did not have an order for the medication. This failure could place residents at risk of exposure to medications and/or biologicals that are expired and/or contaminated. Findings include: Review of the electronic face sheet for Resident #118 revealed an admitted [DATE]. Resident was a [AGE] year-old female with diagnoses of dementia, high blood pressure, and overactive bladder. Review of the electronic physician's orders for Resident #118 revealed no orders for Promethazine cream. During on observation on 07/22/2024 at 09:25 AM of the B Hall medication cart Further observation revealed Promethazine cream with an expiration date of 06/28/2024 for Resident #118. During an interview on 07/22/24 at 01:33 PM, RN-C stated expired or discontinued medications should be removed from the medication cart immediately. She stated it was the medications nurse's responsibility to check the medication cart daily and prior to giving medications for expiration dates. During an interview on 07/23/24 at 10:00 AM, the DON stated all expired and discontinued medications should have been removed from the medication carts immediately. The DON stated it was the nurse's responsibility to check medications and carts routinely for expired medications. She stated it was ultimately her responsibility to ensure this is done. During an interview on 07/24/24 at 10:35 AM, the Administrator stated the issue with the expired medications was related to resident being in the facility for respite care and hospice services and providing their own medications. She stated the nurses should have checked expiration dates prior to accepting the medications and placing them in the medication cart. Review of the policy titled, Storage of Medications, last revised April 2007 read in part: Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 1, Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received .2. The nursing staff shall be responsible for maintain medication storage .3. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions for 1 of 3 medication carts (Hall B medication cart) reviewed for medication labeling and storage. The B Hall medication cart contained two Fiasp flex pen insulins for Resident #116 with no pharmacy label. The B Hall medication cart contained one Novolin R flex pen insulin for Resident #23 with no pharmacy label. These failures could place residents at risk of receiving the wrong medications. Findings Included: Review of the electronic face sheet for Resident #116 revealed an admitted [DATE]. Resident was an [AGE] year-old female with a diagnosis of diabetes, dementia, and irregular heartrate. Review of the electronic physician's orders for Resident #116 revealed orders for Fiasp Injection Solution 100 UNIT/ML Inject as per sliding scale: if 0 - 70 Notify MD and start hypoglycemic protocol; 71 - 200 = 0; 201 - 250 = 3 units; 251 - 300 = 5 units; 301 - 360 = 7 units; 361 - 499 = 8 units; 500 - 600 = 8 units Notify MD, subcutaneously. Review of the electronic face sheet for Resident #23 revealed an admitted [DATE]. Resident was a [AGE] year-old female with a diagnosis of diabetes, depression, and seizures. Review of the electronic physician's orders for Resident #23 revealed orders for NovoLIN R FlexPen Injection Solution Pen-injector 100 UNIT/ML Inject as per sliding scale: if 121 - 150 = 2 units if 0-70=0 Follow hypoglycemic protocol, notify MD; 151 - 200 = 3 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units 400+ give 10 units Notify MD, subcutaneously before meals. During on observation on 07/22/2024 at 09:25 AM of the B Hall medication cart, two Fiasp flex pen insulins for Resident #116 had no pharmacy label and one Novolin R flex pen insulin for Resident #23 had no pharmacy label. During an interview on 07/22/24 at 01:33 PM, RN-C stated the unlabeled insulin pens were residents home medications and that both residents were there just for 5 days on respite care and wanted to use their own medications. (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 07/23/24 at 10:00 AM, the DON stated the unlabeled insulins had been an issue the facility has been working on. She stated the pharmacy won't label any medication that they did not fill. She stated that when residents want to use their own medications, they must let them. The DON stated that per policy all prescription medications must be properly labeled by a pharmacy. The DON stated it was the nurse's responsibility to check medications and carts routinely for miss labeled medications. She stated it was ultimately her responsibility to ensure this is done. During an interview on 07/24/24 at 10:35 AM, the Administrator stated the issue with the unlabeled medications was related to resident being in the facility for respite care and hospice services and providing their own medications. She stated the nurses should have checked to ensur all medications were properly labeled prior to accepting the medications and placing them in the medication cart. Review of the policy titled, Storage of Medications, last revised April 2007 read in part: Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 1, Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received .2. The nursing staff shall be responsible for maintain medication storage .3. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48883 Based on observations, interviews, and record reviews the facility failed to properly store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed. The facility failed to ensure foods were sealed and/or labeled properly in freezer and dry storage. The facility failed to ensure all food was not past expiration date. These failures could place residents that eat out of the kitchen at risk for food borne illnesses. The findings included: During an observation on [DATE] between 9:45 AM and 10:10 AM of the kitchen revealed: Refrigerator #1 1. One unopened container of sour cream with a best by date of [DATE]. Dry Storage 1. One package of breadcrumbs with open date of [DATE] sitting in a see through bag that was unsealed, and food exposed to air. Freezer 1. Two packages of cake that were sealed and out of original package with no item description or date. During an interview on [DATE] at 10:07 AM, the DM stated items stored outside of the original container should be labeled with item description and date on it. She stated the item in freezer was angel food cake. She stated items in the dry storage should be sealed. The DM stated she expected for items in refrigerator to not be expired. She stated she monitors that food was stored properly. She did not know why there was expired goods, unlabeled goods and open to air goods being stored. She stated that improper storing of food could cause residents to become sick. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676278	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pecan Bayou Nursing and Rehabilitation	2700 Memorial Park Dr Brownwood, TX 76801

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 5:03 PM, the ADMN stated she expected food to be stored out of original containers to be labeled and dated. She stated all expired goods should be discarded and all food items to be sealed. She stated facility contracts dietary staff and the DM along with other contracted agency staff monitor that food was stored correctly. The ADMN stated she and other cooperate staff also monitor that food was stored correctly. She did not know why items were stored incorrectly. She stated the DM does check food items and had been diligent in checking dates during the DM's rounds. She stated if food was not stored properly, it had potential to have a negative impact on the residents. She did not state what that negative impact would be but stated that residents should not eat spoiled food. She stated that every resident did eat out of the dining room unless outside food was brought into facility by that resident's family members. Record review of the facility policy titled, Food Storage: Cold Foods dated ,d+[DATE] revealed: All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. Record review of the facility policy titled, Food Storage: Dry Goods dated ,d+[DATE] revealed: The Dining Services Director or designee regularly inspects the dry storage area to ensure it is well lit, well ventilated and not subject to sewage or wastewater back flow or contamination by condensation, leakage, rodents or vermin. All packaged and canned food items will be kept clean, dry, and properly sealed. Storage areas will be neat, arranged for easy identification, and date marked as appropriate. Review of the FDA Food Code 2022 https://www.fda.gov/food/retail-food-protection/fda-food-code accessed [DATE] revealed: ,d+[DATE].11 Food Labels. (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) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement. (2) If made from two or more ingredients, a list of ingredients and sub-ingredients in descending order of predominance by weight, including a declaration of artificial colors, artificial flavors and chemical preservatives, if contained in the FOOD. (3) An accurate declaration of the net quantity of contents. (4) The name and place of business of the manufacturer, [NAME], or distributor; and (5) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or usual name of the respective ingredient. Pf (6) Except as exempted in the Federal Food, Drug, and Cosmetic Act S 403(q)(3) - (5), nutrition labeling as specified in 21 CFR 101 - Food Labeling and 9 CFR 317 Subpart B Nutrition Labeling. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(7) For any salmonid FISH containing canthaxanthin or astaxanthin as a COLOR ADDITIVE, the labeling of the bulk FISH container, including a list of ingredients, displayed on the retail container or by other written means, such as a counter card, that discloses the use of canthaxanthin or astaxanthin. Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48883 Based on observation, interview and record review the facility failed to adequately provide a communication system that would relay a call directly to staff or a centralized staff work are for 1(Resident #20) of 16 residents reviewed for resident call system. The facility failed to provide a working communication system, that was easily at reach, that would allow Resident #20 the ability to safely call for staff for assistance. This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they need support for daily living. The findings included: Record review of Resident #20's face sheet dated 07/23/2024 revealed [AGE] year-old female admitted on [DATE] with original admitted [DATE] with the following diagnoses: cerebral infarction (stroke), peripheral vascular disease (decreased blood flow to lower extremities), acquired absence of left leg above knee (left leg above the knee amputation), muscle weakness, abnormalities of gait and mobility, and aphasia following cerebral infarction (difficulty speaking following stroke). Record review of Resident #20's quarterly MDS dated [DATE] revealed Section C- Cognitive Patterns Resident #20 had a BIMS score of 05 (meaning severe cognitive impairment); Section GG-Functional Abilities and Goals revealed- Resident #20 used wheelchair for mobility and was dependent on staff for bed mobility and bed to chair transfer. Record review of Resident #20's care plan dated 06/26/2024 revealed Focus: Resident #20 is at risk for falls related to confusion, poor communication/comprehension, and unaware of safety needs with date initiated 10/19/2018; Goal: The resident will not sustain serious injury through the review date with date initiated 10/19/2018; Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance .The resident needs a safe environment with even floors free from spills and/or clutter, adequate glare-free light, a working and reachable call light with date initiated 10/19/2018. During an observation on 07/22/2024 at 03:57 PM, Resident #20's room did not have call light plugged into wall on her side of the room closest to window. During an observation on 07/23/2024 at 11:34 AM, Resident #20 was lying in bed with no call light plugged into wall or in reach of her bed. She did not answer any questions. During an observation on 07/23/2024 at 3:12 PM, Resident #20's room had call light plugged into wall and attached to her bed. Attempted phone interview on 7/23/2024 at 11:42 AM with Resident #20's responsible party who did not answer phone call. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/23/2024 at 3:25 PM, the Maintenance Director stated he was informed by RN C on 07/23/2024 around lunch time that Resident #20 did not have call light on her side of room. He stated he went to Resident #20's room right away and plugged in a call light. He stated he was not sure why Resident #20's side of her room did not have access to call light prior. He stated he was responsible for performing call light checks. During an interview on 07/23/2024 at 3:27 PM, RN C stated she was told by a CNA that Resident #20 did not have a call light in her room around lunch time. She could not remember who told her, but she reported to Maintenance Director at that time. She did not know why Resident #20 did not have call light on her side of the room. During an interview on 07/23/2024 at 3:30 PM, the DON stated she expected for all residents to have a call light. She did not know why Resident #20 did not have a call light on her side of the room. She stated there were no negative outcome to because she would not use call light anyway. She stated that CNAs check on Resident #20 frequently and she felt her needs were met. She did not know who monitored that call lights were in residents' rooms. During an interview on 07/23/2024 at 5:10 PM, the ADMN stated she expected for all residents to have call light in every resident's room and in reach of every resident. She stated Resident #20 would not use call light, but call light should be present on her side of the room. She stated everyone working in the building was responsible for ensuring call lights were available in all rooms and working. She stated the facility was already in-servicing staff and managers on her expectations. She did not know why Resident #20 did not have access to call light on her side of the room during observations on 7/22/2024 and 7/23/2024. During a follow up interview on 07/24/2024 at 10:29 AM, the ADMN stated Resident #20 had no incidents or falls since 2019 and did not feel she was negatively impacted from not having call light available on her side of room. Record review of the facility policy titled Answering the Call Light dated March 2012 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. Some residents may not be able to use their call light. Be sure you check these residents frequently. Report all defective call lights to the Nurse Supervisor promptly.